Suicide Prevention

Promising Strategies

Aboriginal Youth: A Manual of Promising Suicide Prevention Strategies

CENTRE FOR SUICIDE PREVENTION

Aboriginal Youth: A Manual of Promising Suicide Prevention Strategies

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Foreword

I feel very honoured to be asked to write a brief foreword for this timely and very useful manual. As an Aboriginal Psychologist and mental health consultant I have too often witnessed the devastating effects that a youth suicide has had on our communities. It is easy for mental health experts such as me to say that many of these deaths were preventable. It is, however, often the case that many of the suffering friends, families, and communities did not have the knowledge, resources, or confidence to deal with this problem.

Knowledge and resources can come from outside a family or community but confidence cannot. Without a sense of confidence or collective willingness to address this problem change is unlikely to occur. The solution to preventing youth suicide will not come from ignoring the problem nor will it come from "parachuting in" an outside expert who will always need to catch the 6pm flight home. I am firmly convinced that the 'secret' to suicide prevention is family and community involvement and commitment to trying as many strategies as is necessary to save the lives of our youth. It can happen and we will be the ones to do it.

Not all strategies will work for everyone as each community is different. That is why it is necessary to explore different strategies and adapt and modify them so that it fits the needs of your youth. Just as all communities are not the same, so it is that all youth are not the same. Communities need to have a wide selection of approaches to offer to their health workers, youth workers, families, school teachers etc.

This manual has been written for people who want to develop and implement suicide prevention programs. The authors have done their best to present this information in a positive, culturally respectful and straightforward way. Take what you can, modify it so it is more likely to work for you. It is important to note that this manual is only able to focus on the first important stage of addressing the suicide problem: prevention. It is hoped that future manuals might address later stages such as crisis management, treatment, and postvention.

The manual starts with a review of the literature of Aboriginal suicide prevention literature and provides some useful statistics and background information that may prove valuable to individuals who which to write a proposal to obtain funding for their prevention program. Some of the main preventative factors are discussed as well as other useful sections that will tell you how you will know when you are making a difference. Practical information such as program contact names and contact information is also provided. Successful projects are divided into categories such as community development, peer helpers, gatekeepers, self esteem building, family and youth support.

Although several strategies and cultural relevant and effective programs are described in this manual, they only represent a starting point. There exist many innovative and often simple strategies that have so far gone unnoticed. It is hoped that the readers of this manual will convince their communities to take action to find these ways that work. For it is only in taking such action that we as Aboriginal peoples will gain the confidence necessary to utilize our newly gained knowledge and resources to deal with this problem. On behalf of myself, the advisory, and the authors of this manual, I wish you success and courage in your efforts to assist our youth.

All my relations,

Dr. Rod McCormick
Mohawk Nation

Acknowledgements

The creation of this manual originated from two separate projects: the *Whitestone* workshop and the document *Before the Fact Interventions: A Manual of Best Practices in Youth Suicide Prevention (1998).*

White Stone is a five-day workshop for Aboriginal youth educators. Part of its research and design process included conducting a literature review and environmental scan across Canada. After compiling the best information possible, it was felt that the findings were unique and should be shared.

The work done in the *Before the Fact Interventions Manual* by Jennifer White and Nadine Jodoin provided an excellent model for presenting our new findings. Jennifer and Nadine agreed to adapt their original work and the draft of the new manual was reviewed by researchers and community caregivers from across the country.

With funding provided by the RCMP, National Aboriginal Policing Services, the project was coordinated by the Centre for Suicide Prevention.

This manual is the result of cooperative efforts and significant contributions made by many dedicated individuals. Thank you to the following people:

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Table of Contents

CHAPTER 1: ABOUT THIS MANUAL 1
Why did we write this manual? 1
How will this manual support your efforts? 2
Who was the manual written for? 3
How is the manual organized? 6
What this manual is not 6

CHAPTER 2: BACKGROUND: ABOUT THE PROBLEM OF SUICIDE AMONGST YOUNG ABORIGINAL PEOPLE 9
How many young Aboriginal people are dying by suicide in Canada? 9
Do statistics accurately reflect the problem of suicide in the Aboriginal population? 11
Are there any commonalities among Aboriginal youth who die by suicide? 11
Why is suicide such an issue for Aboriginal youth? 11
In closing 12
Suggested reading 13

CHAPTER 3: DEVELOPMENT OF A MODEL FOR UNDERSTANDING 15
Why should we be guided by a model? 15
A comprehensive look at youth suicide 15
A summary of risk and protective factors 17
Development of strategies 20
A focus on “before-the-fact” approaches 22
Pulling it all together 22
Suggested reading 24

CHAPTER 4: STRATEGIES IN SUICIDE PREVENTION AMONGST ABORIGINAL YOUTH 25
How did we decide what strategies to include in this manual? 25
What are the strategies? 27
How are the strategies presented? 28

Community renewal strategies 29
Cultural enhancement 29
Traditional healing practices 40
Community development 49
Interagency communication and coordination 64

Community education strategies 80
Peer helping 80
Youth leadership 97
Community gatekeeper training 109
Public communication and reporting guidelines 126
Means restriction 134

School strategies 147
School gatekeeper training 147
School policy 160
School climate improvement 172

Youth/family strategies 185
Self esteem building 185
Life skills training 197
Suicide awareness education 210
Family support 223
Support groups for youth 240

CHAPTER 5: A COMMUNITY-WIDE APPROACH TO SUICIDE PREVENTION 251

APPENDIX A: ABORIGINAL YOUTH: SUICIDE RISK AND PROTECTIVE FACTORS 265

APPENDIX B: GLOSSARY OF TERMS 277

Chapter 1: About This Manual

Why did we write this manual?

Youth suicide, in combination with other life-threatening behaviours, has become a significant issue for many Canadian Aboriginal communities. We know that overall suicide and suicide attempt rates are higher in Aboriginal youth as compared to the general population. Across Canada, the high rate of suicide amongst Aboriginal youth is having a devastating impact upon immediate and extended families, peers, as well as entire communities. All over the country, concerned community groups and individuals are trying to determine how best to manage and prevent further tragedies.

Despite the fact that youth suicide is a complex problem, we know that many of these deaths are preventable. In fact, several Aboriginal communities have already taken up the challenge and have been implementing a number of innovative and culturally-sensitive prevention initiatives. However, for many other individuals and groups, it remains challenging to determine the best approach to prevent youth suicide in their own communities. Even though research has been conducted within Aboriginal populations and a fair amount has been written on the topic, the information can be difficult to find or put into practice in a way that meets the particular needs of individual communities.

As a response, this manual was written to complement and guide the ongoing efforts of groups and individuals, such as yourself, who are interested in developing and implementing suicide prevention programs for Canada's Aboriginal youth. The purpose of the manual is to provide high quality and user-friendly advice and information in order to facilitate the development of successful programs. As such, the manual recommends a number of prevention strategies that follow the best evidence about what works and what should be done to prevent suicide amongst Aboriginal youth. By implementing proven and promising strategies in a timely and coordinated manner, we can make a difference in reducing the number of young people who choose to take their own lives.

The task of writing a manual that will be relevant to all Canadian Aboriginal communities is complicated because of the existence of multiple bands, distinct cultural areas, and different languages.

Referring to all these groups using the term Aboriginal may seem misleading given the wide diversity in cultural history, values, and lifestyles. While it is true that no two communities are alike, it is also true that Canadian Aboriginal people have much in common, especially in terms of their shared interests in increased self-determination and their common history of colonization and oppression – factors which are relevant for the prevention of suicide and other social problems.

The manual was written to reflect these common histories and current realities while remaining fairly generic. It is recommended that individual programs be planned to reflect the specific culture and conditions of the communities implementing them.

How will this manual support your efforts?

The manual will assist you and your group by:

- describing the problem of youth suicide among Canada's Aboriginal communities;
- presenting a model for understanding suicide amongst Aboriginal youth and for situating the prevention strategies;
- presenting a total of 17 suicide prevention strategies for Aboriginal youth;
- providing examples of existing Aboriginal suicide prevention initiatives from across the country;
- suggesting a number of culturally-relevant resources (organizations, curricula, workshops, materials, and web sites) that can further assist you in your implementation efforts;
- providing a step-by-step action plan to mobilize your group and community.

An important acknowledgment...

This manual is very closely based on the document "Before-the-Fact" Interventions: A Manual of Best Practices in Youth Suicide Prevention which was authored by Jennifer White and Nadine Jodoin (1998) and produced by the Suicide Prevention Information and Resource Centre, Mheccu, UBC and funded by the BC Ministry for Children and Families.

That document presented a total of 15 youth suicide prevention strategies which were organized to help British Columbia communities mobilize for youth suicide prevention. Copies of the manual can be ordered from BC Government Publications at:

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Who was the manual written for?

The manual was developed to meet the needs of individuals and groups interested in developing and implementing suicide prevention programs for Canada's Aboriginal youth. In particular, it is hoped that the following groups will make use of the manual:

- youth groups/councils
- community individuals and caregivers
- band and tribal councils
- tribal administrators
- Elders
- agencies and organizations serving youth and families
- mental health workers
- addiction counsellors
- health nurses
- social workers
- government decision-makers
- school administrators and teachers
- community organizations and agencies
- justice system
- police/RCMP members

Background to the manual...

In June 1994, the Royal Canadian Mounted Police (RCMP), Aboriginal Policing Services, began sponsoring the national implementation of a 5-day suicide prevention workshop for Aboriginal caregivers and RCMP Members who were working in Aboriginal communities. This workshop was developed for the RCMP by the Suicide Prevention Training Programs (SPTP), Calgary, Alberta. This workshop was very well received among Aboriginal communities and a 1999 evaluation of the program by a team of evaluators from the University of Calgary revealed clear evidence of success in terms of positive impacts upon communities and individuals.

Based on the success of the initial workshop as well as participant feedback, the RCMP, Aboriginal Policing Service, decided to sponsor the development of a second suicide prevention workshop targeting youth themselves. The Suicide Prevention Training Programs (SPTP) was once again contracted to develop this workshop. The new program, White Stone, took two years of information gathering before it was piloted. The program is grounded in information collected from Aboriginal youth focus groups, current literature, experts in the field, participant feedback, and a review of programs in Canada, the United States, and Australia. The White Stone program was field tested in 2000-2001 in four provinces and is now available to communities across Canada.

While reviewing the literature during the development phase of the White Stone program, it soon became clear that a fair amount has already been written on the topic of suicide prevention amongst Aboriginal youth. However, it also became evident that this extensive knowledge has yet to be collated and published in one comprehensive and practical resource that would support and guide the prevention efforts of Aboriginal communities. From there, the idea of developing a user-friendly manual of suicide prevention strategies for Aboriginal youth was born.

A note to our readers

We recognize that suicide and suicidal behaviour among Aboriginal youth can only be understood through a historical and cultural lens, which gives prominence to the role of cultural oppression, racism, and the dominant culture practices and policies of colonization. We recognize and share many of the concerns and sensitivities that exist as a result of our decision to adapt a document that was originally developed for a mainstream, dominant culture audience for Aboriginal peoples. Having said that, we have been very encouraged by many of our Aboriginal colleagues and friends who have suggested that the material contained in this document will be of considerable value to Aboriginal communities who are working to prevent youth suicide. After considerable discussion and reflection, and based on the invaluable feedback of our Aboriginal advisors, we have decided that the information that was provided in the original Best Practices manual (which was produced in British Columbia) may also be of considerable benefit to Aboriginal communities across the country. Here are the principles and assumptions upon which we have based the revisions:

- *We are starting from the premise that Aboriginal communities have many strengths and resources on which to build. This material is offered as a way to build on, and extend the good work that is already being done.*
- *We bring a spirit of hopefulness to the process and believe in the capacity of Aboriginal communities to engage in practices that promote their own health and well being.*
- *We respect our Aboriginal colleagues and community counterparts. They have the ability to know what will work best in their own local areas, which may require considerable "reinterpretations" of the strategies.*
- *We are humble in our offerings here and do not see this manual as "the answer" or "the only way" to address the youth suicide problem, but we hope that it will provide some useful and practical ideas.*
- *We see this manual as an "invitation" to think about the prevention of youth suicide in a way that makes sense for you and your community. Use what works and adapt or reject the rest.*
- *Finally, we value your feedback, stories, and experiences and would welcome hearing from you regarding your local suicide prevention efforts.*

How is the manual organized?

Understanding the problem of suicide amongst Aboriginal youth

Before you begin planning your suicide prevention program, we invite you to read the first two chapters of the manual. Chapter 2 summarizes the problem of suicide amongst Aboriginal youth in Canada and presents the risk and protective factors that influence the rates of suicide. While the information presented in that chapter will be familiar to many readers, it will provide others who may not come from an Aboriginal background with a better understanding of the realities faced by Aboriginal youth. Chapter 3 is the most "theoretical" chapter of the manual and it describes a model – developed by Jennifer White – for thinking about and organizing suicide prevention programs and services. The model organizes the risk and protective factors (as described in chapter 2) and highlights the existing opportunities for prevention efforts.

What are the most promising youth suicide prevention strategies?

Chapter 4 is the most concrete and practical chapter, and really represents the heart of the manual. The chapter describes a total of 17 promising suicide prevention strategies targeting Aboriginal youth. A number of strategies focus on youth themselves or their families, while others are designed to influence the environments most common to youth, including schools and the communities in which they live. Several examples of existing programs are presented for each strategy as well as links to resources, curricula, workshops, or organizations that may be of further assistance. It is important to point out that the strategies presented in this manual are preventive in nature and do not include crisis intervention, treatment, or postvention strategies.

How do we implement and evaluate these strategies?

Chapter 5 is intended to guide you and your group in mobilizing your community for youth suicide prevention. It contains the following "how to" information: checking your community's assets, capitalizing on others' expertise, gathering pertinent information, organizing for success, coordinating your efforts at the local level, developing a workplan, and evaluating your efforts.

What this manual is not

The focus of the manual is not on crisis intervention or treatment services

The "work of suicide prevention" traditionally encompasses everything from mental health promotion and early intervention to crisis intervention and treatment. Since the assessment and treatment of mental disorders is a fundamental component of any suicide prevention effort and has traditionally received much more attention, we have deliberately chosen to bring more emphasis to initiatives that are preventive in nature and have excluded treatment programs or crisis intervention strategies. We did include, however, strategies which will increase the likelihood that youth-at-risk will be referred to existing mental health services.

The strategies are not described in exhaustive detail

One of the main goals in developing this user-friendly manual was to pull together, in one place, the most promising suicide prevention strategies for Aboriginal youth. Due to the

sheer number of strategies to be included in the document, it was not possible to provide a complete and detailed description of every strategy. In fact, for many of the strategies described in the manual (e.g. peer helping, school climate and community development), whole books have already been written on the topic. As such, you may need to gather additional information about a particular strategy as you move towards implementation. We are confident, however, that enough information has been provided to allow you to make informed decisions about which strategies will best meet your suicide prevention needs.

Chapter 2: Background: About the Problem of Suicide Amongst Young Aboriginal People

This section of the manual highlights basic statistics pertaining to the problem of youth suicide within the Aboriginal population of Canada. Gaining an understanding of the seriousness of this problem is helpful not only for individuals working in suicide prevention but also to help direct the attention of funders and policy-makers to the issue. At the same time, we need to remember and recognize the human beings behind the numbers and the impact that their deaths has on families, friends, and entire communities.

How many young Aboriginal people are dying by suicide in Canada?

Suicide is certainly a problem that is shared by all Canadians. The overall rate of suicide for the Canadian population places this country in the mid to high range among the countries of the world. Suicide amongst Aboriginal people was rare in pre-European contact times but the suicide rate for this population has since increased consistently, especially in the last few decades. Today, the suicide rate among Aboriginal people stands approximately three times higher than the rate for the general Canadian population.[1] In fact, suicide now represents the greatest single cause of injury deaths in this population. Annual suicide rates in recent years for all Canadians and for registered Aboriginal individuals are shown in Figure 1.

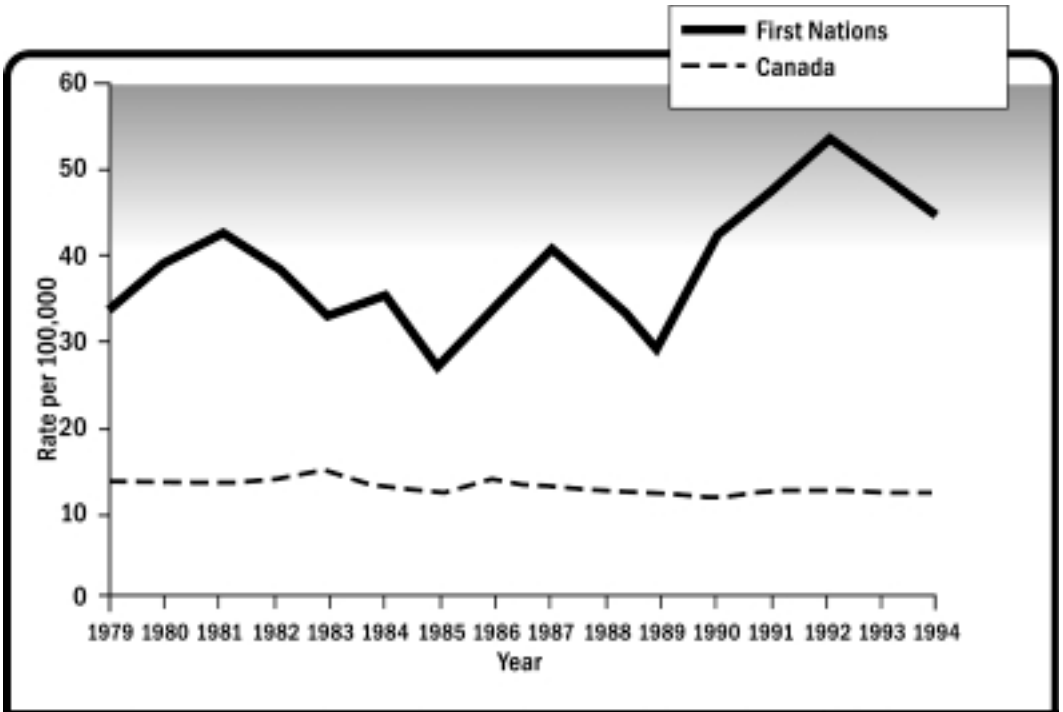

Figure 1. Suicide rate for First Nations and Canada 1979-1994

[1] Kirmayer et al., 1993

While in earlier times suicide was mainly considered by the old and the ill, suicide amongst the Aboriginal population is now especially common in individuals aged 15 to 29. It is estimated that suicide accounts for more than a third of all deaths among young Aboriginal people. Young Aboriginal girls are 7.5 times more likely to die by suicide than the average Canadian adolescent girl, while Aboriginal male adolescents are five times more likely to die by suicide than their average counterparts.[2] Young Aboriginal males between the ages of 15 and 29 are most at risk for suicide, with the highest rates of suicide of any group in Canada (see figure 2).

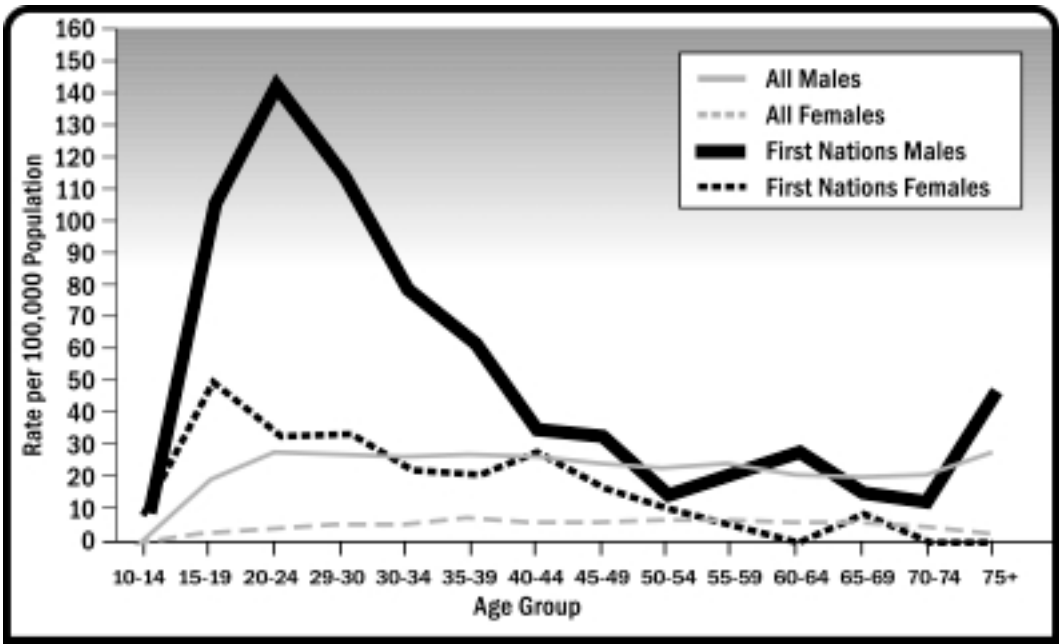

Figure 2. Suicide rates by age and gender for First Nations and Canada, 1990-1994

Even though the overall Aboriginal suicide rate is higher than the rate for other Canadians, it is important to point out that not every Aboriginal community in Canada is experiencing high numbers of suicides. In fact, there are marked differences between provinces, regions, and even between Aboriginal communities belonging to the same geographical region. For example, a recent study done in British Columbia showed that some Aboriginal communities in that province were experiencing youth suicide rates 800 times the national average. On the other hand, the same study found that slightly more than half of the 196 communities studied had not recorded one suicide in a five-year period.[3] Similarly, other researchers have found that suicide rates in northern Alberta were three times higher than southern Alberta. [4]

[2] Kirmayer et al., 1993
[3] Chandler & Lalonde, 1998
[4] Bagley, Wood & Khumar, 1990

Do statistics accurately reflect the problem of suicide in the Aboriginal population?

We know that the Canadian Aboriginal population is experiencing an alarmingly high rate of suicide, especially in young Aboriginal males. Many agree, however, that the problem might be even more serious than what the statistics show. This may be the case for a few reasons.

First, the national data on suicide rates for Aboriginal people only include "registered" (or "status") Aboriginals and Inuit residing in the Northwest Territories, leaving out non-status Aboriginal people, Métis, and Inuit living elsewhere. Therefore, deaths by suicides of individuals belonging to these non-registered groups are not included in the national suicide data. This leads to an underestimation of the actual incidence of suicide in this population.

Second, accidental deaths are four to five times higher among Aboriginal groups (compared to the rest of the population) and we can assume that a certain proportion of these accidental deaths are actually suicides. In fact, it has been estimated that up to 25 per cent of these deaths may represent unreported suicides.[5] This means that an unknown number of deaths by suicide are being incorrectly recorded as accidental or unclassifiable, thereby contributing to the underestimation of true Aboriginal suicide rates at the national level.

It is also important to remember that actual suicides only represent the tip of the iceberg when it comes to the problem of suicide. Although difficult to put in numbers, nonfatal suicide attempts as well as thoughts of suicide must also be factored in when thinking about the whole picture of suicide and its impact on Aboriginal people and communities.

Are there any commonalities among Aboriginal youth who die by suicide?

Keeping in mind that suicide rates amongst Aboriginal youth vary greatly from community to community and region to region, common characteristics are worth mentioning. First, consistent with the general population, Aboriginal people who die by suicide are more likely to be male, young, and single. These suicides are also likely to be associated with alcohol intake. Suicides amongst Aboriginal youth are often carried out by highly lethal means (guns and hanging). There is also a tendency for suicides to occur in clusters, where the suicide of one young person may trigger a series of suicides or attempts in the same group of youth or community within a relatively short period of time.

Why is suicide such an issue for Aboriginal youth?

It is fair to question why young Aboriginal people are experiencing high rates of suicide, especially when compared to their non-Aboriginal counterparts. However, due to the complex and dynamic nature of suicide, the answer to this question is not likely to be straightforward.

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[5] Royal Commission on Aboriginal Peoples, 1995

One way to look at the problem of suicide amongst Aboriginal youth is to focus our attention on what researchers call "risk factors." Risk factors are defined as variables or characteristics that are commonly found in the lives of individuals who die by suicide. These factors may reflect individual vulnerabilities (for example: depression, impulsivity) or they may reflect social or environmental conditions that affect specific individuals or groups (for example: family instability, inaccessible community resources). It is also generally agreed that suicidal risk intensifies as the number or severity of these risk factors increases.

We know that there are a wide range of general risk factors that have been shown to contribute to suicide in all adolescents, regardless of their cultural background. Examples of such risk factors include: depression, alcohol and substance abuse, a family history of suicide, social isolation, and access to firearms. However, in the case of Aboriginal young people, we can argue that they face, *on average*, a greater number of these risk factors at once or that the risk factors are more severe in nature.

In addition, Aboriginal youth often face additional risks that arise, at least in part, from being members of a historically marginalized and economically disadvantaged group. For example, the breakdown of cultural values as a risk factor for suicide is uniquely relevant to Aboriginal people because of the oppressive social forces that have historically characterized relations between Aboriginal people and the rest of Canada.

The number, severity, and type of risk factors experienced by many young Aboriginal people in Canada may partially explain why this group is currently struggling with such high rates of suicide. Having a thorough understanding of the specific risks (as well as protective factors) that are relevant to Aboriginal youth is important when we plan for suicide prevention. This understanding allows us to tailor our strategies to the particular circumstances and conditions that place the group at increased risk for suicide. For a more detailed discussion of the specific risk and protective factors that have been found to be most strongly associated with suicide among Aboriginal youth, please refer to Appendix A.

In closing

The daily realities faced by many Aboriginal youth are often quite grim, with many young people growing up in remote and isolated communities. We must remember, however, that Aboriginal people across the country have continued to show remarkable resiliency in their ability to survive, and in many cases thrive, despite incredible odds. The negative living conditions and stressors faced by Aboriginal young people represent starting points for making change. Through the development of locally-driven initiatives that aim to lessen the impact of risk factors while enhancing those factors that are known to protect against suicide, we can make a difference. Several Aboriginal communities across Canada have already taken up the challenge and have implemented a number of innovative and culturally sensitive suicide prevention initiatives, several of which will be described in later sections. We hope that the remainder of this manual will inspire you and prove helpful in assisting your group and community in this important work.

Suggested reading

Bagley, C., Wood, M. & Khumar, H. (1990). Suicide and careless death in young males: Ecological study of an aboriginal population in Canada. *Canadian Journal of Community Mental Health*, 29, 127-142.

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Chapter 3: Development of a Model for Understanding

Why should we be guided by a model?

Models provide a helpful and quick way for understanding fairly complex issues and problems, like suicide and suicidal behaviour in children and youth. Good prevention models show, usually at a glance, the main characteristics of an issue or problem and they suggest how, when, and where to focus our prevention efforts. Good models are generally straightforward and the concepts can usually be put into practice quite easily. In other words, good models show us the "lay of the land" and suggest some of the best routes for getting us to our destination. In this case, our goal is to reduce suicide and suicidal behaviour among Aboriginal youth in Canada.

A good model is not on the other hand, a mirror of the real world. Instead, a model stands as a symbol of our current knowledge or understanding of the world, shedding light on potential ways to make a difference. Models should not be seen as set in stone, nor should they be so complicated that it takes forever to understand their basic parts.

Setting the stage for the chapters that follow

The model developed here has three purposes:

- to describe the risk and protective factors for suicide amongst Aboriginal youth in a way that shows the complex nature of the problem
- to show how we might move from "what we know" to "what we should do"
- to underline the importance of developing and implementing prevention efforts much earlier in the chain of events, rather than waiting for a crisis to develop. In other words, to focus on the development and implementation of "suicide *risk* prevention" strategies instead of putting all our efforts into "death prevention" strategies, like crisis intervention, for example.

A comprehensive look at youth suicide

We know that suicide amongst Aboriginal youth is caused by multiple factors, which means that no one single solution exists. Individual, family, social, and cultural factors all play a role, making it similar to a lot of other youth behaviours that concern us: substance abuse, dropping out of school, and risky sexual practices. In fact, even though the focus of this document is youth suicide, many of the recommended strategies for reducing risk and increasing protective factors could just as easily apply to the prevention of other social problems among youth.

Multiple layers of influence

Suicide and suicidal behaviour do not take place in a vacuum. Instead, suicide takes place when several factors interact with one another over time and across a number of contexts. One way to appreciate the numerous factors that lead to suicide is to show them through a diagram.

That way, we can begin to see the many layers of human experience and the range of social conditions that can potentially influence an individual's choice to die by suicide.

Figure 3 provides one such diagram. It shows the individual at the centre (which includes spiritual, physical, thinking and feeling dimensions), surrounded by other layers representing family, peers, school, community, culture (including historical factors, shared language and values, and traditional practices), society (which typically refers to the mainstream societal values and beliefs, but can also include political and economic factors), and the environment (both local and global). Each layer represents a source of potential risk or protection, and we can use such a diagram to provide the backdrop for our further discussion about suicide. Basically, this model serves to remind us of the complexity of suicide and the number of influences that must be taken into account when trying to understand and prevent it.

Four types of factors

There are four types of risk and protective factors that we need to be familiar with in order to understand suicide and suicidal behaviour among youth:

- **stage-setting** factors, which set the stage for a vulnerability to suicide (e.g. family history of suicide)
- **contributing** factors, which act to heighten the existing risk (e.g. physical, emotional, and/or sexual abuse)
- **trigger** factors, which act as a trigger for predisposed persons (e.g. feelings of disconnection, feelings of abandonment, or feelings of rejection)
- **protective** factors describing those conditions which act to lessen the risk for suicide (e.g. availability of at least one significant adult who can provide warmth, care, and understanding)

It is important to remember that the first three types of factors represent what we call risk factors because they serve to increase the risk for suicide, while protective factors act to reduce the risk.

What Figure 4 illustrates is that each of the four types of factors, in interaction with one another and across a number of settings, creates the conditions leading to suicide and suicidal behaviour. Suicidal behaviour does not follow a straight line or predictable path. In reality there are several possible routes leading to self-destructive behaviour, which is what makes suicide and suicidal behaviour virtually impossible to predict. We can, however, do something to reduce risks and our challenge as planners is to determine the best points for intervention in order to interrupt the various pathways to suicide.

A summary of risk and protective factors

Even though it does not represent an exhaustive list, Table 1 provides a summary of some of the most well-established risk and protective factors that are relevant to Aboriginal youth. The table is organized by the following key categories: individual, family, peers, school, community, and culture. For a more detailed and in-depth discussion of the specific risk and protective factors that have been found to be most strongly associated with suicidal behaviour among Aboriginal youth, please refer to Appendix A.

Being aware of the risk and protective factors linked to suicide amongst Aboriginal youth is an important first step towards the development of a successful suicide prevention strategy. As such, prevention programs should aim at either reducing the influence of one or more risk factors or enhancing the positive contributions of one or more protective factors. Depending on whether we want to reduce or increase a particular factor's

occurrence or effects, each of the factors listed in Table 1 can serve to suggest a specific course of action or strategy for prevention. For example, using some of the information provided in Table 1, we should be able to determine that each of the following would be good strategies to undertake in the prevention of suicide amongst Aboriginal youth:

- reduce depression in young people
- reduce substance abuse in individuals and families
- reduce child neglect and abuse
- reduce the negative impact of a peer's suicide
- improve problem-solving skills among young people
- improve parenting skills and strengthen families
- reduce sensational public communications about suicide
- increase the capacity of communities to be self-determining

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. This led the investigators to conclude that preventive efforts should include the promotion of protective factors in the lives of all youth.

Since we know that no one single solution exists, we must work towards developing a comprehensive approach to preventing youth suicide and suicidal behaviour that incorporates these key factors in the most efficient, coordinated and systematic manner possible. We also have to concentrate on developing strategies in those areas that are the most modifiable. For example, while we can't change the fact that a person has a history of suicidal behaviour, we can focus on teaching him or her more adaptive coping and problem solving strategies for use in the future.

TABLE 1

STAGE-SETTING FACTORS	CONTRIBUTING FACTORS	TRIGGER FACTORS	PROTECTIVE FACTORS
Individual • previous history of a suicide attempt • depression/psychiatric disorder • prolonged or unresolved grief	• rigid cognitive style • poor coping skills • alcohol and substance abuse • sexual orientation being 'two-spirited' • impulsivity • hypersensitivity • low self-esteem • self perception of poor general health • conflict with the law	• personal failure • humiliation • individual trauma • developmental crisis	• good physical and mental health • creative problem-solving • personal autonomy • previous experience with self-mastery • optimistic outlook • sense of humour • strong spiritual or religious faith
Family • family history of suicidal behaviour/ death by suicide • family violence/abuse • family history of mental health problems • early childhood loss/separation	• substance abuse within family • family instability • ongoing conflict	• loss of significant family member • death, especially by suicide	• family relationships characterized by warmth and belonging • adults modelling healthy lifestyle • realistic expectations
Peers • social isolation and alienation	• negative youth attitudes towards seeking adult assistance • peer modelling of maladaptive behaviours	• teasing/cruelty • interpersonal loss • rejection • bullying • death, especially by suicide	• interpersonal competence • healthy peer modelling • acceptance and support
School • social isolation and alienation	• negative youth attitudes towards seeking adult assistance • peer modelling of maladaptive behaviours	• teasing/cruelty • interpersonal loss • rejection • bullying • death, especially by suicide	• interpersonal competence • healthy peer modelling • acceptance and support
Community • community "legacy" of suicides • community marginalization • political disempowerment • economic deprivation, unemployment • isolated geographic location • lack of proper housing conditions	• sensational media portrayal of suicide • access to firearms or other lethal methods	• high profile/celebrity death, especially by suicide • conflict with the law/incarceration	• opportunities for participation • evidence of hope for the future • community self-determination and solidarity • availability of resources
Culture • breakdown of cultural values and belief systems • loss of control over land and living conditions	• negative attitude of the non-Aboriginal population		• strong traditional culture

Development of strategies

Too often, strategies for preventing youth suicide are developed without being grounded in the existing knowledge base. For example, suicide prevention programs often get developed "reactively" or in response to a particular tragedy. Sometimes nothing more than gut-instinct and good intentions drive suicide prevention program planning. Complicating matters even further, the term "prevention" is applied to everything from early childhood education to crisis intervention to postvention (intervening with groups of individuals who have recently been exposed to a suicide).

One of the primary aims of this chapter is to outline a systematic theory-guided approach to the task of youth suicide prevention that recognizes and underscores the importance of "before-the-fact," suicide *risk* prevention efforts, including mental health promotion and early intervention.

At a very basic level, we can organize approaches-which have historically all been called "suicide prevention"-according to:

- those that are designed to achieve an effect "before-the-fact"
- those that are designed to be implemented "after-the-fact"

The "fact" in this case is the identification or development of suicidal behaviour, including significant levels of suicide ideation (thoughts about suicide), overt threats, attempts at suicide and other deliberate self-harming behaviours.

It's a continuum

In reality, risk levels for suicide tend to exist along a continuum from none to high and Table 2 illustrates how we might consider our prevention and intervention strategies based on levels of risk, using the broad categories of "before-the-fact" (suicide *risk* prevention) and "after-the-fact" (death prevention).

By describing the timing (when), primary target group (who), scope (how broad), key factors of influence and types of interventions to be used (what), Table 2 also serves to show how we can use such a framework to bring more focused intention to the development of our suicide prevention approaches and strategies.

Before moving on to a more detailed discussion about the various "before-the-fact" approaches, a few words about the relationship between prevention and treatment are in order.

TABLE 2

	Before-the-fact*		After-the-fact	
Primary Target Group	Populations and Groups	Groups at Early Risk	Individuals at Identifiable Risk	Individuals at High Risk
Level of Suicide Risk	None	Low Risk	Medium Risk	Acute (high) Risk
Scope of Intervention	Broad focus on risk and protective factors		Narrow focus on preventing imminent self-harm/death	
Type of Intervention	Mental health promotion	Early intervention	Treatment	Crisis intervention
Key Factors of Influence	Protective factors	Stage-setting and Contributing factors		Trigger factors
Promising Strategies	Cultural enhancement Community development Peer helping Youth leadership School climate improvement Self-esteem building Life skills training Family support	Traditional healing practices Interagency communication and coordination Community gatekeeper training Public communication and reporting guidelines Means restriction School gatekeeper training School policy Suicide awareness education Support groups for youth	Individual assessment/treatment Family therapy Clinical training Case management	24 hour crisis response services Hospital in-patient programs Drug interventions
Intermediate Indicators of Progress	Increased personal competencies among all youth	Increased ability to detect and refer youth at-risk Increased capacity and responsiveness to deal with youth at-risk among families, schools and communities Reduced access to lethal means	Increased coping ability among those receiving help Increased ability to manage future crises and increased willingness to reach out among those who received help	Reduced individual risk for imminent self-harm or death by suicide
Ultimate Outcome	**Reduced suicides and suicide behavior**			

* This Manual only deals with the “Before-the-fact” suicide prevention issues

Prevention and treatment

These two concepts, prevention and treatment, often become improperly cast as oppositions or competing thrusts. In reality, these two approaches to youth suicide both play a crucial role and they must always be working in partnership. Reducing the rates of suicide and self-harm among youth requires the coordinated efforts of both the broad-based prevention system (before-the-fact interventions) and the more specialized, individually-focused treatment system (after-the-fact interventions).

Without effective prevention efforts, the treatment system (including counselling services, mental health centres, and hospitals) would become even more overwhelmed than it already is, and would be faced with trying to respond to higher levels of distress and disturbance among greater numbers of individuals. With effective prevention efforts in place, it is more likely that those who truly require the more intensive clinical efforts will be able to access the services they need in a more timely fashion.

A focus on "before-the-fact" approaches

For the purposes of this manual, "before-the-fact" approaches to youth suicide prevention will be our primary focal point. The following concepts will be used to describe various "before-the-fact" approaches:

Mental health promotion. Interventions targeting the entire population, designed to improve personal well-being through strategies aimed at increasing personal strengths or system-focused interventions (like those directed at schools or communities) aimed at increasing social support and belonging.

Early intervention. Interventions targeting groups of young people who are exhibiting signs of early risk to suicide and suicidal behaviour, but where a specific risk for suicide has not yet been identified; designed to reduce the levels of early risk and promote healthy functioning through specific skill-building or social and environmental enhancements; may also include efforts to improve the response capacity of various helping systems.

Pulling it all together

The various approaches to youth suicide prevention described above can be understood to correspond (in a very general sense) with the various types of risk and protective factors identified earlier. See Figure 5 for a diagram of this relationship.

At its simplest, we are engaged in mental health promotion when we are trying to increase the protective factors of a population. We are engaged in early intervention efforts when we have identified groups-at-early-risk (for suicide) to receive specific skill-building sessions. When we intervene with an individual at extreme risk for self-harm, our approach becomes crisis intervention. When we refer a student who has a clinically significant level of suicide ideation to receive follow-up counselling, we have entered the domain of treatment.

To summarize, a comprehensive approach to youth suicide prevention is best and actions should be undertaken across multiple contexts, reflecting the coordinated efforts of broad prevention strategies and more individually-focused clinical approaches. What has been outlined here is a roadmap of sorts that should help us to become more focused and purposeful in our aims, serving as an important point of reference for those who are developing comprehensive youth suicide prevention plans.

Best practices strategies to follow...

The next section of this manual (Chapter 4) lists 17 promising suicide prevention strategies for Aboriginal youth that are distinctly "before-the-fact" in their focus. Every effort is made to show how the strategies link back to this model as a way of making sure that our efforts are well-grounded in sound theory.

Suggested reading

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White, J. (1998). Comprehensive youth suicide prevention: A model for understanding. In A. Leenaars, S. Wenckstern, I. Sakinofsky, R. Dyck, M. Kral, & R. Bland (Eds.), *Suicide in Canada* (pp.275-290). Toronto: University of Toronto Press.

Chapter 4: Strategies in Suicide Prevention Amongst Aboriginal Youth

How did we decide what strategies to include in this manual?

The purpose of the manual is to assist you in the development of successful youth suicide prevention programs in your own community. In order to help you accomplish this, the chapter recommends a total of 17 promising youth suicide prevention strategies. For the purpose of this manual, we define promising as *those activities and programs that have the best chance of having a positive impact on youth suicide and suicidal behaviour, based on the best available evidence*. This means that, based on our existing knowledge, the strategies presented in this manual have either been proven to work or are showing significant promise and give us reason to expect a positive impact on suicide behaviours amongst Aboriginal youth.

In order to be defined as a promising strategy and recommended for inclusion in this manual, we needed to be confident that each strategy had reasonable potential to reduce suicide and suicidal behaviours amongst Aboriginal youth. The following process was adopted in order to identify the *promising* strategies:

1. Review of outcome-based evaluative research studies, specific to Aboriginal populations, as well as other studies which may have less scientific certainty but nevertheless strongly suggest a positive effect.

2. Review of two documents that have already reviewed the nature of the evidence and have recommended a number of youth suicide prevention strategies.

   a) The first document, *Before-the-fact interventions: A manual of best practices in youth suicide prevention*, by White and Jodoin (1998), was produced by the Suicide Prevention Information and Resource Centre of British Columbia. This document reviews the evidence in the field of suicide prevention in the general youth population and presents a total of 15 youth suicide prevention strategies.

   b) The second document, *Suicide prevention and mental health promotion in First Nations and Inuit communities* by Kirmayer, L.J., Boothroyd, L.J., Laliberté, A., & Laronde Simpson, B. (1999), was produced by the Institute of Community & Family Psychiatry - Culture and Mental Health Research Unit (Montreal, Quebec). This report sets out a rationale and guidelines for suicide prevention and mental health promotion programs that are likely to be effective in the First Nations and Inuit communities of Quebec. The report highlights a total of 24 strategies for primary prevention, intervention, and postvention. The recommendations are based on a systematic review of 29 school-based and community-based suicide prevention and mental health promotion programs developed for or potentially applicable to Aboriginal populations.

3. Interviews with numerous Canadian experts working in the field of suicide prevention in Aboriginal contexts.

The nature of the evidence

While the strategies included in this chapter are considered promising, we need to mention a few words about the nature of the available evidence in the suicide prevention field. The science of suicide prevention (i.e. "finding out what really works" in suicide prevention) is not very exact. First, it remains difficult for researchers to determine without a doubt that a certain approach works to reduce suicides and suicidal behaviour, simply because the problem of suicide is so complex and multi-determined. This is in contrast to other areas of medical research where researchers often have far greater control over the variables they are studying, for example, comparing the effectiveness of one medication to another. Second, evaluation studies have been relatively few in number and most of these have been undertaken with the mainstream population. We clearly need to continue to increase our knowledge base about which suicide prevention efforts work best with Canadian Aboriginal populations, which will enable us to feel even more confident about which strategies to recommend in the future.

Having said that, we have to be careful not to interpret this lack of certainty as a negative finding, as it results primarily from a lack of well-designed evaluation studies and not from studies that conclude no effect. Given the seriousness of the problem of suicide amongst Aboriginal youth, we cannot afford to wait until all of the evidence has been conclusively established before we proceed. We must act now and we need to act in the context of "the real world" which is constantly changing and lacks elements of predictability and control - conditions which are often necessary for establishing firm scientific truths. So while the nature of the evidence regarding the effectiveness of suicide prevention strategies is by no means certain, there is a clear foundation of knowledge from which we can and should proceed.

What are the strategies?

The remainder of the chapter will provide you with practical information on 17 youth suicide prevention strategies that have been proven to work or that are showing significant promise. However, before you move on, let us begin by explaining how we have organized the strategies. The strategies have been divided into four groups (community renewal strategies; community education strategies; school strategies; and youth/family strategies) to reflect the specific context in which they are designed to be implemented.

Community renewal strategies
- Cultural enhancement
- Traditional healing practices
- Community development
- Interagency communication and coordination

Community education strategies
- Peer helping
- Youth leadership
- Community gatekeeper training
- Public communication and reporting guidelines
- Means restriction

School strategies
- School gatekeeper training
- School policy
- School climate improvement

Youth/family strategies
- Self-esteem building
- Life skills training
- Suicide awareness education
- Family support
- Support groups for youth

We recognize that school-based strategies cannot always reach all youth because of dropout and attendance problems experienced by some communities. It is therefore important for a community to develop and implement efforts in each of the three areas (community, school, and youth/family) simultaneously in order to reach as many youth as possible and have the most impact. However, given the reality of limited resources, strategies may need to be developed and undertaken more slowly, with an aim towards building them up over time.

As a first step, we recommend that you familiarize yourself with each strategy and then read Chapter 5, *A community-wide approach to suicide prevention*, in order to make an

informed decision as to which strategies will best meet the specific needs of your own community.

How are the strategies presented?

Each strategy has been described as thoroughly as possible within the space limitations of this manual. For each recommended strategy, you will find some theory and background, a summary of relevant research and evaluation findings, tips on how to optimize implementation success, as well as suggestions on how to monitor your progress.

We are confident that enough information has been provided about each strategy to allow you to organize and facilitate a comprehensive youth suicide prevention effort that includes several of the promising strategies. You may, however, find that you will need to gather additional information about a particular strategy as you move towards its implementation.

For each strategy, we answer the following questions:

- What is the strategy all about?
- Why should we implement the strategy?
- How do we know that the strategy holds promise?
- How do we set up for success?
- How will we know if the strategy is making a difference?
- Are there any concerns associated with the strategy?

In addition, look for sections entitled *A place to start* and *In our own backyard*. *A place to start* provides additional information on publications, curricula, resources, workshops, or organizations that can assist you in the implementation of the strategies. Every effort was made to include Canadian resources that were developed for or adapted to Aboriginal youth. *In our own backyard* describes suicide prevention programs that are currently being implemented with Aboriginal youth and which are representative of the great work being done across Canada by Aboriginal groups and communities.

Community Renewal Strategies

Cultural Enhancement

What is cultural enhancement?

The strategy of cultural enhancement includes all efforts at revitalizing and sharing Aboriginal culture and traditions with today's youth. The overall aim of the strategy is to strengthen the cultural identity of adolescents in order to provide them with a feeling of security, a sense of belonging, and hope for the future. This cultural approach starts from the belief that reacquainting youth with their Aboriginal identity will provide them with strong personal resources that will benefit them intellectually, physically, emotionally and spiritually.

In the context of suicide prevention, this approach aims at minimizing the impact of certain known risk factors for suicide including: breakdown of cultural values and belief systems; loss of cultural identity; and the negative attitudes of the non-Aboriginal culture. In addition, the strategy focuses on enhancing a number of factors that are known to protect children and adolescents against suicidal tendencies. These include a strong sense of the value and meaning of life, a sense of belonging, and self-esteem.

Goals

More specifically, the goals of culture-enhancing programs are to:

- share elements of Aboriginal culture and traditions that may have been lost to the new generation
- enhance personal resources of youth such as a sense of well-being, belonging, security, identity, and self-esteem
- provide youth with alternative options that they can rely on when in need
- facilitate the development of meaningful relationships between youth and the older generation
- help children and youth bridge the gap between Aboriginal culture and its non-Aboriginal counterpart

Target population

Culture-enhancing programs are directed towards ALL youth and the communities in which they live.

Brief description

There is a wide range of culture-enhancing initiatives that can have either a direct or more indirect impact on youth's well-being. Some efforts are aimed directly at youth (e.g participation in a wilderness camping trip) while others are pursued as part of other broader social and political agendas (e.g. securing land claims or seeking self-government). Whether targeting youth themselves or the environment in which they live, culture-enhancing initiatives help to develop a strong collective identity and sense of belonging by instilling pride in heritage and traditions and offering a healthy

identification with one's own culture as a distinct and viable way of life for individuals, families, and communities.

Here is a short list of examples of initiatives often implemented in communities:

- transmitting traditional skills through camping on the land (hunting, trapping, fishing, tepee-making)
- pairing youth with Elders
- offering Aboriginal language and history courses
- teaching traditional arts and crafts
- transmitting the traditions and teachings of the Elders
- forming youth drumming and dance groups
- organizing regular ceremonies and feasts

Why should we encourage cultural enhancement?

Aboriginal youth have lost contact with their roots

For many historical reasons, young Aboriginal people are increasingly growing up without the knowledge and wisdom of their own heritage. They are losing contact not only with their traditions and rituals, but with an entire lifestyle. As a result, there is now what many call a "growing generation gap" between youth and Elders, and the failure to pass on Aboriginal wisdom and traditions to younger generations has resulted in an inadequate cultural grounding for many adolescents. In addition, Aboriginal youth may not feel comfortable with the non-Aboriginal culture and end up feeling caught between two cultures while being unable to find satisfaction in either. Elders have said that the emptiness felt by today's Aboriginal youth can only be filled by what is naturally their own. That is why the traditional values which guided the Aboriginal ancestors should be restored, transmitted, and honoured by Aboriginal youth and adults alike.

There is an opportunity to draw on the strengths of Aboriginal peoples

Canada's Aboriginal people have experienced a long and often damaging history of interaction with the non-Aboriginal culture, and yet they have survived. This testifies to the strength and resilience of the Aboriginal culture and its people. Unfortunately, programs for Aboriginal youth are too often designed in an effort to compensate for deficiencies, most of which are defined in the eyes of the non-Aboriginal culture. This type of "deficit model" cannot foster understanding or enhancement of the obvious strengths of the Aboriginal culture. There is an opportunity to utilize these strengths to nurture the youth of the next generation.

Culture-enhancing programs can impact on known risk and protective factors for suicide

It is becoming more and more evident that cultural identity is an important factor in the lives of Aboriginal youth. Research has shown that the alienation from culture and community represents an important risk factor for suicide among Aboriginal youth. The breakdown in the transmission of cultural traditions appears to contribute substantially to the widespread demoralization and hopelessness of youth. On the other hand, research

has also shown that a high sense of cultural identity acts as a protective factor against suicide. Strong community traditions, customs, religious ceremonies and traditional healing provide adolescents with a feeling of security, a sense of belonging, and hope for the future. Unfortunately, security and belonging are feelings that some Aboriginal youth have never or rarely experienced. There is therefore a role for culture-enhancing programs to counteract the negative impact of certain risk factors while enhancing the positive power of protective factors.

Youth want to reconnect with their traditional ways

Youth are demanding to reconnect with their cultural heritage and traditional values as a buffer against suicide. Aboriginal youth who presented in front of the 1995 Royal Commission on Aboriginal Peoples clearly and consistently indicated that rediscovering their cultures and traditions is of great potential significance to them in their struggle to grow up feeling whole. As a group, they asked for the opportunity to reassemble the fragments of their heritage as Aboriginal people. Similarly, Aboriginal youth participating in a number of suicide prevention conferences held in recent years have stressed the need to revive cultural practices and beliefs and recommended that opportunities be provided for youth to learn traditional knowledge, traditional spirituality and land-based skills.

Does cultural enhancement work?

Although there is not, to date, any evaluative research clearly demonstrating a decrease in youth suicide following the implementation of culture-enhancing programs, there is enough indirect evidence to suggest that this strategy has great potential for success.

Cultural enhancement has been shown to help suicidal youth

A recent study investigating what type of strategies had helped a group of 25 Aboriginal youth from British Columbia recover from suicidal tendencies found that connecting with culture and tradition was one of the most successful healing strategies for these young people. Youth who participated in the study mentioned that connecting to First Nations culture and tradition had led to empowerment, pride, purpose, and meaning, and had strongly contributed to their healing from suicidal ideation.

Research found a link between cultural identity and suicide

Research has found a potentially powerful link between positive cultural identity and low rates of suicides in Canadian Aboriginal communities. A different study from British Columbia found that the extent to which communities are actively engaged in a process of rebuilding or maintaining their cultural continuity is directly related to the rate of suicide of that community. As such, Aboriginal communities that have taken active steps to preserve and rehabilitate their own cultures are shown to be those in which youth suicide rates are lowest. The opposite is true of those Aboriginal communities that have not embarked on a process of restoring their own cultural identity.

The researchers of that study concluded that rehabilitation of culture at the community level seems to have an impact on the rates of youth suicide, suggesting that the target of suicide prevention programs should be cultural in character. There is a lot to be said about a strategy that approaches the problem of suicide indirectly by working on the rehabilitation of the cultural background of the community and having youth reconnect with their cultural history.

Experts recommend this strategy

A number of experts in the field of Aboriginal suicide prevention have recommended this strategy. In addition, this strategy was endorsed by the 1995 Royal Commission on Aboriginal Peoples. After carefully looking over studies and case studies, the Commission tried to identify initiatives that appeared most promising for suicide prevention. On the issue of cultural transmission, the Commission concluded that there was evidence that enhancing cultural knowledge, cultural identity and pride in roots and heritage have positive effects for youth. In their National Action Plan for Suicide Prevention, Australia has also endorsed this strategy in order to reduce the problem of Aboriginal suicides.

Setting up for success

Unlike peer helping, life skills training, and suicide awareness education, the strategy of cultural transmission is not well defined in terms of how it should be structured or the type of information that should be transmitted to the audience in order to facilitate effectiveness. However, there are a number of issues to keep in mind when setting up a cultural-enhancement program.

1. **Reach a consensus as to the focus of your program**

   As mentioned earlier, there are a number of different ways to foster positive culture among Aboriginal youth. On the one hand, you may decide to embark on a community-wide journey towards cultural rehabilitation or you may begin on a smaller scale by offering cultural activities for groups of children and adolescents. The right approach for your group will take into consideration the particular history of your community and its people, where the community stands in terms of cultural self-determination, what currently exists in terms of cultural activities, and what community members feel is most important to share with their young people.

2. **Involve Elders**

   The literature overwhelmingly emphasizes that efforts at sharing or transmitting cultural traditions with youth should be led by or include Elders. Elders have an important role in passing on their life experiences, skills, oral traditions and histories, as well as traditional values. Joining Elders and youth serves to provide young people with more insight into traditional ways, while bridging the generation gap.

3. Involve youth

Young people themselves should be involved in the process of developing a program aimed at transmitting and revitalizing a community's cultural heritage. When asked, youth can share their particular interests with respect to their culture and what they would like to learn about. Their suggestions should be taken into consideration by program planners.

How will we know if we're making a difference?

You will know that your cultural enhancement program is making a difference if you can answer yes to questions listed in the table below under the headings *short-term*, *medium-term*, and *long-term indicators*. Please note that in order to detect changes over time we typically need to make a long-term commitment to the overall evaluation process. In other words, measuring success is not something you do at a single point in time and then forget about. The timelines that are included below are only guidelines, but they should give you a good sense about the need to measure the impact of our interventions at several points in time following the initial implementation of the strategy.

Short-term indicators: Short-term indicators are changes that the strategy itself is designed to produce and are usually measured right after, or up to two months following, the implementation of a program. Depending on the type of program being developed, short-term indicators can be measured using quantitative methods (e.g. pre-and-post tests measuring changes in skills or knowledge) or qualitative methods (e.g. interviews or focus groups designed to assess attitudes, opinions, and satisfaction).

Medium-term indicators: Medium-term indicators of success capture changes that you might expect further down the road and are usually measured three to six months after the implementation of a program. Medium-term indicators can be measured using methods such as surveys, questionnaires, interviews, or observations that look at changes in well-being, attitudes, or behaviours in young people or other groups/social environments targeted by the program.

Long-term indicators: Long-term indicators of success measure the ultimate goal of a program (usually a reduction in suicide and suicidal behaviours among youth) and are usually measured on an annual basis, starting two to five years following the implementation of a program.

Keep in mind that the indicators listed in the table below represent examples only and we invite you and your group to develop indicators that are in line with the specific goals and activities of your own cultural enhancement program. As the strategy of cultural enhancement may not easily lend itself to traditional evaluation methods, nor to the use of 'typical' quantitative methods for measuring success, we invite you to be especially creative when choosing indicators and finding ways to measure the strategy's effectiveness. Identifying relevant indicators of success for your own program (and the methods by which these will be measured or monitored) represents one of the most

important steps of your overall evaluation plan (see the section *Evaluate your community-wide suicide prevention efforts* in chapter 5).

Methods to evaluate

	Ask a Key Evaluation Question	Measure the Success
SHORT TERM*	Are young people interested in participating in the activities sponsored by the program?	➢ measure the general interest generated by the program and the number of youth who get involved
	Are young people participating in the program satisfied with the activities of the program and their overall experience with the program?	➢ record participant satisfaction/feedback with the various components of the program
	Are participating youth gaining knowledge and/or skills related to their cultural traditions, language, or any other skills the program is designed to teach?	➢ measure gains in knowledge and/or skills by observing participating youth or by talking with them about what they have learned and the skills they have gained. If the program lends itself to a more formal approach, measure knowledge and skills before and after participation in the program and compare results to determine whether participation in program activities has had an impact.
MEDIUM TERM**	Are young people participating in the program feeling enhanced pride and respect with respect to their heritage and culture as well as an increased sense of identity and belonging with the Aboriginal ways?	➢ invite young people to share how participation in the program has affected their sense of pride, respect, and belonging with respect to the Aboriginal ways and culture
	Are young people participating in the program showing improvements in well-being and self-esteem?	➢ measure well-being and self-esteem in youth who have participated or continue to participate in the program
LONG TERM***	Are suicide and suicidal behaviours among youth decreasing?	➢ measure the number of deaths by suicide and attempted suicides in the community and compare to previous statistics

**** Short-term** (measured immediately to 2 months following program implementation)*
***** Medium-term** (measured 3 to 6 months following program implementation)*
****** Long-term** (measured 2 to 5 years following program implementation)*

Cultural Teachings of the Gathering Circle

Location: Gathering Circle
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E-mail: sweat@tbaytel.net

Contact person: Leonard Bananish, Chairperson

Program description: The Gathering Circle began in the mid-1980's as an informal group formed to provide the sense of community that many Aboriginal people miss when they move from small reserves to the city. Now a registered nonprofit society, the Gathering Circle operates to foster appreciation of and participation in Aboriginal culture, language, and spirituality and to promote the healing process by sharing unresolved grief and abuse issues in a supportive and confidential environment. The organization organizes several activities including sharing circles, cross cultural workshops, Aboriginal ceremonies, cultural event sponsorships, and youth scholarships.

The Gathering Circle is committed to the issue of suicide prevention amongst Aboriginal youth and its members started a cultural suicide prevention program in 1995. The cultural teachings program of the Gathering Circle uses Elders to educate youth in Aboriginal cultural values, traditions, and spirituality in order to create self-respect and strengthen the self-identity of youth. The foundation of the program is the wisdom of Elders, who are knowledgeable in traditional teachings such as: role of smudging, protocol when approaching elders, significance of sacred items, ceremonies and rituals, code of ethics, and the seven Fire Teachings. Through cultural teachings, youth are shown how to develop a better outlook in life, recognize their own gifts, and appreciate themselves.

When invited by a community, an Elder and a member of the Gathering Circle Board will travel to speak and perform ceremonies for groups of youth or, at times, for youth on an individual basis. Youth participating in the presentations may or may not be at-risk for suicidal behaviors. The program serves 10 neighbouring Aboriginal communities (up to 200 kms away from Thunder Bay). On average, the program will travel to each community approximately 3 times a year. The program draws from a pool of approximately 7 Elders who do not live in the communities served by the program.

Target groups: Children and teenagers from 5 to 18 years old.

Partners involved: The Gathering Circle.

Years in operation: The program has been in operation since 1995.

Program costs: Travelling expenses represent the main costs of the program. The Elders are all volunteers.

Resources: Financial resources to cover the travelling costs are generated mainly through local fund raising activities (e.g. bake sales) and through the donations of local agencies.

Evaluation findings: The program has not been formally evaluated. Informally, success has been demonstrated by the popularity of the program and the positive feedback of participating youth.

Advice to others interested in starting this type of program: The President of the Gathering Circle recommends that the Elders participating in the program should be healthy (in body and spirit) and free from political ties.

Available reports and materials: Materials about the Gathering Circle organization as well as the cultural teachings program are available to interested individuals and groups.

A Place to Start

Programs

Junior Canadian Rangers

The Junior Canadian Ranger Program is a youth program for boys and girls between the ages of 12 and 18 who live in remote and isolated communities of Canada, mostly north of 60 degrees and on the coasts. There are currently over 2,000 Junior Canadian Rangers in 79 remote and isolated communities across Canada. Under the supervision of the Canadian Rangers, the aim of the program is to promote traditional cultures and lifestyles by offering a variety of structured activities to young people. Junior Canadian Rangers participate in a variety of activities, including those that focus on Ranger skills, Traditional skills and Life skills. Sixty percent of the program is optional and left to the community's discretion, while forty percent (the Ranger skills component) is mandated by the Canadian Forces. All the activities help to preserve the culture, traditions and customs of the local community and foster good citizenship, community responsibility, personal health and welfare, and increased self-esteem in participants. Some of the Junior Ranger activities include: hunting, fishing and living off the land; building sleds, small boats, canoes and igloos; and learning about Aboriginal spirituality, local dialects, traditional music, singing, and dancing.

Junior Canadian Rangers are taught by qualified Canadian Ranger Instructors with the assistance of adult volunteers such as local band members or council elders (for instruction in traditional and cultural activities). The Junior Canadian Ranger Program is funded by the Department of National Defence (DND) in conjunction with Human Resources Development Canada (HRDC). Junior Canadian Rangers also benefit from additional funding and support from other levels of government and private corporations. Each Junior Canadian Ranger patrol is overseen by a local Adult Committee, which is formed of eight community members. Normally the Adult Committee is made up of respected members of the community like the tribal council elder, the mayor, the local RCMP officer, social workers or teachers, who can bring their professional experience and background to bear on the workings of the JCR Program. Interested communities must request the formation of a Junior Canadian Ranger patrol program and prove to the Department of National Defence that sufficient local interest and support exists to sustain the program in the community. For more information, contact the national office:

Canadian Ranger/Junior Canadian Ranger Coordination
Cell 101 Colonel By Drive
Ottawa, ON
K1A 0K2
Fax (613) 992-8956
E-mail: lauzon.mdn@forces.ca
Web site: www.rangers.forces.ca

Aboriginal Shield Program

The Aboriginal Shield Program is a substance abuse prevention program, developed specifically for Aboriginal youth, which is based on the benefits of cultural enhancement. The program was designed by the NECHI Institute and the RCMP Drug Awareness Program to supplement existing substance abuse programs and school curriculums. It is supported by the NECHI Institute, RCMP Aboriginal Policing Branch, Solicitor General of Canada, PACE (Police Assisting Community Education), Alberta Alcohol and Drug Abuse Commission, and Health Canada.

The Aboriginal Shield Program helps youth feel pride in their heritage by helping them identify with the traditions and spiritual teachings of their Aboriginal culture. It also focuses on the positive aspects of building strong healthy relationships within the context of the traditional Aboriginal community. Finally, the program helps make choices about the dangers of drugs, smoking, impaired driving, and inhalants.

The course is delivered by community police officers who are culturally sensitive and aware of the holistic nature of the program.

For more information, contact:
National Coordinator
Drug Awareness Service
1200 Vanier Parkway
Ottawa, Ontario
K1A 0R2
Telephone: (613) 993-2501

Suggested reading

Berlin, I.N. (1987). Suicide among American Indian adolescents: An overview. *Suicide & Life Threatening Behavior*, 17(3), 218-32.

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Nishnawbe-Aski Nation Youth Forum on Suicide (1996). *Horizons of hope: An empowering journey*. Thunder Bay, ON: Nishnawbe-Aski Nation.

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Community Renewal Strategies

Traditional Healing Practices

What is the strategy of traditional healing practices?

For the purposes of this manual, traditional healing practices include approaches, grounded in Aboriginal culture and history, which assist individuals in moving towards a state of mental well-being. On the other hand, healing efforts which target a whole community, whereby community members come together to solve common problems and move towards positive developments, are thought of as community development. Community development as a suicide prevention strategy is described later in this chapter.

Traditional healing practices can assist Aboriginal children, adolescents, as well as their families deal with various negative life events or circumstances (suicide-related or not). The process of healing is important as we know that certain losses (e.g. having a friend or family member attempting or completing suicide) can have a negative impact on suicide risk. The strategy of healing also aims to enhance a number of factors that protect against suicide (e.g. good emotional health).

Goals

The overall goals of traditional healing practices as a suicide prevention strategy are as follows:

- reconnect youth with traditional healing practices
- teach young people to recognize unhealthy coping strategies such as alcohol, drugs and violence and replace them with positive healing strategies
- support youth in their journey of grief
- promote emotional and psychological health

Target population

In the context of this manual, healing as a general suicide prevention strategy is aimed at all youth, and yet more specific healing strategies are often designed to reach youth who are known to be vulnerable, as well as their family members.

Brief description

Healing, as it is understood in this manual, is a guided and dynamic process which involves working on enhancing all aspects of one's life including the physical, emotional, psychological, and spiritual aspects. It requires individuals to search within themselves to recognize and address the underlying causes of their problems. This process of coming into "balance" or "wholeness" is truly a spiritual process, or a process in which the return to traditional spiritual beliefs and practices becomes an integral part of healing.

How a community approaches the strategy of healing usually depends on the particular circumstances and needs of the youth (or adults) and the level of expertise within the community. Community-based healing initiatives can be short-term (e.g. organizing a one-time healing workshop or ceremony) but usually go on for several months or years. Initiatives are often led by Elders or other natural healers, but can also be facilitated by knowledgeable mental health professionals. Traditional healing practices are central to this strategy and include the use of sweat lodges, healing or talking circles, pipe ceremonies, naming ceremonies, clan dances, sun-dances, drama, art therapy, and other specific herbal or spiritual treatments. The teachings of the medicine wheel that focus on the balance of the emotional, physical, intellectual and spiritual are also used, in some communities, as a teaching tool for healing.

The healing movement

Recently, a strong healing movement has swept Canadian and American Aboriginal populations. Traditional healing practices are being used more and more to mend wounds and promote the spiritual, emotional, mental, and physical well-being of Aboriginal individuals. Countless communities are turning to holistic and community-based healing initiatives to support the healing efforts of their residents. In addition, several healing centres have been established across Canada.

Healing centres or lodges usually offer traditional healing approaches for the treatment of sexual assault, physical abuse, addictions, and family dysfunction. These centres usually promote traditional Aboriginal values and beliefs so as to encourage and foster healing. Some of these centres focus specifically on addictions or other problems affecting youth. A continuum of care from prevention to aftercare is usually available for individuals and families on a residential or outpatient basis. In addition, education and community outreach initiatives are often integrated into programming.

Why should we provide opportunities for healing?

Aboriginal youth face significant issues

Growing up Aboriginal is not always easy. Living conditions are often poor and prospects for the future are few. In addition, Aboriginal young people are often faced with negative life events that can cause a real sense of grief and sadness. If left unresolved, these negative circumstances can lead to difficulty coping and life-threatening behaviours like alcohol and drug abuse. Examples of such difficult circumstances include the loss of a

family member or friend to suicide or accidental death, physical or sexual abuse, and living with chronic family dysfunction.

There is a link between losing someone to suicide and suicide risk

Although the process of healing is important following any type of trauma or loss, it is of foremost importance for youth who have lost a loved one to suicide or violent death. Being exposed to the suicidal behaviours of others is believed to have a powerful and potentially contagious effect on adolescents. This is seen, for example, in "cluster suicides" where identification with the deceased and unresolved bereavement or grief can lead teenagers who are impressionable and vulnerable to follow suit. The loss of friends or family members by violent death is also more likely to lead to complicated grief reactions and increase the risk of subsequent suicide.

A recent study found that the most powerful risk factor for a past suicide attempt among American Indian and Alaska Native male and female youth was having a friend who attempted or died by suicide. The study also found that having a family member who attempted or died by suicide was another significant risk factor for a past suicide attempt among both male and female adolescents. Similarly, the Suicide Bereavement Program of the Sioux Lookout Zone (Nishnawbe-Aski Nation) found that over 50% of the deaths by suicide and suicide attempts in that region were made by survivors of suicide, either immediate family or friends.

The high incidence rates of suicides and violent deaths in many Aboriginal communities mean that a large number of youth are experiencing firsthand the pain of suicide, if not in their family or in their community, then in a neighbouring village. It is therefore important that these young people be adequately supported in their own grieving and healing process.

People surrounding young people also need healing

Often, the people surrounding youth are themselves suffering from unresolved grief and the unhealthy behaviors of these people will in turn impact negatively on the youth. Many feel that historical trauma may be at the source of the deep sense of grief and loss felt by many Aboriginal people. This type of trauma is the result of decades of imposed changes and losses suffered at the hands of various Canadian institutions. These losses are so profound and have impacted so many people that they have led to entire communities being unable to create the type of social, economic, political and cultural context which nurtures individual and family health and promotes collective well-being. Elders say that the spirit of the people needs to be healed and many feel that this can only be done through the use of traditional healing practices.

Grieving and healing are important steps towards emotional and psychological health
The need for healing exists when people have lost the ability to be in harmony with the life process of which they are a part. By coming to understand what has happened to them and how these experiences are affecting them, people can finally come to validate

their reality and begin to develop their mental, emotional, physical and spiritual potential despite adversity. Through certain traditional practices and ceremonies, the pain can then be transformed into a powerful, life-giving force.

How do we know healing holds promise?

Although there is not, to date, any evaluating research demonstrating a decrease in youth suicide following the implementation of healing programs, there is enough indirect evidence to suggest that this strategy has potential for success.

Cleansing has been shown to help suicidal youth

A recent study investigating what type of strategies had helped a group of 25 Aboriginal youth from British Columbia recover from suicidal tendencies found that expressing emotions/cleansing was perceived to be one of the most successful healing strategies for these young people. The participants mentioned that by expressing emotions (whether through writing or crying), they were able to let go of their pain, get rid of bad feelings, and cleanse themselves. The connection to First Nations culture and tradition led to empowerment, pride, purpose, and meaning.

Experts recommend this strategy

The concept of healing is dominant in the Aboriginal literature and some have recommended using traditional healing as a suicide prevention strategy. Recently, the national and provincial governments have begun to notice the power of traditional healing and have been responding. For example, the Aboriginal Healing Foundation was formed in 1998 following a $350 million commitment from the Government of Canada. The Foundation supports community-based healing initiatives for Métis, Inuit, and First Nations people on and off reserve who were affected by the legacy of physical and sexual abuse in Residential Schools.

Setting up for success

1. Decide how you will structure your healing efforts

You have identified that there is a need for healing work in your community. Perhaps a young person has recently died by suicide or you get a sense that it is time for community members to come together and talk about the ills of the past. The next step will be to decide what to do and where to begin. Unfortunately, there is no tried and true recipe when it comes to developing a healing program for a specific segment of the population or mobilizing community members towards healing. The type of initiative that is right for your community will depend on the particular circumstances of the community, your culture, the issues you are trying to address, and the resources that are available locally.

One option is to invite outside professionals to come in and deliver a workshop that will set the community healing in motion so that community facilitators and healers have a process to build on rather than having to start from nothing. See *A place to start* for examples of healing workshops.

2. **Involve youth and community members in the healing process**
   If you decide to focus on young people, they will be important assets in the development and success of the program. Their insights and experiences are crucial to determine what types of healing processes are likely to work. Young adults who have suffered in their past and survived can also be involved in sharing what has helped them and what is most likely to help their younger peers. If you embark on a community-wide healing journey, you will also need to consult with community members-at-large to increase the awareness of the need for the process but also to collect their ideas on how to the process should work.

3. **Ensure that you have prepared for follow-up**
   It can be expected that a certain number of young people (as well as adults) participating in healing workshops or ceremonies may respond more intensely than others and may require more structured help in the form of individual healing work and treatment. Healing workshops and ceremonies sometimes bring to the surface many strong emotions in participants, and young people may open up and talk about very personal issues and experiences which on occasion may signal the need for more intensive follow up from a mental health professional or counsellor. It is the responsibility of workshop facilitators and organizers to identify vulnerable youth (or adults) and take the necessary steps to ensure that they are supported and go on to receive appropriate care.

How will we know if we're making a difference?

You will know that your traditional healing program is making a difference if you can answer yes to questions listed in the table below under the headings *short-term*, *medium-term*, and *long-term indicators*. Please note that in order to detect changes over time we typically need to make a long-term commitment to the overall evaluation process. In other words, measuring success is not something you do at a single point in time and then forget about. The timelines that are included below are only guidelines, but they should give you a good sense about the need to measure the impact of our interventions at several points in time following the initial implementation of the strategy.

Short-term indicators: Short-term indicators are changes that the strategy itself is designed to produce and are usually measured right after, or up to two months following, the implementation of a program. Depending on the type of program being developed, short-term indicators can be measured using quantitative methods (e.g. pre-and-post tests measuring changes in skills or knowledge) or qualitative methods (e.g. interviews or focus groups designed to assess attitudes, opinions, and satisfaction).

Medium-term indicators: Medium-term indicators of success capture changes that you might expect further down the road and are usually measured three to six months after the implementation of a program. Medium-term indicators can be measured using methods such as surveys, questionnaires, interviews, or observations that look at changes in well-being, attitudes, or behaviours in young people or other groups/social environments targeted by the program.

Long-term indicators: Long-term indicators of success measure the ultimate goal of a program (usually a reduction in suicide and suicidal behaviours among youth) and are usually measured on an annual basis, starting two to five years following the implementation of a program.

Keep in mind that the indicators listed in the table below represent examples only and we invite you and your group to develop indicators that are in line with the specific goals and activities of your own traditional healing program. As the strategy of traditional healing may not easily lend itself to traditional evaluation methods, nor to the use of typical quantitative methods for measuring success, we invite you to be especially creative when choosing indicators and finding ways to measure the strategy's effectiveness. Identifying relevant indicators of success for your own program (and the methods by which these will be measured or monitored) represents one of the most important steps of your overall evaluation plan (see the section *Evaluate your community-wide suicide prevention efforts* in chapter 5).

Methods to evaluate

	Ask a Key Evaluation Question	Measure the Success
SHORT TERM*	Are young people (and/or community members) satisfied with the experience and the help received?	➢ measure satisfaction of participating young people (and/or community members) with the experience
MEDIUM TERM**	Are participating young people (and/or community members) showing improvements in emotional well-being?	➢ measure depression, self-esteem, healthy adaptation (e.g. school performance, peer relationships), suicide ideation by following the youth closely over time
	Are participating young people making healthier choices in their daily lives?	➢ measure alcohol and drug consumption, school attendance, involvement in healthy activities
	Are youth (and/or community members) identified as requiring additional counselling support being appropriately referred for professional help as needed?	➢ track the number of youth (and/or community members) being referred for additional professional helpmeasure appropriateness of these referrals
LONG TERM***	Are suicide and suicidal behaviours among youth decreasing?	➢ measure the number of deaths by suicide and attempted suicides in the community and compare to previous statistics

**** Short-term** (measured immediately to 2 months following program implementation)*
***** Medium-term** (measured 3 to 6 months following program implementation)*
****** Long-term** (measured 2 to 5 years following program implementation)*

A Place to Start

Workshops

The Young Warriors Foundation Healing Workshop

The Young Warriors Foundation provides a five-day healing workshop for Aboriginal communities. The workshop helps people walk through their personal trauma using a supportive process. Traditional methods of healing are utilized to facilitate spiritual awakening. Although the workshop has been provided mostly to adult audiences (around 25 people at a time), the Director of the Young Warriors Foundation indicates that this type of workshop would also be effective with a younger audience.

For more information, contact:
Young Warriors Foundation
2536 Kilmarnock
North Vancouver, BC
V7J 2Z5
Telephone: (604) 983-9813
Fax: (604) 983-9013
E-mail: info@lmanconsulting.com

Healing ourselves: Building a community-wide healing movement

This four-day workshop is intended for communities that are motivated to make changes. This intense training-of-trainers process prepares community staff and volunteers to facilitate and support long-term community healing and to link healing to practical, social and economic improvements. The workshop is most effective if repeated 3 or 4 times in a year, each time going deeper and involving more community members. Four Worlds trainers will travel to interested communities to deliver this workshop and will provide ongoing support after the training if requested to do so.

This Workshop:

- begins with ourselves – healing the caregivers and trainers
- introduces an integrative scheme of thought that shows how healing and social and economic betterment are interdependent processes and how neither one is sustainable without the other.
- addresses difficult issues such as substance abuse, co-dependent patterns, the abuse of women, children and elders, sexual abuse, political corruption, dependency thinking, the welfare addiction, community infighting, distrust, disunity, and conflict between families, religious perspectives and community factions.
- sets the stage for a sustained, long-term effort.
- sets the community healing in motion so the community facilitators have a process to support and build on rather than having to start from scratch.

For more information, contact:
Four Worlds International Institute for Human and Community Development
347 Fairmont Boulevard
Lethbridge, Alberta
T1K 7J8
Telephone: (403) 320-7144
Fax: (403) 329-8383
E-mail: 4worlds@uleth.ca
Web Site: www.uleth.ca/~4worlds

Organizations

Aboriginal Healing Foundation

The Aboriginal Healing Foundation is an Aboriginal-driven, not-for-profit corporation that is independent of both Government and the representative Aboriginal organizations. The Foundation is committed to addressing the healing needs of Métis, Inuit and First Nations affected by the legacy of physical and sexual abuse in Residential Schools, including intergenerational impacts.

The Foundation uses the monies received from the Government of Canada to support eligible projects that undertake holistic and community-based healing initiatives addressing the needs of individuals, families, and communities that complement existing programs, and meet healing needs that are not currently being supported. Eligible healing projects include those that incorporate traditional healing methods and other culturally appropriate approaches. Strong consideration is given to the special needs of all segments of the Aboriginal community, including Elders, youth and women. Four main program themes have been developed, and include: Healing (community approaches and healing centres), Restoring Balance, Developing and Enhancing Aboriginal Capacities, and Honour and History.

For more information, contact:
Aboriginal Healing Foundation
75 Albert Street
Suite 801
Ottawa, ON
K1P 5E7
Telephone: (613) 237-4441 or 1-888-725-8886
Fax: (613) 237-4442
E-mail: programs@ahf.ca
Web site: www.ahf.ca

Suggested reading

Adelson, N. (2000). Towards a recuperation of souls and bodies: Community healing and the complex interplay of faith and history. In L.J. Kirmayer, M.E. Macdonald, & G.M. Brass (Eds.), *The mental health of Indigenous peoples* - Culture & Mental Health Research Unit Report No.10 (pp.120-134). Montreal, Quebec: Institute of Community and Family Psychiatry, Sir Mortimer B. Davis - Jewish General Hospital & Division of Social and Transcultural Psychiatry, Department of Psychiatry, McGill University.

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Community Renewal Strategies

Community Development

What is community development?

Community development is a process in which the people of a community come together to take action to improve conditions in their community. The process allows community members to become actively involved in developing better living conditions for the community and to have a positive and meaningful influence on decisions that affect their quality of life.

Through citizen participation and local decision-making, the aim of community development is to enhance the well-being of an entire community in order to enable individuals to experience productive and satisfying lives.

Goals

More specifically, the goals of community development are to:

- strengthen the ability of communities to respond effectively to their social, economic, and health needs
- increase self-reliance and decision-making power of a community
- increase self esteem, self-confidence, social contact and mutual support among community members
- improve the level of skills and knowledge of community members
- improve social health and community cohesion
- build a sense of community belonging

Target population

By focusing on enhancing community well-being, this strategy targets those who live and work within the community as well as schools, businesses, organizations, and various levels of government.

Brief description

Community development is a process that is based on the belief that people and communities have the right and power to make decisions for themselves. The process encourages community members to identify the problems they share, make plans to meet their needs and solve their problems, and execute the plans with a maximum reliance on community strengths and resources. Community development therefore draws on the resources, talents, and energies of community residents to address and solve their own problems.

Bringing people together to solve local community problems is not a new idea. The principles and processes that characterize a community development approach have been used extensively by communities around the world to tackle a wide variety of economic, social, and health issues. Examples of issues that have been successfully addressed

through a community development model include lack of recreational activities, lack of subsidized housing, inadequate child care, high crime rates, and inaccessible health care services.

While the types of problems and related solutions naturally vary from place to place, community development initiatives typically adhere to a number of general beliefs and assumptions:

- progress is possible
- "bottom-up" initiatives have a better chance of success
- communities have innate talents and resources as well as the ability to solve their own problems and make changes on their own behalf
- the changes people make for themselves have more meaning and validity that those recommended by external people and organizations
- collective action is more effective than individual action
- participation in the public life of a community by all its citizens is a valuable thing

The strategy of community development follows an orderly process, usually led by a project team, which includes the following steps: Create awareness; Analyze community needs and resources; Identify priorities for action and develop an action plan; Accomplish the tasks identified in the action plan (See the section *Setting up for success* for more details).

Why should we engage in community development?

Social problems are best understood in the context of the community

Social problems are best understood when viewed within the context of a particular community. In addition, effective solutions to identified social problems are more likely to emerge through the involvement of those individuals or groups who have the most direct involvement with the issue or problem. It follows that in order to address complex social factors and problems within a community, recommendations for action should be generated by community members themselves.

For example, community members who are concerned with high young offender rates may, in consultation with youth, realize that the problem is exacerbated by a lack of meaningful work and leisure opportunities for youth. Community development principles highlight the fact that problems exist within the unique context of a community, that solutions require collective responsibility and action, and that everyone has a potential role to play.

The process of community development is relevant to youth suicide

On the one hand, we know that certain broad-level community characteristics can significantly compromise the healthy development of children and adolescents. For example, social indicators of community distress, including substance abuse, family violence and school dropout rates, are often interrelated and are linked with suicidal behaviour. On the other hand, we also know that there are a number of protective factors

at the community level that can protect children and adolescents against risk for suicide. These include a hopeful social climate that offers opportunities to be meaningfully engaged, community self-determination and solidarity, and availability of resources.

Does community development work?

The community development model has withstood the test of time

The strategy of community development has been around for a long time and represents a well-established and time-tested approach to solving community problems and empowering community members. In addition to creating meaningful change, meeting needs, and fostering a sense of community belonging, this strategy has also proven to hold additional benefits for the citizens who actively participate in such projects. These include substantial personal growth and the development of valuable social support resources.

Community development models have been successfully applied to the problem of suicide

A noteworthy community development model for addressing the problem of suicide was developed in the state of Alaska. The Community-Based Suicide Prevention (CBSP) project was implemented in a number of small Aboriginal communities. Project evaluation findings have been impressive and provide further support for adopting a community development model to address the problem of suicide.

For example, the CBSP evaluation found that participating communities had instituted a number of community-based programs and responses for dealing with self-destructive behaviours. The evidence has also shown that individuals living in these communities had been positively influenced by these changes. In addition, there is evidence suggesting that suicide rates in CBSP communities have declined at a faster rate than the state-wide suicide rates for Alaska Natives.

Setting up for success

There are seven issues that you should consider when setting up your community development initiative.

1. **Create awareness**

   There is no single clear path to follow in a community development process. Often, a person or group concerned about the quality of community life, or the impact of a particular problem, will begin by organizing and talking with others. The group may begin by doing a little background research on the issue at hand. As interest grows, additional informal linkages may form. Finally, a consensus is reached that the community is "ready" for moving ahead because there is: recognition of the problems, motivation to change, and willingness to take responsibility for making things happen. Therefore, all it takes to start the process is for an individual or a group to take responsibility, initiate a process of discussion, and create the impetus for action. The ball has begun rolling.

2. Learn more about community development

Success with community development initiatives will be maximized if project leaders are committed to the principles of community development and have a good understanding of the "how to" process. There are a number of user-friendly publications that can guide you through the steps of assessing, planning, implementing, and evaluating a community development project. Alternatively, you may want to begin by organizing a workshop on community development to be attended by community members interested in participating in your project. Please refer to *A place to start* for examples of workshops and resources that are Aboriginal-specific.

3. Form a core group to lead the community development initiative

Setting up a core group of committed community members is critical to the success of a community development approach. The crucial element which makes this core group different from any other group in the community is that its members have in some way identified and articulated a problem or set of problems in their community which need to be addressed. This is also a group which is prepared to take a risk and initiate some method or approach to dealing with the problems. To ensure that the committee is sustainable, it should be made up of committed individuals who agree to work collectively for the benefit of the community. It is wise to encourage representation from a wide array of sectors including key community and social organizations, seniors and youth groups, family members of suicide victims, small businesses, schools, police/RCMP, local government, and others.

4. Emphasize citizen participation

Citizen participation represents a cornerstone of any community development initiative. Channels should be created for citizens to voice their concerns and clear opportunities for participation in the decision-making process should be easily apparent. Such opportunities can include sitting on the core committee, attending open community forums, working on subcommittees, and attending decision-making meetings. Creating and sustaining high levels of citizen involvement in this type of project can be a complex undertaking and is often more difficult than expected. Here are a few tips that can facilitate citizen participation:

Accessibility and concrete support. To maximize opportunities for participation, residents can be offered financial assistance and/or practical help with such things as transportation to meetings, child care during meetings, and compensation for time spent serving on committees. Other considerations include scheduling meeting times and settings to meet the needs and accommodate the lifestyles of all participants.

Training/preparing community members for their roles. Training sessions, workshops, and skill development opportunities offered by other qualified

community members or outside professionals have reportedly helped residents to increase their knowledge and extend their capacities for participation.

5. Follow a formal process

Community development is known for following a fairly formal but logical approach. The steps are as follows:

a) *Analyze community needs and resources.* Any successful community development initiative starts with a little introspection. Through community analysis, a core working group begins to draw a realistic picture of the actual and perceived needs of a community. It is fairly easy to gather information about a community by reviewing existing statistical data (demographic, social, health, and economic indicators) and by consulting community members themselves. In consulting with community members, people are asked about their concerns and what they think are the roots of the particular problem being addressed. This can be done informally, through conversations and observations, or formally, through surveys and open community meetings. As facts and opinions are emerging about the needs in the community, the group will also want to learn what resources, services, programs and funding sources are already available within the community.

b) *Identify priorities for action and develop an action plan.* After basic information has been gathered about community needs and existing resources, the group selects priority issues to tackle and determines what they would like to accomplish by setting goals. In order to increase the community's commitment to these goals, opportunities for input are usually created to hear from specific stakeholders as well as the community-at-large. Once a consensus has been reached and the community has validated and endorsed the overall vision, the group proceeds to develop a plan of action. This plan spells out how the goals will be met, and who will do what and when. It should also articulate how success will be measured.

c) *Accomplish the tasks identified in the action plan.* At this stage, it is time to mobilize the resources so the plan can be carried out. If community members have been involved along the way, they are more likely to be motivated to commit time to organizing the necessary resources to ensure the project's success. During this phase, regular meetings are scheduled in order to make sure that all components of the action plan are being implemented correctly. Project progress and milestone successes can be shared with the community through the media or community events, in order to maintain momentum.

d) *Review your efforts.* Reviewing your efforts is an important step as it will allow your group to see whether your community development initiative has met your goals and objectives. In addition, you should take the time to find out if people involved in the process were satisfied with the experience and whether there were any unforeseen positive or negative outcomes of the project.

6. When in doubt, start with what is most likely to succeed

Community development work is a slow process that demands a lot of time and energy on the part of those committed to seeing it through. In order to sustain the momentum and provide all involved with a sense of mastery, you may start by tackling issues that have the best chance of success within the shortest period of time. You can augment existing programs or revitalize current public education campaigns to amplify the impact of your activities. Once a track record of community credibility and support has been established, you can move on and tackle more difficult issues.

7. Consider hiring help from outside

Sometimes, hiring someone from outside the community to help your group through your community development effort is a good idea. Outsiders can help your group get started and help restart a community process that has become stuck. Someone with training in community development and experience can bring examples of projects from other communities, offer suggestions and insights that are difficult for insiders to see, and help identify and resolve unspoken issues that block growth. If your group decides to make use of an outside community development specialist, make sure that the person has the necessary skills and experience. You should remember that your group should always maintain their roles and ownership in the process even when you have someone helping you, as community development works only if the community itself is doing it.

How will we know if we're making a difference?

You will know that your community development program is making a difference if you can answer yes to questions listed in the table below under the headings *short-term*, *medium-term*, and *long-term indicators*. Please note that in order to detect changes over time we typically need to make a long-term commitment to the overall evaluation process. In other words, measuring success is not something you do at a single point in time and then forget about. The timelines that are included below are only guidelines, but they should give you a good sense about the need to measure the impact of our interventions at several points in time following the initial implementation of the strategy.

Short-term indicators: Short-term indicators are changes that the strategy itself is designed to produce and are usually measured right after, or up to two months following, the implementation of a program. Depending on the type of program being developed, short-term indicators can be measured using quantitative methods (e.g. pre-and-post tests

measuring changes in skills or knowledge) or qualitative methods (e.g. interviews or focus groups designed to assess attitudes, opinions, and satisfaction).

Medium-term indicators: Medium-term indicators of success capture changes that you might expect further down the road and are usually measured three to six months after the implementation of a program. Medium-term indicators can be measured using methods such as surveys, questionnaires, interviews, or observations that look at changes in well-being, attitudes, or behaviours in young people or other groups/social environments targeted by the program.

Long-term indicators: Long-term indicators of success measure the ultimate goal of a program (usually a reduction in suicide and suicidal behaviours among youth) and are usually measured on an annual basis, starting two to five years following the implementation of a program.

Keep in mind that the indicators listed in the table below represent examples only and we invite you and your group to develop indicators that are in line with the specific goals and activities of your own community development program. As the strategy of community development may not easily lend itself to traditional evaluation methods, nor to the use of typical quantitative methods for measuring success, we invite you to be especially creative when choosing indicators and finding ways to measure the strategy's effectiveness. Identifying relevant indicators of success for your own program (and the methods by which these will be measured or monitored) represents one of the most important steps of your overall evaluation plan (see the section *Evaluate your community-wide suicide prevention efforts* in chapter 5).

Methods to evaluate

	Ask a Key Evaluation Question	Measure the Success
SHORT TERM*	Has your project adhered to the principles of community development and followed the proposed process (assessment, planning, implementation, and evaluation)?	➢ review project-related documentation for evidence that the project has adhered to the principles and process of community development
	Are people participating in the community development project satisfied with the overall experience?	➢ measure satisfaction with respect to the training received, overall process, and results accomplished
	Are people participating in the community development project showing improvements in personal resources and use of social support networks?	➢ measure skills in participants (e.g. decision-making, project management) before and after the implementation of the community development program and compare results to determine whether the program has made a difference ➢ measure personal development in participants (e.g. self-esteem and self-confidence) before and after the implementation of the community development program and compare results to determine whether the program has made a difference ➢ measure perceived social support in participants before and after the implementation of the community development program and compare results to determine whether the program has made a difference
MEDIUM TERM**	Do community members (including youth) feel a sense of increased control over community matters and a sense of belonging to the community?	➢ measure perceived sense of control over community matters ➢ measure perceived sense of belonging to the community
	Is there evidence that the project has led to positive changes within the community?	➢ review new policies, programs, services related to the area of concern identified by community members ➢ measure community well-being (e.g. employment opportunities, leisure/ recreational opportunities, crime rate, alcohol and drug consumption)
LONG TERM***	Are suicide and suicidal behaviours among youth decreasing?	➢ measure the number of deaths by suicide and attempted suicides in the community and compare to previous statistics

** **Short-term** (measured immediately to 2 months following program implementation)*
*** **Medium-term** (measured 3 to 6 months following program implementation)*
**** **Long-term** (measured 2 to 5 years following program implementation)*

'Namgis First Nation Youth Suicide Prevention

Location: 'Namgis Health Centre
Box 290
Alert Bay, BC
V0N 1A0
Telephone: (250) 974-5522
Fax: (250) 974-2736
Web site: www.namgis.org

Contact person: Margaret Lloyd, Mental Health Counsellor and Project Director

Program description: The 'Namgis First Nation reserve is located on the Cormorant Island, in B.C. Sharing the island with the reserve are the small community of Alert Bay, a small Whe-La-La-U Council Area, and a barely populated unincorporated area. The total population of the island is approximately 1400, of which about 60% are First Nations people. Approximately 740 First Nations people live on the 'Namgis reserve.

The 'Namgis Health Centre is situated on the 'Namgis reserve, but serves all the population on the island in the areas of health, community health, mental health, and social services. In June 2001, the Community Development department of the Health Centre organized a "Listening to Our People" weekend of consultation with the reserve population. Residents were invited to come to the Big House and provide their input on what they wanted for their community. Using that input, staff developed a community development plan, which is currently in the process of being formally approved. One of the issues raised by the residents was the need for locally developed suicide prevention efforts.

As a result of this community process, the health centre staff proceeded to draft a suicide prevention project, which was submitted for a grant in July 2001. The main purpose of the project is for the 'Namgis First Nation people to be involved in the development and implementation of youth suicide prevention approaches that are based on and sensitive to the culture of the Kwakwakawakw people. To accomplish this goal, the project plans to invite youth and their families to participate in a series of cultural camps. The first cultural camp will bring youth and elders together. The same young people and their families will attend the second cultural camp. The topic of suicide will be discussed during the camps and participants will be prompted to provide their views on what should be done to prevent youth suicide. In addition to this consultation process, other activities are planned for the camps including: story-telling, teaching of cultural skills, circles, teaching of family and band history, teaching of life skills, general relationship-building, and recreation.

Following the camping experience, project staff will use the information gathered to design culturally appropriate suicide prevention strategies and implement them as much as is possible.

Target groups: Youth (12 to 18 years old) from the 'Namgis First Nation reserve and their families.

Partners involved: The following agencies or organizations have agreed to be part of the project: 'Namgis Health Centre (Mental Health Department, Social Services Department, Community Development Department); School District #85 (Alert Bay Elementary, North Island Secondary School); T'lisalagilakw School; Band office; Children and Youth Council; RCMP, Alert Bay Detachment.

Years in operation: The project began in the summer of 2002.

Sources of funding: A grant has been secured from the BC Ministry for Children and Family Development through the Suicide Prevention Information and Resource Centre, Mheccu, Department of Psychiatry, UBC. The grant will be used to cover the following costs: salary of the Project Coordinator (who will be hired for a one-year period), honoraria for elders and youth, and travel costs. In-kind contributions (Health Centre personnel, administrative costs, camping supplies) will also be provided by the 'Namgis Health Centre.

Evaluation findings: An evaluation component to the project is being planned. The following changes are expected as a result of the project: a) increased awareness of and understanding of suicide and contributory factors by community members; b) increased availability of culturally-appropriate suicide prevention programs; and c) continued growth of people's comfort level to talk about suicide and its prevention. In addition, community suicide behaviours (actual suicides, attempts, threats, etc.) will be monitored.

Advice to others interested in starting this type of program:

- Get as much community support as possible when developing this type of project;
- Develop a strong team of enthusiastic members to help you with the project.

A Place to Start

Workshops

Weaving the Web: Suicide Prevention and Community Development for Aboriginal People

Using a 4-phase community development model, participants in this three-day workshop will learn about how to initiate and implement suicide prevention initiatives that will make a difference in their community. The goal is to build a sense of community that recognizes the need for collaboration and cooperation. The community development wheel starts with reflecting on the needs and challenges of your community and for you personally. From there, it moves through goal setting, building a team, initiating action, persevering through the hard times and reviewing your journey. The three-day workshop is interactive, with many examples from other communities and ample opportunity to work on your community strategy.

For more information, contact:
Centre for Suicide Prevention
Suicide Prevention Training Programs (SPTP)
Suite 320, 1202 Centre Street S.E.
Calgary, Alberta
T2G 5A5
Telephone: (403) 245-3900
Fax: (403) 245-0299
E-mail: sptp@suicideinfo.ca
Web site: www.suicideinfo.ca

Community Development Basics

This three-day workshop provides a practical, hands-on introduction to community development. It is aimed at program leaders and frontline workers who want to learn how to move from an agency-centered service-delivery approach to a people-centered community-development approach. Four Worlds trainers will travel to interested communities to deliver this workshop.

This workshop:

- introduces an integrative model (a map) that has proven highly effective in guiding practitioners through community development processes.
- provides a set of guiding principles and tools to use them which shows how we must work if we really want to get communities involved and empowered.
- introduces a tool kit of games, exercises, stories, and instruments that have proven highly effective in many different community development situations.
- uses participatory and experiential learning strategies as the primary workshop methodology.

- is based on practical case studies from around the world.
- is designed so that the learners' specific needs and situations become central to the curriculum.
- is structured to be personally revitalizing for learners and effective in strengthening work team solidarity by modeling community building processes throughout.

For more information, contact:
Four Worlds International Institute for Human and Community Development
347 Fairmont Boulevard
Lethbridge, Alberta
T1K 7J8
Telephone: (403) 320-7144
Fax: (403) 329-8383
E-mail: 4worlds@uleth.ca
Web Site: www.uleth.ca/~4worlds

Resources

Community Action Resources for Inuit, Métis and First Nations: A community development kit

Community Action Resources for Inuit, Métis and First Nations is a community development kit developed by Health Canada specifically for Aboriginal people, taking into consideration their values, culture and way of life. The series of six manuals contains information, tips, examples and ready-to-use charts that you can copy for yourself or use to train others in your community. Each of the first five manuals in the kit presents one of the stages of the community development process in detail: Assessing needs; Planning; Finding Resources; Making it happen; and Evaluating. The last manual is a "toolbox" that contains information useful at any stage in the process.

You can view the manuals (in PDF format) on the Health Canada web site at following address: www.hc-sc.gc.ca/hecs-sesc/cds/publications/index.htm (scroll down to the heading "Aboriginal Peoples" where you can access all six manuals).

Alternatively, you can order a copy of the *Community Action Resources for Inuit, Métis and First Nations* kit online at www.hc-sc.gc.ca/fnihb/bpm/prc/prc_orderform.htm (MC-14 Toolbox, MC-15 Assessing needs, MC-16 Planning, MC-17 Finding resources, MC-18 Making it happen, MC-19 Evaluating). If you are unable to order online, you can mail or fax your order to:

The Publication Resource Centre
First Nations and Inuit Health Branch
Business Planning Management Directorate
Information Management & Administration Services Division
20th Floor, Jeanne Mance Bldg.

Tunney's Pasture, Postal Locator 1920A
Ottawa, ON
K1A 0L3
Fax: (613) 954-8107
E-mail: CHPD_Clearinghouse-centre_d'information_DPSC@hc-sc.gc.ca

Developing Healthy Communities: Fundamental Strategies for Health Promotion
This basic text reflects the struggle for healing and self development among Indigenous peoples and the need for community development as part of holistic, culturally-based health promotion process. A holistic framework is presented to understand community development thinking, followed by down-to-earth strategies for community level workers and outside agencies implementing community development programs.

This resource can be ordered from:
Four Worlds International Institute for Human and Community Development
347 Fairmont Boulevard
Lethbridge, Alberta
T1K 7J8
Telephone: (403) 320-7144
Fax: (403) 329-8383
E-mail: 4worlds@uleth.ca
Web Site: www.uleth.ca/~4worlds

Pulling together: A manual for community development
This user-friendly manual, developed by the Alaska Department of Health & Social Services, came about from the work of the Community-Based Suicide Prevention Program. The manual provides an easy-to-use approach to community development. Some of the topics covered include: the community development process; the roles of community workers, volunteers, and committees; issues related to meetings; special issues like interpersonal tensions and personal development; and getting help from outside (community development specialist).

This resource can be obtained from:
Community-Based Suicide Prevention Program
Rural Services, Division of Alcoholism & Drug Abuse
Alaska Department of Health & Social Services
Box 110607
Juneau, Alaska
99811-0607
USA
Telephone: (907) 269-3790
Fax: (907) 269-3786
E-mail: susan_soule@health.state.ak.us
Web site: www.hss.state.ak.us/dada/suicide.htm

Suggested reading

Bernier, J.A. (1994). *Community-based suicide prevention program: An innovative strategy to reduce suicide and drinking in small Alaskan communities*. Alaska: Alaska Department of Health and Human Services.

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Camiletti, Y.A. (1996). A simplified guide to practising community-based/community development initiatives. *Canadian Journal of Public Health*, 87(4), 244-247.

Chalmers, K.I. & Bramadat, I.J. (1996). Community development: Theoretical and practical issues for community health nursing in Canada. *Journal of Advanced Nursing*, 24, 719-726.

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Labonte, R. (1993). Community development and partnerships. *Canadian Journal of Public Health*, 84(4), 237-240.

Ministry of Health (1989). *Healthy communities: The process*. Victoria, BC: Ministry of Health.

Pancer, S.M. & Cameron, G. (1994). Resident participation in the Better Beginnings, Better Futures prevention project: The impacts of involvement. *Canadian Journal of Community Mental Health*, 13(2), 197-211.

Pancer, S.M. & Nelson, G. (1990). Community-based approaches to health promotion: Guidelines for community mobilization, *International Quarterly of Community Health Education*, 10(2), 91-111.

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

Shaffer, C. & Anundsen, K. (1993). *Creating community anywhere: Finding support and connection in a fragmented world*. New York: Jeremy P.Tarcher/Perigee Books.
State of Alaska (1990). *Pulling together: A manual for community development*. Alaska: Dept. of Health and Social Services, Division of Mental Health & Developmental Disabilities, Rural and Native Services.

White, J. & Jodoin, N. (1998). *Before the fact interventions: A manual of best practices in youth suicide prevention*. Vancouver, BC: Suicide Prevention Information & Resource

Centre of British Columbia, Co-operative University-Provincial Psychiatric Liaison (CUPPL), University of British Columbia.

Community Renewal Strategies

Interagency Community and Coordination

What is interagency communication and coordination?

Interagency communication and coordination involves the coming together of various key agencies and organizations within a geographic area in order to facilitate a coordinated response to the behaviours of youth-at-risk. The end product of this interagency process usually entails the development of protocols which guide the actions of all local agencies following, for example, a youth suicide or suicide attempt.

The aim of this strategy is two-fold. The development of interagency protocols ensures that at-risk and vulnerable youth will receive coordinated, timely, and effective support (assessment, treatment and follow-up) from the network of community service providers. Following a suicide, interagency protocols also ensure that the appropriate postvention steps will be undertaken to effectively support family, friends and other community members and prevent cluster suicides.

Goals

More specifically, the goals of interagency communication and coordination are to:

- clarify the roles and responsibilities of various service agencies within a community
- increase awareness of the range of community services available to at-risk and vulnerable youth as well as their families
- increase accessibility of community services for at-risk and vulnerable youth as well as their families
- increase coordination between agencies
- open communication channels between agencies
- ensure a timely flow of client-related information between agencies, while respecting rules of confidentiality
- avoid service duplication, agency confusion, and inappropriate referrals
- identify gaps in services for at-risk youth and determine which agency is best equipped and mandated to meet the identified gap

Target population

The strategy of interagency communication and coordination is designed to enhance the coordination of services to at-risk and vulnerable individuals. Once developed, interagency protocols should guide the actions and improve the coordinated response of a number of community agencies and services including mental health centres, hospitals, mobile crisis teams, child protection offices, distress lines, counselling centres, medical clinics, police/RCMP, schools, and religious organizations.

Brief description

This strategy brings together representatives from key agencies within a community (preferably those with some decision-making authority) in order to develop community-wide intervention and postvention protocols that will benefit at-risk youth and their families, as well as survivors and those exposed to a suicide. Protocols are formal, written statements that document the procedures to be followed by each community agency in the aftermath of a youth suicide attempt or suicide in the community.

Typically, an interagency protocol incorporates the following elements:

- detailed description of an intervention (procedures undertaken to prevent a potential suicide) and postvention (procedures undertaken following a death by suicide) components (see the box on next page for more detail)
- list of key service agencies within the community, along with respective roles and responsibilities, contact names and telephone numbers, and even copies of their internal procedures
- training plans and expectations of key personnel from community agencies
- directions as to how the protocol will be communicated, reviewed, and evaluated

Guidelines related to intervention and postvention

Interagency protocols should provide guidelines for intervention and support (to be activated once a suicidal youth has been identified) as well as postvention (to be activated after a suicide has taken place).

1. ***Intervention.*** *The intervention component of the protocol deals with the intake, assessment, treatment, and follow-up of at-risk individuals at the system-level. Some of the points to be addressed include:*

   - *Which agency(ies) will be responsible for the assessment and treatment/support of a suicidal youth at low risk? At medium risk? At imminent risk? Following a suicide attempt?*
   - *How will client-related information flow from one agency to another (e.g. when a youth who has attempted suicide is discharged from the hospital for follow-up treatment/counselling, what, if any, information will be shared with the mental health centre? child protection? the school?)?*
   - *How will parents become informed and supported?*
   - *How will issues of confidentiality be respected?*
   - *In what circumstances will a case management approach be utilized and who will act as case managers?*
   - *What types of linkages will be established with the school system?*

Guidelines related to intervention and postvention

Interagency protocols should provide guidelines for intervention and support (to be activated once a suicidal youth has been identified) as well as postvention (to be activated after a suicide has taken place).

2. ***Postvention.*** *The postvention component of the protocol refers to the manner in which an agency or community responds to a suicide death and specifies how vulnerable and at-risk survivors will be identified and provided with immediate and follow-up services. Some of the points to be addressed include:*

   - *How will information about the suicide be disseminated to the various service agencies? To parents? To school staff and the student body? To the media?*
   - *Is there a need for a crisis response debriefing team?*
   - *Which agency(ies) will be responsible for identifying, assessing, and treating/supporting vulnerable and at-risk survivors?*
   - *How will information be shared across agencies?*
   - *How will issues of confidentiality be respected?*
   - *Where will postvention services be provided, on-site or agency-based?*
   - *In what circumstances will a case conference take place to ensure all survivors have been properly identified and supported?*
   - *Who will participate in a follow-up review process to determine what was done well and what can be learned for the future?*

Why should we invest in interagency communication and coordination?

It is wise for community agencies to put plans in place in advance of a crisis

There are a number of different service agencies in existence in every community. Each of these agencies is guided by its own mandate and each provides a specific service to community members. The process of bringing together representatives of these agencies, prior to the emergence of a crisis, to develop a coordinated system-wide approach to the management of at-risk and suicidal youth reduces the likelihood that vulnerable young people will "fall through the cracks." The process also provides an opportunity for agencies to work out any disagreements, turf-issues, or feelings of competitiveness; issues which in the long run only serve to disrupt the effectiveness of the community-wide suicide prevention effort.

At-risk youth need immediate attention regardless of where they show up

There are a number of different ways for an individual at-risk to come to the attention of a community service provider. For example, a suicidal youth could call a crisis line, come to the attention of a teacher, or be taken to a medical facility by concerned parents. Regardless of how the problem of suicide was first identified, the suicidal youth must have an equal chance of receiving the most prompt and appropriate assessment and follow-up treatment. A well-communicated intervention protocol that specifies which agencies are responsible for seeing youth with different levels of suicide risk (low, medium, or high) facilitates fast and effective referral. Such a protocol is critical for maximizing the likelihood that the right type of assistance will be provided at the time when it is most likely to make a positive difference.

Efficient movement through the medical, mental health and school systems is important

Consider the case of a 15-year-old female who has attempted suicide by drug overdose and has been taken to the emergency room of the local hospital. Following medical clearance and discharge from the hospital, the youth now returns to school but she has been referred for follow-up counselling at the local mental health centre. In the best interest of the young girl and her family, it is important that these key organizations (hospital, mental health centre, school) communicate amongst each other regarding general treatment goals and progress, in a way that does not compromise the young girl's privacy. At this point, the family may also need support, especially if the youth resists treatment. An interagency intervention protocol can specify how this is to be accomplished, for example through a case management approach and through the use of client consent forms, in order for the youth to experience a smooth transition from one organization to the next.

After a suicide, survivors need help too

A youth suicide can deeply affect an entire community. The victim's family and friends as well as community members are likely to feel intense shock and grief. There is a real concern that adolescents exposed to a peer's suicide may be at increased risk to engage in suicidal behaviours themselves. It is therefore important for youth who knew the victim

to receive the news in an appropriate manner and that they be given immediate support. Other vulnerable youth also need to be identified to ensure that they will receive the appropriate level of follow-up care.

An "information-dissemination tree," which is a suggested component of an interagency postvention protocol, can serve to alert the victim's school, other schools, as well as helping agencies about a youth suicide before the media is informed. In addition, by identifying which agency will be responsible for responding to the needs of the survivors, the postvention protocol can facilitate the prompt and effective utilization of resources for the benefit of the community.

How do we know interagency communication and coordination holds promise?

Well-written protocols represent effective tools to guide the actions of a range of service providers

The effectiveness of interagency protocols in reducing suicidal behaviours in youth has not been specifically tested. However, we do know that written procedures and joint agreements in general represent effective approaches for improving the coordination of community-wide action in a time of crisis. Assuming that the protocol incorporates up-to-date information about "what works" in terms of intervention and postvention, and agency decision-makers and personnel are aware of the existing guidelines, then we can be confident that this strategy represents an effective tool for reducing suicidal behaviours in youth.

Setting up for success

There are five steps that should be addressed when setting up this strategy.

1. **Form an interagency working committee**

   The development of interagency protocols should, of course, involve and draw on the expertise of representatives from as many community service agencies as possible and should include the views of youth and their families who have been through the system. Family members who have survived the loss of a loved one to suicide have a very valuable perspective and often want to share their experiences with others in the hopes of preventing future suicides.

   It is therefore recommended that an interagency committee, representing a cross-section of views, be responsible for the development of the protocols. If your community already has such an interagency body in place, this may be the logical group to call upon for this task, depending on the group's composition. In the absence of such a group, a certain amount of preliminary work will be required to gather and empower key players to take on this task (see the box *Steps to interagency protocol development*).

2. Review existing interagency protocols and relevant reports

A number of communities have already developed and implemented interagency protocols. It may be valuable for your group to review a number of these protocols or speak with individuals who have had prior involvement in developing them. Doing this may speed up the process for your group and get you started "on the right track."

3. Have protocols "signed off" by the highest level of decision-making authority

Protocols that have been formally endorsed and validated by agency administrators and organizational leaders will have a greater chance of being adhered to than those that represent more informal or verbal understandings.

4. Link up with schools

A number of schools may already have their own suicide intervention and postvention policies and procedures in place. These procedures provide clear guidelines for school staff on how to respond to various situations involving students at-risk for suicide. However, school personnel often do not have the training to handle at-risk students or students bereaved by the suicide of a peer and are encouraged to refer these students to outside service agencies. It is therefore important that the procedures developed at the school or school district be compatible with the system-wide interagency protocol.

5. Publicize and disseminate the protocols to relevant community organizations and key service providers

Representatives from community agencies who have participated in the development of the interagency protocols will be responsible for ensuring they get disseminated within their own organizations. In addition, the interagency working committee should publicize and distribute the protocols to physicians, community gatekeepers, and other service providers who may not be aware of their existence. Systematic dissemination of the interagency protocols represents a crucial step to ensure that services provided to vulnerable or at-risk youth and their families are timely, coordinated, and appropriate.

Steps to interagency protocol development

1. *Define what geographical area your protocol will be covering.*

2. *Identify key stakeholders to form an interagency committee, and designate a chairperson. Stakeholders are agencies which have a primary responsibility for providing services to individuals who are potentially at risk. Examples of key stakeholder agencies and individuals include RCMP/tribal police, paramedics, mental health centres, hospital emergency departments, child protection offices, mobile crisis teams, distress lines, medical clinics, counselling centres, clergy and spiritual leaders, Elders, and schools.*

3. *Develop working definitions for all key words in the development of the protocol to ensure consistency and common understanding between all key stakeholders. Examples of key words include low risk, medium risk, imminent risk, risk factors, postvention, survivors, case management, and client consent.*

4. *List services currently offered by each agency (for example, medical treatment, counselling, crisis response, psychotherapy, self-help/support groups). Compile each agency's internal policies and procedures, specifying how they deal with at-risk youth as well as survivors of suicide.*

Adapted from Dube, J. (1995). Suicide prevention in rural communities, Lethbridge, AB: Lethbridge Family Services.

Steps to interagency protocol development

5. *Examine how at-risk individuals currently move through the existing system and specify how survivors are currently identified and supported. What are the key sources of this information (anecdotal or formal records)? Identify strengths and weaknesses.*

6. *Based on the information gathered under points 4 and 5, establish subcommunities to work on various elements of the system-wide protocol: intervention procedures, postvention procedures, information dissemination tree, training requirements, monitoring and evaluation, review and renewal.*

7. *Combine the recommendations of the subcommunities into an easy-to-read draft document. Review, circulate and make changes as necessary.*

8. *Officially adopt the system-wide protocol for the community through a formal and written "sign-off." Distribute widely throughout the community.*

9. *Monitor and evaluate.*

10. *Commit to undertaking an annual review and update as necessary.*

Adapted from Dube, J. (1995). Suicide prevention in rural communities, *Lethbridge, AB: Lethbridge Family Services.*

How will we know if we're making a difference?

You will know that your interagency protocol development initiative is making a difference if you can answer yes to questions listed in the table below under the headings *short-term*, *medium-term*, and *long-term indicators*. Please note that in order to detect changes over time we typically need to make a long-term commitment to the overall evaluation process. In other words, measuring success is not something you do at a single point in time and then forget about. The timelines that are included below are only guidelines, but they should give you a good sense about the need to measure the impact of our interventions at several points in time following the initial implementation of the strategy.

Short-term indicators: Short-term indicators are changes that the strategy itself is designed to produce and are usually measured right after, or up to two months following, the implementation of a program. Depending on the type of program being developed, short-term indicators can be measured using quantitative methods (e.g. pre-and-post tests measuring changes in skills or knowledge) or qualitative methods (e.g. interviews or focus groups designed to assess attitudes, opinions, and satisfaction).

Medium-term indicators: Medium-term indicators of success capture changes that you might expect further down the road and are usually measured three to six months after the implementation of a program. Medium-term indicators can be measured using methods such as surveys, questionnaires, interviews, or observations that look at changes in well-being, attitudes, or behaviours in young people or other groups/social environments targeted by the program.

Long-term indicators: Long-term indicators of success measure the ultimate goal of a program (usually a reduction in suicide and suicidal behaviours among youth) and are usually measured on an annual basis, starting two to five years following the implementation of a program.

Keep in mind that the indicators listed in the table below represent examples only and we invite you and your group to develop indicators that are in line with the specific goals and activities of your own interagency protocol development initiative. Identifying relevant indicators of success for your own program (and the methods by which these will be measured or monitored) represents one of the most important steps of your overall evaluation plan (see the section *Evaluate your community-wide suicide prevention efforts* in chapter 5)

Methods to evaluate

	Ask a Key Evaluation Question	Measure the Success
SHORT TERM*	Has your community developed and adopted a system-wide protocol in accordance with the guidelines described in this section?	➢ review the adopted protocol to ensure that it includes the following elements: • role and responsibilities of each community agency • detailed description of the intervention (related to a suicide crisis) and postvention (related to a death by suicide) components • list of contact names and telephone numbers of community service agencies • specifications about how the protocol will be communicated, reviewed, updated and evaluated
	Has the system-wide protocol been communicated to all relevant service agencies, hospitals and clinics, schools, police/RCMP, religious institutions, and other relevant community organizations?	➢ verify that the protocol has been properly communicated to all relevant individuals and groups
	Are all relevant individuals aware of the protocol, its purpose, and its contents and do they understand their respective roles and responsibilities?	➢ measure level of knowledge and understanding of the system-wide protocol among relevant community individuals ➢ measure understanding of respective roles and responsibilities
MEDIUM TERM**	In the event of a clear suicide risk (e.g. young person imminently at-risk for suicide or an actual suicide), is the protocol correctly implemented?	➢ review the actions taken by involved individuals during the incident and ensure that these are in accordance with the contents of the system-wide protocol ➢ collect feedback from at-risk youth, families, service providers and agency personnel regarding the quality and usefulness of various components of the protocol (intervention measures, postvention measures) ➢ measure client satisfaction (ease of access, timeliness, level of personal stress/disruption based on transitions from one agency to another, expectations met)

**** Short-term** (measured immediately to 2 months following program implementation)*
***** Medium-term** (measured 3 to 6 months following program implementation)*

Methods to evaluate

	Ask a Key Evaluation Question	Measure the Success
MEDIUM TERM**	Are young people imminently at-risk for suicide correctly being identified and referred for further assessment and treatment?	➢ measure the number of youths referred by community individuals and the appropriateness of these referrals
	In the event of a youth suicide, are there any other suicide attempts or completions directly related to the first one?	➢ record the number of copycat attempts or suicides following the suicide of a young person in your community
LONG TERM***	Are suicide and suicidal behaviours among youth decreasing?	➢ measure the number of deaths by suicide and attempted suicides in the community and compare to previous statistics

*** **Medium-term** (measured 3 to 6 months following program implementation)*
**** **Long-term** (measured 2 to 5 years following program implementation)*

First Nations Suicide Prevention Protocol

Location: Dilico Ojibway Child & Family Services
200 Anemki Place
Fort William First Nation
Thunder Bay, Ontario
P7J 1L6
Telephone: (807) 623-8511
Fax: (807) 626-7999
E-mail: dilico@tbaytel.net
Web site : www.dilico.com

Contact person: Arnold Devlin, District Mental Health Supervisor and Chair of the Dilico Suicide Prevention Protocol Committee.

Program description: Dilico Ojibway Child & Family Services is a multi-purpose, integrated First Nation agency located in Northwestern Ontario that provides Child Welfare Services, Community Health Nursing Program, Long Term Care Services, and Child and Adult Mental Health Services. The latter includes a District Mental Health Service, a Child and Family Counselling Program, a Family Resource Team, a six-bed residential treatment program, day treatment program, and an adult drug and alcohol treatment program. In total, Dilico employs 180 full-time staff and over 300 foster homes.

Through these programs, Dilico serves the thirteen Robinson Superior First Nations and the Aboriginal populations in the urban communities of Northwestern Ontario such as Thunder Bay, Marathon, Geraldton, and Nipigon.

Alarmed by high number of suicides in clients who had been discharged from care, the agency set out to develop a Suicide Prevention Protocol that would build the capacity of staff to address these high rates of suicidality. As a result, the Dilico Suicide Prevention Protocol Committee was formed in September 2000 and continued meeting twice a month until September 2001. The Committee initially included 5 representatives from the various Dilico mental health programs. In June 2001, additional representatives from Child Welfare and Health Care Services were added as the work of the Committee began to move towards implementation.

The Committee first conducted a survey which revealed that only 8% of employees and foster parents felt capable of managing a person who was at risk for suicide, while 56% reported that they encounter persons whom they suspect may be suicidal at least once a month. Following the survey, the Committee set out to develop policies and procedures

regarding suicide to be followed by the entire agency. These policies and procedures include the following:

- program-specific flow charts that identify what staff are to do if they encounter a person who expresses suicidal thoughts, feelings, or behaviour
- procedures for the initial assessment of suicide risk
- procedures for care planning
- intake/referral/assessment procedures for suicidal clients
- definitions of immediate, moderate, and mild risk
- procedures for the management of suicidal clients at immediate risk
- procedures for clinical recording
- procedures for discharging clients from Dilico care who pose a risk for suicide
- postvention procedures for supporting a First Nations community who has lost a loved one to suicide
- death review procedures

In addition, two instruments have been developed as part of the Suicide Prevention Protocol to identify suicide risk. The first is the ASAP Suicide Screening Tool to be used by frontline staff (except mental health workers), supervisors, senior managers, support staff, maintenance workers, and foster parents. The second instrument is the Dilico Anishinabek Suicide Risk Assessment which is a thorough five-part assessment that will be used by mental health staff.

Training for all staff is crucial to the success of the Suicide Prevention Protocol and the appropriate use of the two instruments. Mental health workers will receive more intensive training (two days in length) that will focus on the use of the Risk Assessment instrument, intervention and counselling skills. The training for staff in all other programs will focus on the ASAP Screening Tool they will be using. Training for Health and Welfare staff will be accomplished in one day while Senior Management, support staff, and foster parents will participate in a half-day training session.

Target groups: The First Nations Suicide Prevention Protocol has been designed to guide the actions of all employees and foster parents working for Dilico Ojibway Child & Family Services (including administrative staff and senior management) when coming into contact with children, adolescents, and adults at-risk for suicide.

Partners involved: Although the project was initiated by Dilico Ojibway Child & Family Services, a link is currently being established with the Thunder Bay Regional Hospital (more specifically with the child & adolescent inpatient psychiatric unit as well as the Emergency department). Longer-term plans involve linkages with the First Nations schools, First Nations Policing, and the Crisis Response Teams from neighbouring communities.

Years in operation: The development of the First Nations Suicide Prevention Protocol began in September 2000 with the formation of the Dilico Suicide Prevention Protocol Committee. Staff training on policies and procedures as well as the use of the screening and risk assessment instruments began in 2003.

Resources: Dilico Ojibway Child & Family Services developed and began implementing the protocol using internal resources only as the agency was unsuccessful at securing external funding for the project. The agency also employed summer students from Lakehead University and the University of British Columbia to work on this project.

Evaluation findings: The agency has developed a tracking form that will be filled out by staff as they come in contact with suicidal clients. This information will thereafter be entered in a database. This system will allow for the tracking of suicide-related incidences as well as provide information as to whether the protocols and instruments are being used appropriately by agency staff.

Advice to others interested in starting this type of program: The implementation of suicide-related protocols in a large organization such as Dilico Ojibway Child & Family Services can be time-consuming and challenging. Therefore, individuals involved in the development and implementation of such protocols should be patient and prepared to meet with some resistance. In order to facilitate the process in your own organization, you should:

- get support and approval from senior management/Board
- locate and enlist the help of people in each program or department who are supportive of the process and the proposed changes

Available reports and materials:

- Dilico Suicide Prevention Manual (includes all policies and procedures as well as all relevant forms for documenting client suicidality, the ASAP Suicide Screening Tool, and the Dilico Anishinabek Suicide Risk Assessment)

A Place to Start

Organizations

Centre for Suicide Prevention
Suicide Information & Education Collection (SIEC)
Suite 320, 1202 Centre Street S.E.
Calgary, Alberta
T2G 5A5
Telephone: (403) 245-3900
Fax: (403)245-0299
Email: siec@suicideinfo.ca
Web site: www.suicideinfo.ca

SIEC is the largest English-language suicide information resource and library in the world, with extensive information on suicide prevention, postvention and intervention. The collection includes many samples of actual interagency protocols from communities across Canada. SIEC will copy the information and deliver the materials for a nominal cost.

Suggested reading

Dube, J. (1994). *CISPP subcommittee: Protocol meeting, February 4, 1994, Lethbridge*, AB: Lethbridge Family Services.

Dube, J. (1995). *Suicide prevention in rural communities*. Unpublished manuscript, Lethbridge Family Services, Alberta.

May, P. (1990). A bibliography on suicide and suicide attempts among American Indians and Alaska Natives. *Omega*, 21(3), 199-214.

Paul, K. (1995). The development process of a community postvention protocol. In B.L. Mishara (Ed.), *The impact of suicide* (pp.64-72). New York, NY: Springer Publishing Company.

Paul, K. (1993). *Post-vention (after-suicide) protocols*. Unpublished manuscript, Some Other Solutions, Fort McMurray, AB.

White, J. (1994). After the crisis: Facilitating the suicidal student's return to school. *Guidance and Counselling*, 10(1), 10-15.

White, J. & Jodoin, N. (1998). *Before the fact interventions: A manual of best practices in youth suicide prevention*. Vancouver, BC: Suicide Prevention Information & Resource Centre of British Columbia, Co-operative University-Provincial Psychiatric Liaison (CUPPL), University of British Columbia.

Community Education Strategies

Peer Helping

What is peer helping?

Peer helping programs select and train a number of children and adolescents to become "helpers" for other youth within their own peer groups. These programs serve to strengthen and improve the bonds and natural helping networks that already exist within peer groups. While peer helping programs have become a popular suicide prevention strategy in school settings across North America since the early 1980's, efforts to implement this strategy within Aboriginal communities are relatively more recent.

Goals

A peer helper program is generally structured around any or all of the following goals:

- to train selected students in basic helping and communication skills
- to promote the development of young people participating in the peer helping training in such areas as self-confidence, communication skills with adults and peers, problem-solving and decision-making abilities
- to provide peer helpers with action skills that can thereafter be used to influence certain risk and protective factors related to suicide including: substance abuse, self-esteem, loneliness, academic and personal achievement
- to utilize peer helpers in schools and other settings in a role of support for their peers
- to provide a source of referral for counsellors and teachers for young people experiencing such problems as isolation and poor achievement
- to provide a bridge between troubled youth and professional counselling resources
- to contribute to the development of a positive and caring environment in schools and other settings

Target population

This strategy targets young people from a range of diverse backgrounds to become peer helpers. The strategy also indirectly targets all youth who subsequently benefit from the helping work of the peer helpers.

Brief description

Peer helper programs train and support adolescents to provide supervised assistance to other adolescents who may be experiencing certain concerns or problems. Peer helping programs can be implemented in schools or any youth-friendly settings.

While these programs are all based on similar principles, they typically differ in terms of program goals, type of training and supervision provided, and roles and responsibilities assigned to peer helpers. How a school, organization, or community chooses to organize a peer helper program will depend on the particular needs of the organizing group as well as the resources that are available to implement and maintain the program.

There are five major components of peer helper programs:

1. *Selection of peer helpers.* The selection of young people who will be trained to become peer helpers usually begins by a nomination process (by self, peers, teachers, counsellors) followed by interviews (collective or individual) to validate the interest, commitment, and abilities of the young people.

2. *Training.* Training can be provided in many different ways. It can be offered as part of a formal school curriculum or on a volunteer basis. The length of the training will depend on the organization as well as the particular roles the peer helpers will be expected to fulfill. Typically, training focuses on any or all of the following:
   - knowledge of oneself
   - verbal and nonverbal communication skills
   - empathic listening, problem-solving and decision-making skills
   - referral process
   - ethics and confidentiality
   - information on community resources
   - special issues training (such as suicide, death and dying, drug and alcohol abuse, peer pressure, sexual issues, family issues)

3. *Peer helper roles.* Peer helpers are taught to recognize the signs of distress in their peers and will seek the help of a responsible adult if necessary. As such, they can be thought of as a bridge between troubled friends and the appropriate professional resources. Peer helpers can be trained and supervised to provide any of the following services:
   - listening and understanding
   - friendship and support
   - problem-solving assistance
   - referral to professionals
   - tutoring and academic help
   - orientation of new students
   - role modelling for younger children
   - career and educational assistance (for example goal-setting and course selection)
   - support for gifted children
   - one-to-one listening
   - conflict mediation
   - prevention programs (for example drug abuse and bullying)
   - referral to professionals

4. *Supervision.* Supervision and support of peer helpers can be done by qualified individuals such as school counsellors, teachers, community mental health workers, as well as former peer helpers. The amount and level of supervision will depend mostly on the roles and responsibilities of the peer helpers.

5. *Advertising the services of peer helpers.* A number of strategies can be used to market the program to the other youth within a school or community. These include posting on bulletin boards, introduction of peer helpers at school assemblies or other gatherings, or a story describing the program in a school newspaper or community paper. Some programs will prefer to avoid publicizing the names of the peer helpers in order for the helping relationship to develop in a more informal and spontaneous manner.

Why should we provide peer helping programs?

Peers naturally confide in each other so it makes sense to train youth to help their friends

Young people have a natural tendency to turn to their own peers and friends whenever problems or concerns arise, well before they will go to an adult, professional or other resource. As a result, peers are often the most knowledgeable about which young people may be experiencing certain problems like feelings of depression, drug and alcohol abuse, or an eating disorder. In addition, we know that the majority of suicidal adolescents will select a friend as the first person they will confide in. Young people also want to help each other but they do not always know how to do it.

Training young people in basic helping skills serves to capitalize on existing peer networks and enables peers to help each other, while facilitating referrals to appropriate professionals. There are several reasons why peer helpers represent a particularly effective way of reaching troubled youth:

- peer helpers can have more credibility with young people in contrast to adult professionals
- compared with adult helpers, peers may have a better understanding of the concerns and pressures facing young people their own age
- peer helpers are more likely to interact with other young people on a daily basis outside more formal settings such as a classroom

Peer support can enhance protective factors while tackling many risk factors for suicide

It is well known that having a healthy support network can act as a protective factor against suicide for young people. On the other hand, when youth perceive that they are being negatively received by their peers, they are more likely to develop emotional problems. The strategy of peer helping seems particularly well-suited to reducing risks factors for suicide which typically include isolation, alienation, withdrawal, and low social supports.

Peer helping also makes sense for Aboriginal communities

While the strategy of peer helping has found strong roots in non-Aboriginal settings, there is evidence that the strategy is also well suited to Aboriginal communities. For example, there are certain values naturally found in many Aboriginal communities (e.g.

kinship, generosity, respect) that can be further developed within the boundaries of a peer helping program.

We also know that Aboriginal children and adolescents form strong bonds with their peers. Some say that this is due, in part, to the fact that many parents have difficulty properly nurturing and educating today's youth because of their own past experience with residential schools and alcohol abuse. The lack of parental guidance and attachment problems between parent and child may therefore contribute to the importance of peers and peer groups in the eyes of many Aboriginal teenagers.

Finally, Aboriginal young people participating in a 1995 suicide prevention forum indicated that they knew when their peers had suicidal thoughts and feelings but didn't know what to do or say to stop them, nor where to send them to get further help.

How do we know peer helping holds promise?

Although peer helping has become a popular strategy in the fight against youth suicide across North America, there have not been many comprehensive outcome evaluations conducted to determine the effectiveness of this type of program. This is partly due to the multipurpose goals, diversity of peer roles and responsibilities, and range of target populations that characterize peer helping programs.

Impact on peer helpers and youth who come in contact with them

A number of research studies have noted that peer helping programs have a number of positive impacts on helpers themselves. These include: increased self-esteem, increased confidence, higher social and moral values, and increased decision-making ability. Studies have also shown that youth are generally satisfied with the support of a helping peer and that they would make use of the service again. The number of youth experiencing significant difficulties that have been referred to mental health professionals has also been shown to increase following the implementation of a peer helping program.

Evidence is emerging from Aboriginal settings

The US Centers for Disease Control recently published a report on the evaluation of a program implemented in 1990 in an Athabaskan tribe in rural New Mexico. This particular tribe has implemented a comprehensive suicide prevention program as a response to a high rate of youth suicide. One of many prevention activities implemented as part of the overall program was a school-based "natural helpers" program. The study showed that the level of suicidal acts had been significantly reduced following the implementation of the program and that this improvement was sustained over time. Of course, it is not possible to ascertain how much of that impact was due to the "natural helpers" program or the other components of the comprehensive suicide prevention initiative, but the results of the study are encouraging.

Experts and young people themselves recommend this strategy

Support for this strategy was found in the Aboriginal suicide prevention literature. Young Aboriginal people participating in recent suicide prevention forums and workshops have endorsed this strategy, especially when it is implemented in the schools and becomes part of the school curriculum.

Setting up for success

There are a number of steps that should be addressed when setting up a peer helper program in the school system or in a community-based setting.

1. **Become familiar with peer helping**

   The individuals involved in the development of a peer helping program must be able to anticipate and answer as many questions as possible about the topic. A good way to learn about peer helping is visit schools and organizations that have implemented peer helping programs or talk with the people involved with the programs. Studying the administrative and program procedures of other programs will help identify concepts and ideas that can be easily be transferred to your setting. You will also find a lot of books and articles that have been written on the topic. We invite you to refer to the boxes *A place to start* and *In our own backyard*.

2. **Gain the support of relevant stake holder groups**

   It is always important to gain the support of relevant groups when youth programs are being planned by a community. This becomes especially important when the long-term goal of the program is to have an impact on suicide rates, as suicide always represents an emotional and anxiety-provoking topic. As such, the rationale for the program, proposed training, as well as roles for trainees should be endorsed by all relevant individuals and groups. Such important stake holder groups include: youth themselves, parents, community members, caregivers, Elders, teachers, school administrators, and community professionals. Members of these stakeholder groups can also be invited to sit on an advisory committee that will oversee the planning and implementation of the program.

3. **Plan for your peer helping program**

   Planning for a peer helping program begins by setting clear goals and objectives that are related to the specific needs and concerns of the school or community. Once you have identified program goals and objectives, you can then focus on program design.

Planning involves answering the following questions:

- *Who will train the peer helpers?*
- *What roles and responsibilities will the peer helpers have?*
- *Who will supervise the peer helpers?*
- *How will the peer helpers be selected?*
- *How will the peer helpers be trained and by whom?*
- *How will the program be advertised?*

Research has identified a number of standards that should be present for a peer helping program to be successful:

- The program must be led and supervised by adults specifically trained and experienced in peer helping. The trainers and supervisors must be able to demonstrate and model the skills peer helpers are expected to learn. After a peer helping network has been well established, the initial helpers can become mentors/ trainers to the new peer helpers working side by side with the professional counsellors.

- Selection criteria must ensure that the trainees are representative of the social composition of the school or community. In other words, it is important to ensure that there is representation from all known natural "peer groups" within the school or organization. At the same time, trainees should include teens that have exhibited risk behaviours or suicidal tendencies as well as youth who have not. It is a good idea to approach children and adolescents who are already natural helpers within their own peer groups.

An innovative selection process

The Community Resource Centre serving the regions of Goulbourn, Kanata & West Carlton, in Ontario uses an innovative way to select peer helpers for their program. Implemented at the high school level, the program selects and trains both students and adults to become "Community Helpers." The selection process begins by anonymously asking all students to identify two youths and two adults they would likely approach for help with their personal problems. Adults and youth identified through this process (by at least three students for the future youth helpers and two students for the future adult helpers) are then asked for their participation as community helpers and go on to receive the appropriate training. This selection process ensures that the selected student helpers represent a true cross-section of the student population.

- The program must include structured training sessions for the selected future peer helpers that will be based on a proven curriculum (see *A Place to Start*). The training should be relevant to the needs of the group as well as the goals and of the group initiating the program. Curriculum content should be adapted for and relevant to the Aboriginal communities in which the training is being instituted.

- Children and adolescents selected as trainers must feel that their training is special and based on their needs and existing skills. Training must encourage enjoyment, involvement, and self-management. The trainees must gradually be involved in the determination of training activities, as well as the development and distribution of program information and services.

- Training methods must be interactive and experiential using coaching and feedback and include role rehearsal, homework, and practical assignments. Training sessions should be energetic in order to keep the kids entertained and focused. A training curriculum should include approximately 12-16 training sessions (two hours in duration) over a period of several weeks.

- Peer helpers must have on-going supervision during their term and continuing opportunities for learning are recommended. Supervisors should cultivate a good quality relationship with the peer helpers. This is important so that the work of the peer helpers can be adequately monitored and to allow for referrals to be made to professionals. Trainers can retain a resource role following the initial training.

4. **Consider using a peer helping training curriculum**
   There are several well established and well-accepted training curricula that can be readily implemented or modified to meet the specific needs of your school or organization (see the box *A place to start*). When selecting a curriculum, keep in mind that it should fit with the goals and objectives of your peer helper program. On the other hand, you may also invite professional trainers to come to your community to train your future peer helpers (again, see *A place to start* for some suggestions).

Are there any concerns associated with this strategy?

Some say peer helping is too much responsibility for young people

A number of people have voiced a concern related to the level of responsibility placed on the young helpers who are expected to provide a service for which they may not be adequately prepared or mature enough to handle. Some critics have reported that many peer helping programs attempt to address conditions that are much more serious than academic and developmental problems. Additionally, the heavy reliance on one-to-one helping roles suggests that we may be placing far too much responsibility on some peer helpers in dealing with potentially serious issues.

We need to keep peer helping programs in perspective

There is a real need for both professional counselling services and peer helping programs to coexist within a community. By assisting with the promotion of social and interpersonal wellness, peer helping programs can be seen as an extension of professional counselling services. However, we have to be vigilant and ensure that the focus of the peer helping programs remains on training young people to become helpers, not counsellors, and that their roles remain limited to academic and developmental issues.

In particular, peer helpers should be given a clear message that they need to involve an adult or professional whenever a potentially serious situation arises. As such, it is essential that the adult coordinator maintain contact with the peer helpers and schedule regular meetings to provide support for the peer helping team, with a strict emphasis on referring the more serious problems to the professional counselling team.

How will we know if we're making a difference?

You will know that your peer helping program is making a difference if you can answer yes to questions listed in the table below under the headings *short-term*, *medium-term*, and *long-term indicators*. Please note that in order to detect changes over time we typically need to make a long-term commitment to the overall evaluation process. In other words, measuring success is not something you do at a single point in time and then forget about. The timelines that are included below are only guidelines, but they should give you a good sense about the need to measure the impact of our interventions at several points in time following the initial implementation of the strategy.

Short-term indicators: Short-term indicators are changes that the strategy itself is designed to produce and are usually measured right after, or up to two months following, the implementation of a program. Depending on the type of program being developed,

short-term indicators can be measured using quantitative methods (e.g. pre-and-post tests measuring changes in skills or knowledge) or qualitative methods (e.g. interviews or focus groups designed to assess attitudes, opinions, and satisfaction).

Medium-term indicators: Medium-term indicators of success capture changes that you might expect further down the road and are usually measured three to six months after the implementation of a program. Medium-term indicators can be measured using methods such as surveys, questionnaires, interviews, or observations that look at changes in well-being, attitudes, or behaviours in young people or other groups/social environments targeted by the program.

Long-term indicators: Long-term indicators of success measure the ultimate goal of a program (usually a reduction in suicide and suicidal behaviours among youth) and are usually measured on an annual basis, starting two to five years following the implementation of a program.

Keep in mind that the indicators listed in the table below represent examples only and we invite you and your group to develop indicators that are in line with the specific goals and activities of your own peer helping program. Identifying relevant indicators of success for your own program (and the methods by which these will be measured or monitored) represents one of the most important steps of your overall evaluation plan (see the section *Evaluate your community-wide suicide prevention efforts* in chapter 5).

Methods to evaluate

	Ask a Key Evaluation Question	Measure the Success
SHORT TERM*	**About the peer helping training process:**	
	Are peer helpers satisfied with the training program?	➢ measure satisfaction regarding the training (e.g. materials, methods, trainers), supervision (e.g. process, supervisors), and program (e.g. helper roles, commitment)
	Do peer helpers hold more favorable attitudes related to helping a peer after after the training sessions?	➢ measure attitudes of peer helpers (e.g. favorable to help, non-judgmental) before and after the training and compare results to determine whether the training sessions have made a difference
	Do peer helpers show more knowledge related to helping after the training?	➢ measure knowledge of peer helpers (e.g. about confidentiality, referral process) before and after the training and compare results to determine whether the training sessions have made a difference
	Do peer helpers demonstrate more skills after the training?	➢ measure skills of peer helpers (e.g. questioning skills, empathy and listening skills, problem-solving skills) before and after the training and compare results to determine whether the training sessions have made a difference
	Are peer helpers showing improvements in their own personal resources and strengths?	➢ measure personal development (e.g. self-esteem, self-confidence, interpersonal abilities) before and after the training and compare findings to determine whether the training sessions have made a difference
	About youth receiving a peer intervention:	
	Are young people accessing peer helpers?	➢ measure number of contacts with peer helpers by the youth of the community
	Are young people in the community satisfied with the service provided by the peer helpers and do they feel it is a useful service?	➢ measure satisfaction regarding the "helping" experience from those who have accessed a peer helper for assistance

**** Short-term** (measured immediately to 2 months following program implementation)*

Methods to evaluate

	Ask a Key Evaluation Question	Measure the Success
SHORT TERM*	**About the peer helping training process:**	
	Are peer helpers satisfied with the training program?	➢ measure satisfaction regarding the training (e.g. materials, methods, trainers), supervision (e.g. process, supervisors), and program (e.g. helper roles, commitment)
	Do peer helpers hold more favorable attitudes related to helping a peer after after the training sessions?	➢ measure attitudes of peer helpers (e.g. favorable to help, non-judgmental) before and after the training and compare results to determine whether the training sessions have made a difference
	Do peer helpers show more knowledge related to helping after the training?	➢ measure knowledge of peer helpers (e.g. about confidentiality, referral process) before and after the training and compare results to determine whether the training sessions have made a difference
	Do peer helpers demonstrate more skills after the training?	➢ measure skills of peer helpers (e.g. questioning skills, empathy and listening skills, problem-solving skills) before and after the training and compare results to determine whether the training sessions have made a difference
	Are peer helpers showing improvements in their own personal resources and strengths?	➢ measure personal development (e.g. self-esteem, self-confidence, interpersonal abilities) before and after the training and compare findings to determine whether the training sessions have made a difference
	About youth receiving a peer intervention:	
	Are young people accessing peer helpers?	➢ measure number of contacts with peer helpers by the youth of the community
	Are young people in the community satisfied with the service provided by the peer helpers and do they feel it is a useful service?	➢ measure satisfaction regarding the "helping" experience from those who have accessed a peer helper for assistance

**** Short-term** (measured immediately to 2 months following program implementation)*

Methods to evaluate

	Ask a Key Evaluation Question	Measure the Success
SHORT TERM*	**About community caregivers:**	
	Are community caregivers satisfied with the service provided by the peer helpers?	➢ measure caregivers' levels of understanding of the program, their experiences with the peer helpers, and their opinions about the program's impact
MEDIUM TERM**	Are young people who are making use of the peer helping program showing improvements in emotional well-being?	➢ measure depression, self-esteem, and healthy adaptation (e.g. peer relationships)
	Are youth identified as requiring additional counselling support being appropriately referred for professional help as needed?	➢ measure perceived effectiveness and appropriateness of these referrals
	Are young people in the community demonstrating improved social well-being?	➢ measure well-being (e.g. young people can identify personal supportive contacts, young people report experiencing a sense of belonging, young people report feeling cared about)
LONG TERM***	Are suicide and suicidal behaviours among youth decreasing?	➢ measure the number of deaths by suicide and attempted suicides in the community and compare to previous statistics

**** Short-term** (measured immediately to 2 months following program implementation)*
***** Medium-term** (measured 3 to 6 months following program implementation)*
****** Long-term** (measured 2 to 5 years following program implementation)*

Peer Helpers of the Native Alcohol and Drug Abuse Counselling Association

Location: Native Alcohol and Drug Abuse Counselling Association
70 Gabriel St., P.O. Box 7820
Eskasoni, Nova Scotia
B1W 1B4
Telephone: (902) 379-2262
Fax: (902) 379-2412

Contact person: Dawna Gillis-Prosper, Special Projects Coordinator

Program description: This peer helping program is sponsored and coordinated by the Native Alcohol and Drug Abuse Counselling Association (NADACA), in Eskasoni, Nova Scotia. To date, over 160 young people from 12 First Nations communities have been trained as peer helpers.

Training is offered once a year in three different central locations. Prior to the delivery of the training session, the program is advertised in the neighboring First Nations communities. Interested young people are invited to contact their local Community Addictions Counsellor to discuss the program and register if they decide to participate. Parents of prospective peer helpers are informed about the purpose of the program and the contents of the training session.

The two-day training session focuses on interpersonal communication skills as well as expected roles and responsibilities as peer helpers. Peer helpers are trained to listen to their peers, recognize a variety of warning signs, and make appropriate referrals to the Native Alcohol and Drug Abuse Counselling Association of Nova Scotia Counsellors in their respective communities. Peer helpers also attend additional two-day workshops, in their own communities, that usually deal with specific topics such as suicide, loss and grieving, and drug abuse. These workshops are facilitated by various professionals who are hired by the Native Alcohol and Drug Abuse Counselling Association of Nova Scotia. In addition, peer helpers have the opportunity to attend regional youth rallies where they are able to exchange and share their respective experience in helping other youths.

In addition to their role as peer helpers, trained youth are also expected to act as role models for their peers and younger children in their communities. As such, they all volunteer for the local Boys and Girls Club chapter. Peer helpers help organize "diversion activities" for all youth in their respective communities. For older youth, this may entail dances, karaoke nights, camps while activities for younger youth include storytime, science, arts and crafts, and movies. Peer helpers also act as youth advisors for various organizations/programs in their communities.

Once the peer helpers are trained, the local Community Addictions Counsellors of the Native Alcohol and Drug Abuse Counselling Association of Nova Scotia become responsible for supervising and supporting the efforts of the peer helpers. Local group meetings are regularly scheduled to give peer helpers the opportunity to share their experience and learn from each other.

Target groups: In and out-of-school youth ranging in age from 13 to 19 years old are targeted to become peer helpers.

Partners involved: The Native Alcohol and Drug Abuse Counselling Association in partnership with several other local organizations.

Years in operation: This peer helping program has been in operation since January 1999.

Resources: The program is mostly funded by the Native Alcohol and Drug Abuse Counselling Association. There is also some cost-sharing with the local bands and other local organizations.

Evaluation findings: The training sessions are evaluated by youth in an open forum. The information gathered is used by the trainer to improve the format and contents of the training sessions. Focus groups and community feedback are also solicited.

In addition, the Coordinator of the program is in regular contact with Field Counsellors in order to stay informed about what is happening in each community. The Coordinator of the program writes a quarterly report which is presented to the Board of Directors of NADACA (all Chiefs of Nova Scotia).

Advice to others interested in starting this type of program: The most important advice is to involve young people right from the start in the development of a peer helper program. Throughout the life of the program, you should make sure to implement young people's ideas quickly in order for them to stay "on board."

Available reports and materials: Please contact the Special Projects Coordinator for more information about the program.

A Place to Start

Organization

Peer Resources
1052 Davie Street
Victoria, BC
V8S 4E3
Telephone: 1-800-567-3700
Fax: (250) 595-3504
E-mail: info@peer.ca
Web site: www.peer.ca/peer.html

Peer Resources is a national, nonprofit organization with the most experienced and published experts in peer, mentor, and coach systems in Canada. The organization delivers training workshops, administers the National Certification system for peer helper trainers, and publishes the Peer Counsellor Journal as well as training manuals and other information resources. The organization also provides consultation in peer helping to school, post-secondary institutions, professional groups, corporations, First Nations and other cultural organizations, as well as community agencies. This organization distributes the following resources:

- The Peer Counselling Starter Kit. The starter kit is a comprehensive training manual for teen and adult peer programs. The manual includes 12 training sessions and activities for 36-48 hours of training of youth to work in peer programs. Another portion of the manual deals with setting up a peer program. The third section of the manual offers an extensive bibliography on peer programs. This is Canada's most widely-used peer training manual.
- Peer Counsellor's Workbook. This student workbook includes activities, poems, and areas for note-taking. The workbook was written to accompany the Starter Kit.
- Peer Helping Guide for a Native Community. This author describes how to implement peer helping programs in First Nations communities.
- A Peer Counselling Program Evaluation for a Secondary School. This publication provides details and forms for evaluating school-based peer helping programs.

Curriculum

NAFC Youth Peer Counselling Project
This Youth Peer Counselling Project was developed by the National Association of Friendship Centres (NAFC) with the financial assistance of Health Canada, Addictions and Community Funded Programs, in 1994. The program was developed to deal primarily with substance abuse but it also aims to alleviate some of the many pressures facing urban Aboriginal youth. The program was implemented in Friendship Centres across Canada.

The NAFC program is not school-based so does not deal primarily with school-oriented problems. The program is designed to train young people to help other young people who live in an urban environment (not only those in school) to deal with the effects of alcohol, drug, and substances, which often interrupt young people's learning process and their lives. The training for the peer counsellors does not simply look at the problem of alcohol, drug, and substance abuse among young people, but also looks at why young people turn to alcohol, drug, and substances in the first place. The training is therefore holistically oriented.

Although this program deals primarily with alcohol, drug, and substance abuse, the training manual includes a section on suicide. That section examines suicide and suicide attempts among First Nations youth. The section outlines the warning signs of suicide, how to assess whether someone is suicidal, and how to deal with suicidal children, adolescents, and adults in both the early and the crisis stages.

For more information, contact:
National Association of Friendship Centres
275 MacLaren Street
Ottawa, ON
K2P 0L9
Telephone: (613) 563-4844
Fax: (613) 594-3428
E-mail: nafcgen@nafc-aboriginal.com
Web site: www.nafc-aboriginal.com

Workshop

Peer Helper Workshop

The Peer Helper workshop provides participants with the understanding and skills necessary to identify, support, and assist their peers in crisis to reach out to community resources. The workshop concentrates on the following topics: understanding loss and crisis; the role and responsibility of a helper; responding to a person in crisis: three steps; responsibility, consultation, and confidentiality; specific issues; and self-care for helpers. The format of the workshop is interactive and includes many exercises, practice-circles, small and large group discussion, and role plays in order to encourage the youth to share their experiences and skills and to build on their own strengths.

The workshop is geared to accommodate 25 participants or less and is facilitated by Darien Thira of Thira Consulting. Darien offers a number of workshops in a variety of fields to Aboriginal and non-Aboriginal professionals and community members.

For more information, contact:
Thira Consulting
2837 Yale Street
Vancouver, BC
V5K1G8
Telephone: (604) 255-0181
Fax: (604) 255-0181
E-mail: thira@telus.net

Suggested reading

AADAC (1994). *Peer support: Resource bibliography*. Edmonton, AB: Alberta Alcohol and Drug Abuse Commission.

Bodnar, A. & Devlin, A. (1994). *Suicide epidemic among First Nations youth: Patterns of grieving, new models or healing*. Prepared for the International Conference on Grief and Bereavement in Contemporary Society, Stockholm, Sweden.

Carr, R. (n.d.). *The theory and practice of peer helping*. Victoria, BC: Peer Resources.

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Kirmayer, L.J., Boothroyd, L.J., Laliberté. A., & Laronde Simpson, B. (1999). *Suicide prevention and mental health promotion in First Nations and Inuit communities* (Report No.9). Montreal, Quebec: Culture & Mental Health Research Unit, Sir Mortimer B. Davis - Jewish General Hospital.

Laurendeau, M.C., Tourigny, M., & Gagnon, G. (1990). Implantation et évaluation d'un programme d'aide par les pairs à l'école secondaire: bilan d'une première année d'opération. *Canadian Journal of Community Mental Health*, 9(1), 107-121.

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Morey, R., Miller, C., Fulton, R., Rosen, L., & Daly, J. (1989). Peer counseling: Students served, problems discussed and reported level of satisfaction. *The School Counselor*, 37, 137-143.

Nishnawbe-Aski Nation Youth Forum on Suicide (1996). *Horizons of hope: An empowering journey*. Thunder Bay, ON: Nishnawbe-Aski Nation.

Peer Resources. (n.d.). *Peer helping, Youth working together, Information for children, adolescents, and parents* (pamphlet). Victoria, BC: Peer Resources

White, J. & Jodoin, N. (1998). *Before the fact interventions: A manual of best practices in youth suicide prevention*. Vancouver, BC: Suicide Prevention Information & Resource Centre of British Columbia, Co-operative University-Provincial Psychiatric Liaison (CUPPL), University of British Columbia.

Community Education Strategies

Youth Leadership

What is youth leadership?

The strategy of youth leadership involves recruiting and training a number of young people to become youth leaders within their own communities. The approach aims to empower young people to become active participants in decisions that affect them as well as effectively address the problems faced by their peers in their respective communities. In addition to increasing the competencies and self-esteem of participating youths themselves, the approach of youth leadership can have a significant impact on other young people as well as the community as a whole.

Goals

Goals related to the youth leaders include:

- create opportunities for participating young people to develop life skills such as leadership, decision-making, problem-solving, communication, team-building, and task completion skills
- enhance the self-esteem and self-confidence of participating young people
- provide opportunities for young people to form meaningful friendships with peers sharing common experiences and/or interests
- provide youth with meaningful work experience
- give youth alternate and fun ways to spend their free time

Goals related to all youth as well as the community as a whole:

- create positive role models within communities
- encourage young people to become change agents within their communities
- empower young people to effectively address the problems faced by their peers
- facilitate the development of programs and services directed at youth that meet their needs and expectations
- foster a sense of belonging to the community
- contribute to the well-being and vitality of communities

Target population

This strategy targets young people from a range of diverse backgrounds to become youth leaders within their community. The strategy also indirectly targets all youth who subsequently benefit from the work and efforts of the trained youth leaders.

Brief description

Youth leadership programs can be implemented in schools or any youth-friendly settings. While these programs are all based on similar principles, they typically differ in terms of program goals, type of training and supervision provided, and the roles and responsibilities of the youth leaders.

How a school, organization, or community chooses to organize a youth leadership program will depend on the particular needs of the organizing group as well as the resources that are available to implement and maintain the program. There are four major components of youth leadership programs:

1. *Selection of youth leaders.* The selection of those young people who will be trained to become youth leaders usually begins by a nomination process (by self, peers, teachers, counsellors) followed by interviews (collective or individual) to validate the interest, commitment, and abilities of the young people.

2. *Training.* Once youth leaders have been identified, they undergo a formal training process. Training may include any or all of the following:
   - leadership and public speaking skills
   - needs assessment, project management, and fund raising
   - advocacy and lobbying
   - problem-solving and decision-making skills
   - personal development and self-esteem building
   - peer helping
   - suicide awareness education
   - community service delivery

   There is a real opportunity during the training session to talk about what problems youth are facing and what type of activities the participating youth would like to implement in their respective communities in order to address these problems. The goal would be for participating youth to leave the training session with a clear vision and tentative workplan of activities to be implemented.

3. *Roles of the youth leaders.* In each and every community, there are unique opportunities for young people to become involved and make a difference in the life of their peers. Examples include:
   - setting up a drop-in centre for youth
   - developing a local youth council
   - organizing recreational activities for youth
   - planning events related to health promotion and suicide prevention
   - speaking up against drug and alcohol abuse, school dropout, or school violence
   - volunteering time with younger children and acting as role models
   - representing youth at local council meetings and other community meetings

4. *Support for youth leaders.* The amount of adult support typically depends on the age of participants, their skill level, and the type of activities that they plan to implement. Overall support typically comes from an adult employee of a local organization or school. This person is responsible to check in with the team of youth leaders on a regular basis and can provide technical or logistical support, additional training, and general advice.

Youth Councils - Supporting the Leaders of Tomorrow

Several Aboriginal communities and regions across Canada are supporting the organization of Youth Councils or Youth Advisory Committees at the local, regional, or even provincial level. Typically, Youth Councils are made up of young people representing all surrounding communities but may also welcome a few ex-officio members like a paid Youth Coordinator or an Elder. Typically, the mission of Youth Councils is to provide direction to a regional Council or other structure with respect to youth-focused programs and services and any other matters pertinent to the youth population. Some Youth Councils also develop their own programs or services to directly address certain youth-related problems (like suicide or alcohol and drug abuse) that are felt to be of importance to the Council members. As well, participation in a Youth Council represents an excellent opportunity for young people to develop and strengthen their own leadership skills as training is often provided for members.

Why should we promote youth leadership?

Programs and services should be developed based on the needs of youth

Typically, decisions pertaining to programs for young people are made by adults and, at times, these decisions do not reflect young people's needs or interests. On the other hand, if young people are provided with the appropriate knowledge and skills and are supported in their efforts, we are more likely to see services and activities that more closely reflect the needs of these young people and their peers.

Youth have the knowledge to take action against suicide and other teenage problems

Youth suicide is a reality and a specific concern among young people. Youth involvement makes sense because most young people have direct experience with the issue of youth suicide as well as the other relevant problems faced by their peers such as drug and alcohol abuse and school violence. The same young people also possess valuable insight as to how these issues should be tackled at the community level.

Does youth leadership work?

There are benefits to participating youth

Once involved, youth are generally pleased and satisfied with the opportunity to participate, especially when their work and opinions get recognized and taken into account. There is also some anecdotal evidence that exists to suggest that participation can positively influence a number of protective factors against suicide, like improving self-esteem, creating opportunities for meaningful peer relationships, and enhancing specific skills like decision-making and problem-solving.

Experts and young people themselves recommend this strategy

Aboriginal youth participating in a number of suicide prevention conferences held in recent years indicated that they want to be involved in decisions that affect them and participate in meaningful ways. It is empowering to create opportunities for young people to speak in their own voices and run their own programs, as doing so gives them a sense of responsibility. Youth are generally very open to sharing their own experience and knowledge and participating in the development of solutions. In addition, experts working in the area of adolescent health recommend that young people themselves need to be given more opportunities to define the issues that most affect them.

Setting up for success

1. Build significant ties with relevant organizations within the community

The youth leadership program as well as the specific roles youth leaders take on must have the support of relevant groups, organization, and caregivers in a community. Relevant organizations and individuals in the community need to be aware of the program and its goals, the names of the youth leaders, as well as their proposed activities. This is important to ensure that the whole community is understanding and supportive of their efforts.

2. Plan for your youth leadership program

Planning for a youth leadership program begins by setting clear goals and objectives that are related to the specific needs and concerns of youth as well as the school or community sponsoring the program. Once you have identified program goals and objectives, you can then focus on program design.

Several Aboriginal communities and regions across Canada are supporting the organization of Youth Councils or Youth Advisory Committees at the local, regional, or even provincial level. Typically, Youth Councils are made up of young people representing all surrounding communities but may also welcome a few ex-officio members like a paid Youth Coordinator or an Elder. Typically, the mission of Youth Councils is to provide direction to a regional Council or other structure with respect to youth-focused programs and services and any other matters pertinent to the youth population. Some Youth Councils also develop their own programs or services to directly address certain youth-related problems (like suicide or alcohol and drug abuse) that are felt to be of importance to the Council members. As well, participation in a Youth Council represents an excellent opportunity for young people to develop and strengthen their own leadership skills as training is often provided for members.

During the planning phase, keep in mind the following:

- *Use wide selection criteria*. Selection criteria must ensure that the trainees represent the social composition of the community in which they will be working so that their future efforts stand a better chance of reaching all youth. As such, trainees do not need to include only young people who are considered "good kids" but should also include at-risk teens.

- *Provide adequate training.* Children and adolescent selected as trainees must feel their training is special and based on their needs and existing skills. This is important in order enable the youth to become effective leaders of change as well as to keep them interested, motivated, and empowered. This would involve structured training sessions or retreats using a combination of curricula (depending on the type of training provided). Training contents should be adapted to and contain materials relevant to the Aboriginal communities in which the training is being instituted. After a youth leadership program has been well established, the initial leaders can become mentors/trainers to the new apprentices.

- *Offer on-going support and supervision*. Although the youth leadership training program will initially help youth in developing a vision and planned suicide prevention activities, their efforts will need to be supported over time. Therefore, each community where the program is implemented should have one motivated and committed adult or group of adults who would be responsible for supporting the on-going efforts of the youth leaders or providing additional training. Initial trainers can retain a resource role following the initial training.

3. Choose a curriculum

There are several well-established and well-accepted training curricula that can be readily implemented or modified to meet the specific needs of your school or organization. When selecting a curriculum, keep in mind that it should fit with the goals and objectives of your own youth leadership program. On the other hand, you may also invite professional trainers to come to your community to train your future peer helpers (again, see *A place to start* for some suggestions).

How will we know if we're making a difference?

You will know that your youth leadership program is making a difference if you can answer yes to questions listed in the table below under the headings *short-term*, *medium-term*, and *long-term indicators*. Please note that in order to detect changes over time we typically need to make a long-term commitment to the overall evaluation process. In other words, measuring success is not something you do at a single point in time and then forget about. The timelines that are included below are only guidelines, but they should give you a good sense about the need to measure the impact of our interventions at several points in time following the initial implementation of the strategy.

Short-term indicators: Short-term indicators are changes that the strategy itself is designed to produce and are usually measured right after, or up to two months following, the implementation of a program. Depending on the type of program being developed, short-term indicators can be measured using quantitative methods (e.g. pre-and-post tests measuring changes in skills or knowledge) or qualitative methods (e.g. interviews or focus groups designed to assess attitudes, opinions, and satisfaction).

Medium-term indicators: Medium-term indicators of success capture changes that you might expect further down the road and are usually measured three to six months after the implementation of a program. Medium-term indicators can be measured using methods such as surveys, questionnaires, interviews, or observations that look at changes in well-being, attitudes, or behaviours in young people or other groups/social environments targeted by the program.

Long-term indicators: Long-term indicators of success measure the ultimate goal of a program (usually a reduction in suicide and suicidal behaviours among youth) and are usually measured on an annual basis, starting two to five years following the implementation of a program.

Keep in mind that the indicators listed in the table below represent examples only and we invite you and your group to develop indicators that are in line with the specific goals and activities of your own youth leadership program. As the strategy of youth leadership may not easily lend itself to traditional evaluation methods, nor to the use of typical quantitative methods for measuring success, we invite you to be especially creative when choosing indicators and finding ways to measure the strategy's effectiveness. Identifying relevant indicators of success for your own program (and the methods by which these will be measured or monitored) represents one of the most important steps of your overall evaluation plan (see the section *Evaluate your community-wide suicide prevention efforts* in chapter 5).

Methods to evaluate

	Ask a Key Evaluation Question	Measure the Success
SHORT TERM*	Are youth leaders satisfied with the program?	➢ measure satisfaction regarding the experience, training received (e.g. materials, methods, trainers), perceived learning, as well as adult involvement and support
	Are youth leaders demonstrating more skills in decision-making, leadership, and project management?	➢ measure skills in peer leaders (decision-making, leadership, project management, etc.) before and after the training/participation in the program and compare findings to determine whether the program has made a difference
	Are project goals as set out by the youth leaders being met?	➢ measure project success such as outcomes achieved, timelines and budget respected
	Are young people in the community satisfied with the projects or activities organized by the youth leaders?	➢ measure satisfaction with the components of projects or activities organized by the youth leaders
MEDIUM TERM**	Are youth leaders showing improvements in personal resources?	➢ measure personal development (e.g. self-esteem and self-confidence) in youth leaders who have participated in the program
	Do young people in the community feel that projects/activities organized by the youth leaders have brought positive personal benefits in their lives?	➢ invite young people to share how their participation in the projects/activities organized by the youth leaders has made a difference in their lives and what positive benefits were generated
LONG TERM***	Are suicide and suicidal behaviours among youth decreasing?	➢ measure the number of deaths by suicide and attempted suicides in the community and compare to previous statistics

**** Short-term** (measured immediately to 2 months following program implementation)*
***** Medium-term** (measured 3 to 6 months following program implementation)*
****** Long-term** (measured 2 to 5 years following program implementation)*

Youth Leadership Initiative

Location: Assembly of Manitoba Chiefs
200 - 260 St-Mary Avenue
Winnipeg, Manitoba
R3C 0M6
Telephone (204) 956-0610
Fax (204) 956-2109
E-mail: jasonw@mb.sympatico.ca
Web site: www.mfnyc.mb.ca

Contact person: Jason Whitford, Youth Initiatives Coordinator

Program description: The Youth Leadership Initiative is a program coordinated by the Assembly of Manitoba Chiefs. The goal of the program is to set up youth leadership structures/drop-in centres in Aboriginal communities across Manitoba in order to empower young people to effectively address the problems faced by peers in their respective communities. A current focus is the establishment of Youth Resource Centres in Manitoba First Nation Communities. The ultimate goal is a positive environment for all youths to gather and partake in organized activities.

The AMC Youth Secretariat and the Youth Advisory Committee are the main structures behind the program. The Youth Secretariat is comprised of a Regional Youth Coordinator and a Youth Coordinator's Assistant. The Youth Secretariat is supported by a 17-member Youth Advisory Committee. This Committee include young people (Youth Coordinators or other youth) representing all 5 tribal groups in Manitoba (approximately 12 urban and rural communities). This Committee meets 4 times a year to give advice and input on youth-related issues at the Assembly of Manitoba Chiefs level. Training is also provided to the members in the areas of leadership, suicide prevention, decision-making, team building, and self-governance, as well as culture. The members of the Advisory Committee are expected to report back to each of their areas and facilitate the development of local youth leadership structures or drop-in centres in their own communities. They are encouraged to share the information and training received with their peers and empower them to identify and work on locally relevant problems.

Recently, the Youth Advisory Committee recognized that training in suicide intervention was needed in local communities. A project will soon be submitted for funding which plans to train 20 youth to be suicide interveners and eventually to train 10 Youth or Youth Coordinators from across the province to become suicide intervention trainers. These youth would then train other youths in their own or adjacent communities in suicide intervention skills.

Once a year, a larger gathering is organized where youth leaders from communities across the province meet to share their experience, take part in further training opportunities, and build networks. These large gatherings are an opportunity to recognize and reward the local achievements of youth leaders. As such, youth leaders who have made a significant contribution in their own communities are given the spotlight and the chance to share their ideas and successes with their peers.

The Coordinator of the program, based at the Assembly of Manitoba Chiefs, is responsible for supporting the process of setting up and maintaining local youth leadership structures in individual communities, organizing the gatherings/meetings, and acting as a resource to the Youth Advisory Committee.

Target groups: This program targets youth from teenagers to young adults.

Partners involved: Assembly of Manitoba Chiefs

Years in operation: The program has been in operation since September 1998.

Program costs: Funded by Heritage Canada, HRDC, Indian & Northern Affairs Canada and fund-raising initiatives.

Evaluation findings: Surveys are filled out by participants of the regional gatherings. Feedback by participants has been very positive. Youth have indicated that they appreciate the opportunity to meet other youths and they feel they are taking home very valuable information to their communities. An evaluation of the Youth Advisory Committee is being planned.

Advice to others interested in starting this type of program: Please refer to the section “Start your own Youth Council” (on the web site www.mfnyc.mb.ca) for suggestions on how to start a youth council.

Available reports and materials: A description of the Youth Leadership Initiative is available by contacting the Youth Initiatives Coordinator.

A Place to Start

Organizations

The White Stone Project: An Aboriginal Youth Suicide Prevention Program

The White Stone Project: An Aboriginal Youth Suicide Prevention Program trains youth from First Nations communities to deliver life skills sessions to other youth in their own community. The White Stone Program was developed in a partnership between the RCMP National Aboriginal Policing Services and the Suicide Prevention Training Programs (SPTP), Calgary, Alberta. The vision for and the curriculum of the White Stone Project was informed by Aboriginal youth focus groups, current literature, participant feedback, and a review of programs in Canada, the United States and Australia. The term White Stone comes from an Ojibwa concept: one who teaches others how to grow old.

Aboriginal and Inuit youth 18-25 years of age who have been identified as natural leaders by their community and community-based service providers (youth worker, teacher, nurse, police etc.) are invited to take part in a *Training for Youth Educators* workshop. The five-day workshop is divided into two components: youth suicide prevention training (16 hours) and leadership training (19 hours). The suicide prevention training component focuses on: exploration of beliefs around suicide, dynamics of suicidal behaviours, discussions around the role of culture of origin, risk and protective factors, and intervention skills, as well as practice through simulations. The leadership skills component of the training concentrates on enhancing knowledge and experience in: group dynamics, planning and preparation of a Youth Education Session, presentation and leadership skills, working with vulnerable youth, as well as self-care and community implementation.

Learning takes place in a skill-affirming environment: simulations, individual and group presentations, pen and paper activities, group discussions, personal reflection, talking circle, stress busters, and random acts of leadership. In an open and flexible environment participants are encouraged to take charge of their learning through individual and group learning contracts, as well as by providing daily feedback. Responsive to the needs of participants, the training format can be modified to reflect their vulnerability, strengths, as well as their skills and abilities.

Following the training, youth leaders return to their community and work in partnership to offer Youth Education Sessions to other youth. The Youth Education sessions are intended to be presented to youth over the age of 16 who are not known to be actively at risk of suicide. The sessions are designed to be flexible and responsive to local needs. The sessions have a life skills development focus that incorporate self-esteem, problem solving, goal setting, as well as communication and coping skills. It is expected that the Youth Education Sessions would be offered as part of a larger community suicide prevention strategy.

For more information about this program, contact:
Centre for Suicide Prevention
Suicide Prevention Training Programs (SPTP)
Suite 320, 1202 Centre Street S.E.
Calgary, Alberta
T2G 5A5
Telephone: (403) 245-3900
Fax: (403) 245-0299
E-mail: sptp@suicideinfo.ca
Web site: www.suicideinfo.ca

Youth Councils: What A Great Way To Lead The Future

This workshop was developed and is being offered by Dave Jones, an Ojibway of the Garden River First Nation through his company, *Turtle Concepts: Options for People*, located in Garden River, Ontario. The workshop assists with the formation of an effective youth council, structuring and promoting your youth council and how to keep it active.

For more information, contact:
Turtle Concepts: Options for People
580B, Highway 17 East
Garden River First Nation, ON
P6A 6Z1
Telephone: (705) 945-6455 or toll Free: (877) 551-5584
Fax: (705) 945-7798
E-mail: info@turtleconcepts.com
Web site: www.turtleconcepts.com

Suggested reading

Coggan, C., Patterson, P., & Fill, J. (1997). Suicide: Qualitative data from focus group interviews with youth. *Social Science & Medicine*, 45(10), 1563-1570.

Collins, S. & Angen, M. (1997). Adolescents voice their needs: Implications for health promotion and suicide prevention. *Canadian Journal of Counselling*, 31(1), 53-66.

Hart, R.A. (1992). *Children's participation: From tokenism to citizenship*. Florence, Italy: UNICEF.

Kohler, M.C. (1982). Developing responsible youth through youth participation. *Child & Youth Services*, 4(3-4), 5-12.

Nishnawbe-Aski Nation Youth Forum on Suicide (1996). *Horizons of hope: An empowering journey*. Thunder Bay, ON: Nishnawbe-Aski Nation.

Nishnawbe-Aski Nation (2000). *Proceedings and resolutions from the conference: The Journey Continues: A Change for Our Children*, January 25-27, 2000. Thunder Bay, ON: Nishnawbe-Aski Nation.

White, J. & Jodoin, N. (1998). *Before the fact interventions: A manual of best practices in youth suicide prevention*. Vancouver, BC: Suicide Prevention Information & Resource Centre of British Columbia, Co-operative University-Provincial Psychiatric Liaison (CUPPL), University of British Columbia.

Community Education Strategies

Community Gatekeeper Training

What is community gatekeeper training?

Community gatekeeper training is an educational and skill-building effort designed to improve the knowledge and competency of certain community members in the recognition and crisis management of potentially suicidal young people. In the field of suicide prevention, the term "gatekeeper" refers to those individuals who typically come into contact with youth as part of their professional duties or volunteer responsibilities. Training community members in suicide risk recognition, imminent risk reduction, and referral procedures extends the work of youth suicide prevention to the whole community, thus maximizing the opportunity for youth at-risk to be recognized and appropriately referred to mental health professionals.

Goals

More specifically, community gatekeeper training aims to achieve the following goals:

- increase attitudes favourable to intervention
- increase knowledge about depression and the problem of youth suicide
- improve competency in the identification and crisis management of potentially suicidal adolescents
- increase awareness of helping resources

Target population

Community gatekeepers include parents, foster parents, health care professionals, child and youth care workers, police officers and RCMP members, corrections staff, coaches, natural helpers, and can be extended to include other youth-oriented service providers in the community such as recreational facility staff.

Brief description

The main purpose of this strategy is to train a number of "community gatekeepers" in suicide prevention and intervention. Community gatekeepers may or may not have a specific or explicit mandate to provide clinical assessment and crisis intervention, but are generally not in a position to provide continuing supportive counselling services to vulnerable youth.

Training is typically provided within the local community with the length of training varying from two to five-day workshops. The following topics are usually covered:

Knowledge. Community gatekeepers are provided with basic information about the magnitude of the problem of youth suicide; youth depression; risk and protective factors; warning signs; basic considerations for assessing risk; and community resources.

Attitudes. Participants are helped to understand how their attitudes will generally determine how they behave towards potentially suicidal youth. For community gatekeepers who hold attitudes that are incompatible with effective helping (e.g. "suicidal youth are just looking for attention, so it's best to ignore them") this aspect of the training – through the provision of basic knowledge and facts about the suicidal process – can serve to modify these detrimental attitudes.

Skills. Participants are given the opportunity to learn basic intervention skills for accurately assessing the level of risk and for providing a timely and effective response. Skills include how to initiate an intervention; how to assess the current level of risk; how to establish an effective plan for safety and follow-up; how to reduce imminent risk; and how to engage other helpers.

Referral sources. Participants are given information about local helping resources; how to access them; and how to make an appropriate referral for a suicidal young person.

Why should we provide community gatekeeper training?

Community gatekeepers have existing relationships with young people

Since those community members who are targeted to receive gatekeeper training are those who already have regular contact with youth by virtue of their occupations or volunteer roles, most of them will have natural skills for relating to young people. It is their level of contact with youth and the fact that they typically have existing relationships with groups of young people that make community gatekeepers ideal candidates to serve as "early detectors" of young people who are at potential risk for suicide.

Many community gatekeepers have never received any formal training

Health professionals, foster parents, police and RCMP members, coaches, volunteers do not typically receive formal training in suicide risk detection and intervention as part of their professional development. Community gatekeeper training will support them to develop some basic competencies in this area.

Suicidal young people do not always access the existing services

Vulnerable and suicidal youth can be found in a variety of settings within a community and many of them never seek out the services of a formal helping agency when they are feeling vulnerable. Therefore, we cannot rely on the efforts of the formal helping system alone to identify all potentially suicidal youth. It therefore becomes important to increase the number of people in a community who are skilled in the early detection and recognition of those who may be vulnerable, thus increasing the likelihood that suicidal youth will be identified and referred for appropriate follow-up.

How do we know community gatekeeper training holds promise?

Positive results have been noted

Research studies conducted in the general population have demonstrated that participants in community gatekeeper training programs have shown greater knowledge of warning signs and of community resources, as well as more confidence in dealing with high-risk youth when compared with the general public. Investigators have also reliably established that a two-day suicide intervention workshop can lead to improvements in the skills of participants and find that these skills can be maintained up to six months later. Following gatekeeper training, some participants have also shown an increase in their use of community resource networks when dealing with a potentially suicidal individual.

A recent study done on the south coast of New South Wales, Australia, evaluated a series of community gatekeeper training workshops which aimed to increase the potential of members of the Aboriginal community to identify and support people at risk of suicide and to facilitate their access to helping services. The results of the evaluation study demonstrated an increase in participants' knowledge about suicide, greater confidence in identification of people who are suicidal, and high levels of intentions to provide help. The project indicated community members could be successfully trained in the recognition of individuals at risk of suicidal behavior.

Experts recommend this strategy

The Centers for Disease Control, Australia's Youth Suicide Prevention Plan, and the United Nations' Expert Working Group have all included community gatekeeper training in their summary of recommended strategies for addressing the problem of youth suicide.

Setting up for success

There are five steps that should be addressed in setting up a successful community gatekeeper training program.

1. **Target the right people to receive the training**
   Community gatekeepers are those who have significant and existing relationships with young people but do not necessarily have a formal mandate to provide crisis intervention or mental health services. They typically lack formal training in the area of youth suicide risk assessment and intervention strategies. When offering a community gatekeeper training workshop, program planners should ensure that significant groups have not been overlooked. Conversely, the training should *not* be a priority for those who have little face-to-face contact with youth.

2. **Use or adapt an existing training program**
   Several excellent community gatekeeper training programs have already been developed (see *In our own backyard* and *A place to start*). While program modification may be desirable, there is often no need to develop a new program from scratch. In general, community gatekeeper training programs should be organized around specific, results-oriented goals, and program developers should be able to easily answer the following question, "What will participants do or understand differently as a result of the training?"

What areas should the training focus on?

At a minimum, training efforts should seek to achieve results in the following areas:

Attitudes

- *favourable to intervention*
- *non-judgmental*
- *willingness to make referrals/seek consultation*

Knowledge

- *warning signs*
- *risk factors*
- *role of school*
- *school policies*
- *referral sources*

Behaviours

- *initiate intervention (establish rapport, reflect back what you have noticed/understood, ask the question "are things so bad that you are considering suicide?"and be specific, direct and unambiguous)*
- *assess risk (actively explore and consider the following dimensions: specificity of plan, availability of method, lethality and availability of support)*
- *develop action plan (share information, make referral, consult with others, contact parents, make a structured plan for safety and document)*

3. Focus on knowledge and skills acquisition

Training programs should be designed to influence attitudes, improve knowledge, and enhance skill levels, reflecting an appreciation for the fact that changing human behaviour is a complex undertaking and it requires a comprehensive approach (see the box *What areas should the training focus on?*). Information-only efforts are inadequate for promoting the development of new skills, particularly in the area of suicide risk detection and crisis response; interventions which by definition require active involvement.

4. Emphasize the active participation of learners

Adult learners bring a wealth of knowledge, skill, and relevant experience to the training endeavour and will be more responsive to an approach that involves them in the learning process. An active, participatory approach to learning that recognizes the participants' existing knowledge level is superior to a passive or lecture-style-only approach. Training for community gatekeepers should include plenty of opportunities for doing or practising what has been taught.

5. Heighten awareness about community services

Community gatekeepers need to be informed about the existing and available local services and should know how to contact them. Services that gatekeepers ought to be aware of include the following: 24 hour distress lines, suicide and crisis response programs, hospital emergency services, police/RCMP and other emergency personnel, mental health centres, child abuse hotline, child protection services, family support programs, and local private practitioners.

Are there any concerns associated with this strategy?

Aren't we in danger of overwhelming the mental health system?

Some mental health professionals worry that by heightening the awareness of community gatekeepers we may be guilty of setting off a chain of events that could prove ultimately problematic for caregivers and suicidal people alike. They see things this way: as a result of community gatekeeper training, more potentially suicidal people will be identified which will lead to increased referrals to mental health centres, which in turn will put increased pressure on an already taxed mental health system. As a result, mental health professionals will become even more overwhelmed and, even worse, potentially suicidal people will have to be turned away because the system cannot respond to the high level of need.

Suicidal people will exist in spite of the lack of services available

Of course we do not want to identify suicidal persons only to have them denied appropriate service because the system cannot keep up with the increased demand. On the other hand, the fact remains that suicidal people will continue to be present - in community centres, in schools, on sports teams - regardless of whether someone recognizes them as such. Suicidal people will exist in spite of the fact that there are waiting lists at the mental health clinics and no beds available at the hospital.

We should anticipate the impact of our training activities and plan accordingly

These observations are not meant to discount the reality that an increase in community awareness about suicide will inevitably have an impact on the formal helping system and we clearly need to attend to this issue in our planning efforts. We should be as proactive as possible in our planning efforts, both by anticipating the impact of our training activities, and by increasing the capacity of the helping system to respond to a potential increase in the recognition of suicidal people.

We need to be realistic and creative

We need to be both realistic and creative in our use of limited resources, while always ensuring that those at moderate to high risk for suicide – who require the resources of the formal system – consistently receive a timely and appropriate response. For community gatekeepers, training must always include information about how to make appropriate referrals. This way, the resources of the formal mental health system will always be appropriately engaged and reserved for those individuals who truly require that level of service.

How will we know if we're making a difference?

You will know that your community gatekeeper training program is making a difference if you can answer yes to questions listed in the table below under the headings *short-term*, *medium-term*, and *long-term indicators*. Please note that in order to detect changes over time we typically need to make a long-term commitment to the overall evaluation process. In other words, measuring success is not something you do at a single point in time and then forget about. The timelines that are included below are only guidelines, but they should give you a good sense about the need to measure the impact of our interventions at several points in time following the initial implementation of the strategy.

Short-term indicators: Short-term indicators are changes that the strategy itself is designed to produce and are usually measured right after, or up to two months following, the implementation of a program. Depending on the type of program being developed, short-term indicators can be measured using quantitative methods (e.g. pre-and-post tests measuring changes in skills or knowledge) or qualitative methods (e.g. interviews or focus groups designed to assess attitudes, opinions, and satisfaction).

Medium-term indicators: Medium-term indicators of success capture changes that you might expect further down the road and are usually measured three to six months after the implementation of a program. Medium-term indicators can be measured using methods such as surveys, questionnaires, interviews, or observations that look at changes in well-being, attitudes, or behaviours in young people or other groups/social environments targeted by the program.

Long-term indicators: Long-term indicators of success measure the ultimate goal of a program (usually a reduction in suicide and suicidal behaviours among youth) and are usually measured on an annual basis, starting two to five years following the implementation of a program.

Keep in mind that the indicators listed in the table below represent examples only and we invite you and your group to develop indicators that are in line with the specific goals and activities of your own community gatekeeper training program. As the strategy of cultural enhancement may not easily lend itself to traditional evaluation methods, nor to the use of 'typical' quantitative methods for measuring success, we invite you to be

especially creative when choosing indicators and finding ways to measure the strategy's effectiveness. Identifying relevant indicators of success for your own program (and the methods by which these will be measured or monitored) represents one of the most important steps of your overall evaluation plan (see the section *Evaluate your community-wide suicide prevention efforts* in chapter 5).

Methods to evaluate

	Ask a Key Evaluation Question	Measure the Success
SHORT TERM*	Are community gatekeepers satisfied with the training program?	➢ measure community gatekeeper feedback regarding the training and their overall satisfaction with the material presented
	Are community gatekeepers more confident in their abilities to intervene with a potentially suicidal youth?	➢ measure perceived comfort and confidence before and after the training and compare results to determine whether the training has made a difference
	Do community gatekeepers hold more favorable attitudes?	➢ measure attitudes (e.g. favourable to intervention, non-judgmental, willingness to get help) before and after the training and compare results to determine whether the training has made a difference
	Are community gatekeepers more knowledgeable?	➢ measure knowledge (e.g. warning signs of suicide, available community resources) before and after the training and compare results to determine whether the training has made a difference
	Do community gatekeepers demonstrate appropriate intervention and referral skills?	➢ measure skills (e.g. ask the question, assess the level of risk, make a plan for safety) before and after the training and compare results to determine whether the training has made a difference
MEDIUM TERM**	Are community gatekeepers retaining the skills learned?	➢ measure retention of skills over a period of time
	Are community gatekeepers correctly identifying and referring youth at-risk for suicide?	➢ track the number of youths referred by community gatekeepers ➢ measure the appropriateness of these referrals
LONG TERM***	Are suicide and suicidal behaviours among youth decreasing?	➢ measure the number of deaths by suicide and attempted suicides in the community and compare to previous statistics

**** Short-term** (measured immediately to 2 months following program implementation)*
***** Medium-term** (measured 3 to 6 months following program implementation)*
****** Long-term** (measured 2 to 5 years following program implementation)*

Northwest Territories Suicide Prevention Training Program

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Contact person: Sandy Little, Mental Health Consultant

Program description: In response to the dramatic increase in suicide rates in the Northwest Territories during the 1980's, the Department of Social Services held a series of regional forums in order to address community concerns and develop recommendations for solutions. A key recommendation of the report was that suicide prevention training should be developed and made accessible to community members across the Northwest Territories. In response, the Department of Health and Social Services, in collaboration with the Canadian Mental Health Association, the Department of Education, Culture and Employment, the Dene Cultural Institute, the Nunavut Social Development Council, and other agencies, developed the Northwest Territories Suicide Prevention Training Program (NTSPT). The goal of the NTSPT is to create community expertise in recognizing and intervening with those at risk of self-harm.

Basic training. The NTSPT is a three-week course consisting of 15 full working days. The first component of the training, "Grieving and Healing," helps participants address their own grief and loss issues as well as healing needs. The second program component, "Prevention, Intervention and Postvention Skills," provides participants with the knowledge and the skills that are needed to manage a suicide crisis in the community. Finally, the third training component, "Leadership Skills and Community Based Strategies," supports and encourages participants to take a leadership role in their own communities to address the problem of suicide. Each of these program components takes a week to complete.

Program participants include caregivers in paid positions as well as natural community helpers. Participants complete a detailed application and submit personal references in order to be screened for leadership potential and commitment to self-care and personal wellness. The training is delivered in the local communities by trained facilitators.

Training sessions usually accommodate between 10 and 20 participants. Training methods include group exercises, video presentations, role-plays or guided practice with feedback to participants. Interpreters are available at training sessions as needed.

To date, the NTSPT has been delivered to the following regions: Inuvik, Kitikmeot, Baffin, Keewatin, and Hay River. A total of 124 participants were trained in the Northwest Territories and Nunavut from 1996 to 1998. Since division of the Northwest Territories and the creation of Nunavut Territory, two additional courses have been held in Fort Good Hope and Hay River (NWT).

Train the Trainer Program (TTP). The Government of the Northwest Territories plans to have the NTSPT offered to as many NWT residents as possible. In order to meet the demand for local training at a reasonable cost, it was essential to build a group of Trainers capable of delivering the NTSPT. The four-week Train-the-Trainer Program (TTP) was designed by the Dene Cultural Institute in consultation with the Tatigiit group. The primary purpose of the TTP is to train individuals who have already completed the basic training, and who have the willingness and aptitude to become NTSPT Trainers. The secondary purpose of the TTP is to train participants to develop more effective communication and self-care skills, suicide assessment and intervention skills, and to provide them with an opportunity to explore more extensively their own feelings, biases, and judgements regarding the issue of suicide.

In order to be accepted into the TTP program, potential trainees undergo an extensive selection process. Every applicant submits a seven-page application form, provides references, and undergoes an interview. A Selection Committee (made up of members of the Steering Committee as well as community members) is responsible for reviewing the applications and selecting the trainees. It is necessary for the trainees to have strong support from the community and the Band Council in order for these individuals to fulfill their responsibilities following participation in the program. To date, the TTP has been delivered once (in 1998) and produced 19 graduates, seven of whom reside in the NWT and twelve in Nunavut. At present, there are no plans to offer a second Train-the-Trainer course until the first graduates have experience delivering the program.

Target groups: Community caregivers and natural community helpers.

Partners involved: Current partners: GNWT Department of Health and Social Services, with territorial Steering Committee (representatives from GNWT Department of Education, Culture and Employment; Canadian Mental Health Association, NWT Seniors Society, and community representatives from NTSPT Phase 1 and Phase 2.

Years in operation: The program has been in operation since 1996.

Program costs: A local training session costs approximately $25,000. A regional training session incurs higher travel and accommodation costs for participants in neighbouring communities.

Resources: Program costs are funded by the Northwest Territories Department of Health and Social Services. Communities are encouraged to contribute funds or in-kind support to demonstrate community support for the training.

Evaluation findings: An evaluation done during the testing period of this program showed that it was well-received in the NWT communities. Trainees agreed they had gained useful knowledge. After three years of active use of this program, an evaluation was conducted with participants from Phase 1 and Phase 2. Results indicated:

- Positive feedback to maintain the curriculum components
- Experiential learning and time to address personal reactions was seen as different from other suicide prevention programs and more successful for northerners
- Caregivers requested ongoing Department support, links with other suicide prevention caregivers, and a desire to be further integrated into community interagency groups

Advice to others interested in starting this type of program:

a) Fifteen days is a lengthy and intense training, but feedback from community members deeply affected by suicide indicates that it is a worthwhile commitment.

b) While community members are very keen to take the training and have no difficulty making arrangements for time away from work/family, the program may be limited by lack of support from community leadership (such as Band council, Regional and Community Health and Social Services Boards). The Suicide Prevention Steering Committee feels that education about suicide in the NWT and the potential benefits of the NTSPT is needed before caregivers will receive support from their communities, employers, and boards. A suicide awareness campaign is underway, brochures supporting the NTSPT caregivers' role and training have been distributed, and stronger links with Health and Social Services Boards are being developed. The Train the Trainers have proven to be an excellent resource in promoting the NTSPT and delivering community awareness workshops.

c) Youth Suicide Prevention requires a different approach in the NWT. This curriculum is not recommended for delivery to youth without consideration of best practices in youth suicide prevention and subsequent modification.

Available reports and materials:

- Northwest Territories Suicide Prevention Training Manual
- Trainee handouts
- Evaluation report
- NTSPT Caregiver's Brochure

A Place to Start

Workshops

Aboriginal Community Suicide Prevention Workshop

This workshop has been presented throughout Canada, in every province and territory. Many of the workshops have been presented as part of suicide prevention strategy of the Royal Canadian Mounted Police (RCMP), National Aboriginal Policing Services. The Suicide Prevention Training Programs (SPTP) developed the program for the RCMP, making it the first national initiative to address suicide prevention in Aboriginal Communities.

The workshop targets community based frontline workers including mental health workers, school counsellors, Aboriginal police, teachers, nurses, and other community members. The workshop is presented over five days (35 hours) with a maximum group of 30 participants.

While the format of the workshop is fairly generic, each program is tailored to fit the needs of the particular community. The workshop is interactive and engaging, involving small and large group discussions, videos, practice role plays, Talking Circles and group strategy sessions. When appropriate, local Elders are invited to speak about local traditions and to conduct ceremonies.

While the program is flexible and is retooled before each workshop, the following outlines the core components that are most often used:

Day 1 and 2: ASIST

The first two days are spent in the Living Works/SPTP ASIST (Applied Suicide Intervention Skills Training). The training is divided into five modules which focus on attitudes, knowledge and interventions critical to the prevention of youth suicide. The training is designed to improve the gatekeeper's ability to intervene until either the immediate danger of suicide is reduced or additional assistance or resources can be accessed.

Day 3: Critical Incident Stress Debriefing (CISD)

This component of the workshop is grounded in the belief that caregivers working on the frontline need to have a system that allows them to deal successfully with the stress of their job. Burnout, identifying stressors and strategies for dealing with stress are discussed.

Day 4: Talking Circle

It is important to understand how your life experiences impact you ability to be an effective caregiver. The full-day talking circle gives participants the opportunity to

explore their own feelings and fear about suicide in a very sage and supportive environment. This segment is generally co-facilitated by a SPTP Trainer and a local Elder.

Day 5: Development of a Suicide Prevention Strategy
It is essential that communities develop practical strategies to address their high rate of suicide behaviour. This segment introduces the concept of community development and encourages groups to examine gaps in services and develop a realistic plan for suicide intervention/prevention.

For more information, about this workshop contact:
Centre for Suicide Prevention
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Through the Pain: Community-Based Suicide Prevention
Through the Pain is a community-based suicide intervention and prevention workshop with a focus to mobilize professional as well as informal resources within a community. The main goal of the workshop is to deliver the skills and information required to:

- recognize a suicidal person
- offer a suicidal person immediate support
- assist a suicidal person to reach out to community resources
- assist a community to respond to the suicide of one of its members

The target groups for this workshop include community-based human service providers and natural helpers, as well as any other community members. The workshop is presented over the course of five days (35 hours) with a maximum of 30 participants. The workshop covers the following contents:

- Crisis and the community
- History, tradition, and healing
- Understanding suicide
- Signals of suicide
- Role and attitude of caregiver
- Three step-method of response
- Confidentiality and responsibility issues
- After a suicide
- Culturally sensitive counselling
- Care for the caregiver

The workshop uses an interactive approach which includes: practice circles, small and large-group discussions, questionnaires, role plays and other exercises in order to encourage the participants to share their experience and skills with one another.

The workshop is facilitated by Darien Thira of Thira Consulting. Darien offers a number of workshops in a variety of fields to Aboriginal and non-Aboriginal professionals and community members.

For more information, contact:
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ASIST – Living Works training

The ASIST workshop is the most widely used suicide intervention training workshop in the world. The goal of the ASIST workshop is to provide community caregivers with emergency "first aid" skills for helping persons at risk of suicidal behaviors. The workshop provides participants with an understanding of: their own attitudes about suicide; how to recognize and estimate the risk of suicide; effective suicide intervention techniques, as well as community resources for caregivers. As such, the workshop is divided into five modules: introduction; attitudes; knowledge; skills intervention; and resourcing / networking. Providing the basis for skill development are: mini-lectures, group discussions, simulations, role plays, and award-winning audio-visuals.

This workshop is designed for anyone who may come in contact with a person at risk of suicide. This may include mental health professionals, volunteers working in the community, physicians, nurses, police, teachers, counsellors, clergy, youth workers, and others. Aboriginal and Non-Aboriginal trainers come together to present this two day workshop (14 hours). While the information presented is basically the same as workshops presented in Non-Aboriginal communities, the trainers working with Aboriginal groups are experienced in adapting the material so that it is relevant to the group.

For more information about this workshop, contact:
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Curriculum

Youth Suicide Awareness Presentation Package
The youth suicide awareness presentation is an 80-page instructional guide with a set of 32 overhead transparencies. The guide examines issues such as definitions of suicide, the magnitude of the problem, warning signs, how to help, and community resources. The package also includes participant handout masters, organizer's guide, and reading lists. Although the presentation is designed to be delivered by trainers and caregivers with some familiarity with the subject, it can also be used by the novice. The presentation is designed for an audience consisting of adults who want to know about youth suicide. Materials included in the package can be covered in a two-hour period.

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Suggested reading

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Community Education Strategies

Public Communication and Reporting Guidelines

What are public communication and reporting guidelines?

This strategy aims to educate the public, the media, as well as anyone reporting or speaking about suicide, about responsible suicide reporting practices. This is done in an effort to lower the negative and potentially contagious effects that sensational publicity about suicides can have on vulnerable youth.

Goals

More specifically, the strategy of public communication and reporting guidelines aims to accomplish the following goals:

- raise awareness of the public about the need to communicate about suicides in a way that reduces risks for future imitative suicidal behaviours
- raise awareness of members of the media about the potential "contagion effect" of news stories about suicide
- increase responsible reporting practices in news stories
- reduce the number of imitative suicidal behaviors

Target population

The population to be educated includes the whole community, plus media personnel including, editorial boards, local journalists, television reporters and staff, radio announcers, as well as anyone writing or speaking publicly about the topic of suicide, including Elders and spiritual leaders.

Brief description

This strategy can be implemented as a community-wide effort to educate everyone writing or speaking publicly about the topic of suicide. These individuals should be provided with:

- Information about the potential "contagion effect" of news stories about suicide on vulnerable adolescents and the rationale behind prudent reporting practices.

- Guidelines on how to report a suicide in order to minimize the potential for contagion (without compromising the independence or professional integrity of news media professionals). See the box on the next page for a summary of these guidelines.

Written information and guidelines can be distributed to all concerned individuals or can be presented during a workshop. The information and guidelines should be reviewed with all concerned on a regular basis.

Guidelines on responsible reporting of a suicide

Reports about a suicide should AVOID:

- *presenting the story on the front page of the publication or as the lead story of a news broadcast*
- *presenting simplistic cause-effect explanations for suicide such as "Teen kills himself because he failed a test"*
- *engaging in a repetitive, ongoing, or excessive reporting of suicide in the news*
- *presenting the story in a sensational manner by providing details and the use of dramatic photographs related to the suicide*
- *reporting technical "how-to" descriptions about how the method of suicide*
- *presenting suicide as a tool for accomplishing certain ends*
- *glorifying suicide or persons who die by suicide*
- *focusing solely on the person's (who died by suicide) positive characteristics in a glorifying manner*
- *mentioning other past suicides as part of the news story or hinting at a suicide epidemic*

In addition, the media should always include an educational component describing the warning signs for suicide and where to go for help (for example, counselling services, a crisis line, or a mental health centre) in any news story about suicide.

Why should we provide public communication and reporting guidelines?

Inappropriate discussions or reporting of a suicide can negatively influence vulnerable youth

People who are distressed and vulnerable can sometimes be influenced to attempt or die by suicide by being exposed to the suicide stories of other people. This "contagion" effect appears to be strongest among adolescents because of their particular developmental stage which typically includes a heightened need for acceptance, belonging, and approval from their peers. One avenue which provides adolescents with direct exposure to suicide is the mass media, which sometimes publicizes or romanticizes stories about suicides. In the general population, research has shown that prominent displays of real or fictional suicide stories on television and in newspapers can lead to a significant increase in suicidal deaths, especially among teenagers, during a one- to two-

week period following the story. The more publicity is given to a suicide story, the greater becomes the cluster of suicides.

Media exposure has been related to a number of cluster suicides in Aboriginal communities

There is a known tendency for suicides to occur in clusters among groups of Aboriginal youths. Researchers think that the high number of cluster suicides seen in Aboriginal communities could be partially explained by media exposure. It is therefore important to ensure that suicide stories run in local papers and televised newscasts be presented in a way that will lessen the likelihood of "contagion" for young Aboriginal people.

How do we know that public communication and reporting guidelines work?

Experts recommend this strategy

Based on the strong research evidence which shows that the number of suicides rises following highly publicized and repeated suicide stories, leading experts in the field of suicide prevention as well as organizations such as the Canadian Association for Suicide Prevention, the American Association of Suicidology, and the International Association for Suicide Prevention, highly recommend this strategy as a means of reducing suicide contagion. Support for this strategy is also found in the Aboriginal literature.

Setting up for success

There are a number of issues you should consider for the overall success of this strategy.

1. **Act pro-actively to develop a relationship with the local media**
   Suicide prevention program advocates should cultivate relationships with the media prior to a suicide crisis to build trust and arrive at a mutual understanding of each other's roles and responsibilities. If not, it may be very difficult to persuade media personnel to utilize prudent reporting practices in the midst of a crisis or during a period when the news media are in the throes of reporting an extraordinarily newsworthy suicide.

2. **Follow published media reporting guidelines**
   Both the Canadian Association for Suicide Prevention and the American Association of Suicidology (see *A place to start*) have published a list of recommendations on responsible reporting practices for the media.

3. **Avoid advocating for censorship of suicide coverage**
   Suicide is often newsworthy and it will probably be reported. However, if the nature and apparent mechanisms of suicide are understood, the news media are more likely to present the news in a manner that minimizes the likelihood of contagion. Therefore, your goal should be to assist reporters and editors in their efforts to be both responsible and accurate.

4. **Learn and educate others about how to work with the media**
   It helps to educate potential spokespersons on how to work with the media. These individuals will then have the opportunity to influence both the angle and content of the news story when they are interviewed by media representatives. If someone does not feel comfortable with a reporter, a spokesperson can always be engaged. Or you can write out a statement and read it to a reporter to ensure the best possible communication.

5. **Provide feedback**
   Following media coverage of a suicide in your community, let them know what you thought about their presentation of the issue, based on the considerations highlighted throughout this section. Write a letter to the editor or news director, specifically highlighting what they did well, and which aspects of their reporting practices could be improved on. Capitalize on the opportunity to educate by providing them with factual information about youth suicide and the risks of contagion, and provide them with media reporting guidelines. Make yourself or another knowledgeable person available to discuss these issues further.

How will we know if we're making a difference?

You will know that your public communication program is making a difference if you can answer yes to questions listed in the table below under the headings *short-term*, *medium-term*, and *long-term indicators*. Please note that in order to detect changes over time we typically need to make a long-term commitment to the overall evaluation process. In other words, measuring success is not something you do at a single point in time and then forget about. The timelines that are included below are only guidelines, but they should give you a good sense about the need to measure the impact of our interventions at several points in time following the initial implementation of the strategy.

Short-term indicators: Short-term indicators are changes that the strategy itself is designed to produce and are usually measured right after, or up to two months following, the implementation of a program. Depending on the type of program being developed, short-term indicators can be measured using quantitative methods (e.g. pre-and-post tests measuring changes in skills or knowledge) or qualitative methods (e.g. interviews or focus groups designed to assess attitudes, opinions, and satisfaction).

Medium-term indicators: Medium-term indicators of success capture changes that you might expect further down the road and are usually measured three to six months after the implementation of a program. Medium-term indicators can be measured using methods such as surveys, questionnaires, interviews, or observations that look at changes in well-being, attitudes, or behaviours in young people or other groups/social environments targeted by the program.

Long-term indicators: Long-term indicators of success measure the ultimate goal of a program (usually a reduction in suicide and suicidal behaviours among youth) and are

usually measured on an annual basis, starting two to five years following the implementation of a program.

Keep in mind that the indicators listed in the table below represent examples only and we invite you and your group to develop indicators that are in line with the specific goals and activities of your own public communication program. Identifying relevant indicators of success for your own program (and the methods by which these will be measured or monitored) represents one of the most important steps of your overall evaluation plan (see the section *Evaluate your community-wide suicide prevention efforts* in chapter 5).

Methods to evaluate

	Ask a Key Evaluation Question	Measure the Success
SHORT TERM*	Are members of the media as well as anyone writing or speaking publicly on the topic of suicide more knowledgeable about correct reporting guidelines to minimize the risk for suicide contagion?	➢ measure awareness and knowledge of members of the media and of anyone else writing or speaking publicly on the topic of suicide about correct reporting guidelines (before and after program implementation)
MEDIUM TERM**	Are media reports or any other public presentations on the topic of suicide reflecting appropriate reporting practices?	➢ check that media reports as well as other written or spoken information going out to the general public consistently reflect high quality reporting standards over time
	Have media organizations adopted policies regarding responsible suicide reporting?	➢ review policies of media organization to ensure that they are consistent with guidelines advocated by the Canadian Association for Suicide Prevention
LONG TERM***	Are responsible reporting practices having an impact on copycat suicide attempts or completions?	➢ measure the number of apparent copycat suicide attempts or completions following a youth suicide in the community
	Are suicide and suicidal behaviours among youth decreasing?	➢ measure the number of deaths by suicide and attempted suicides in the community and compare to previous statistics

**** Short-term** (measured immediately to 2 months following program implementation)*
***** Medium-term** (measured 3 to 6 months following program implementation)*
****** Long-term** (measured 2 to 5 years following program implementation)*

A Place to Start

Resources

The following resources are available by contacting the appropriate organizations or through their web site easily available for download on the internet or can by contacting the organizations:

- ***Media guidelines*** (n.d.)
  The guidelines were developed by the Canadian Association for Suicide Prevention (CASP) and are available on the CASP web site at www.suicideprevention.ca (go under 'Resources' and look for Media Guidelines). Alternatively, you can contact CASP at (780) 482-0198 or at casp@suicideprevention.ca.

- ***Reporting on Suicide: Recommendations for the Media*** (2001)
  This document was prepared by the American Foundation for Suicide Prevention in collaboration with the American Association of Suicidology and the Annenberg Public Policy Center. You can download the document from the American Foundation for Suicide prevention web site at www.afsp.org/education/recommendations/5/index.html or call 1-888-333-AFSP to receive a copy.

- ***Suicide and the media: The reporting and portrayal of suicide in the media: A resource*** (1999)
  This document was published by the New Zealand Ministry of Health in consultation with media organizations. You can download the document from the New Zealand Ministry of Health web site at www.moh.govt.nz/wwwsandm.nsf/Contents or e-mail moh@wickliffe.co.nz to receive a copy.

- ***Reporting Suicide and Mental Illness - a resource for media professionals*** (n.d.)
  This Australian resource was developed with assistance from media professionals, media peak bodies, suicide and mental health experts, consumer organizations, and the Commonwealth Government. You can download the document at www.mindframe-media.info or e-mail auseinet@flinders.edu.au to receive a copy.

Suggested reading

American Association of Suicidology (nd). *Guidelines for interviews*. Denver: American Association of Suicidology.

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Bechtold, D.W. (1988). Cluster suicide in American Indian adolescents. *American Indian and Alaska Native Mental Health Research*, 1(3), 26-35.

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Tower, M. (1989). A suicide epidemic in an American Indian community. *American Indian and Alaska Native Mental Health Research*, 3(1), 34-44.

Washington State Department of Health (1995). *Youth suicide prevention plan for Washington state*. Olympia, WA: Washington State Department of Health.

White, J. & Jodoin, N. (1998). *Before the fact interventions: A manual of best practices in youth suicide prevention*. Vancouver, BC: Suicide Prevention Information & Resource Centre of British Columbia, Co-operative University-Provincial Psychiatric Liaison (CUPPL), University of British Columbia.

Community Education Strategies

Means Restriction

What is means restriction?

The purpose of a means restriction strategy is to reduce young people's access to the most common and harmful means of completing suicide such as guns, poisons, and medications.

It is important to note that, in the context of this manual, the strategy of means restriction *is not related to gun legislation* such as the Canadian Firearms Act (Bill C-68). It has been the position of many Aboriginal groups and individuals that since First Nations people require the use of firearms and ammunition in the exercise of their inherent Aboriginal and Treaty rights, the passing of such legislation and its enforcement represents an infringement of those rights. On the other hand, the strategy of means restriction represents a locally-driven initiative that focuses on educating and encouraging community members to *voluntarily* keep firearms, potent medications, and poisons safely away from youth.

Goals

More specifically, the strategy of means restriction aims to accomplish the following goals:

- raise awareness of community members about the dangerous link between lethal means of suicide (e.g. firearms, potent medications, and poisons) and youth suicide
- educate the public about safe storage of guns and medications in the home
- educate physicians about appropriate prescribing practices for potent medications

Target population

The target population for this strategy includes: gun owners; parents, guardians, and other relatives; foster parents; community gatekeepers (police/RCMP members, physicians, young offender system); local government decision-makers; and youth leaders.

Brief description

The strategy of means restriction typically represents a locally designed initiative that involves educating community members about the dangers of readily accessible means (such as firearms, medications, and poisons) and youth suicide. This is usually accomplished through a public education campaign targeting gun owners, parents and guardians, physicians as well as other health workers.

For example, a community-wide means restriction strategy could include any or all of the following components:

1. Raising awareness and educating the public about the link between harmful means in the home and youth suicide. At the least, parents and guardians should be educated about:
   - the safe handling and storage of guns within the home environment
   - safe methods for storing medications, particularly prescription medications and those that are dispensed in large quantities
   - safe methods for storing poisonous substances

2. Soliciting help from community gun owners and sellers to support campaigns for safe gun handling and storage.

3. Encouraging physicians and other mental health practitioners in the community to routinely ask parents or guardians about the presence of firearms in the home, especially in the homes of their most potentially vulnerable patients/clients, and to warn parents and guardians about the dangers of firearms or medications that are inappropriately stored.

4. Educating physicians practicing in the area about responsible prescribing practices including: keeping refills to a minimum and prescribing low medication dosages.

Why should we engage in means restriction?

Firearms ownership in Aboriginal communities is likely to be high

Canada's Aboriginal people have a long history of hunting, fishing and trapping as a way of life and means of subsistence. Although data regarding firearm ownership among Aboriginal people in Canada are scarce, it is probably safe to suggest that it is high. A recent study which surveyed four East James Bay Cree communities found that the vast majority of the households (88%) contained one or more guns. These households contained, on average, 6.1 guns and almost two individuals per household identified themselves as "gun owners." For the Crees, hunting was the primary reason for ownership (cited by almost 75% of the gun owners), while another 22% acknowledged that the purpose of gun ownership was to pass their guns down to future generations as a legacy. With respect to safe storage, the study found that 12% of gun owning households contained both a gun locker and one or more safety locks, 31% of households used one safety device, and over half of the households did not make use of either of these safety devices.

The availability of lethal methods is linked to suicide

We know that the availability of firearms (and other lethal means) increases the likelihood of self-destructive behaviours. A research study on suicide among Aboriginal people in Manitoba suggested that *access* to firearms was a pivotal factor. In the general population, studies have shown that the risk of suicide is five times higher in homes with

guns than in those without guns. Guns are also twice as likely to be found in the homes of suicide victims and attempters. These statistics tell us that distressed young people (especially young males) who live in a home with guns have a greater risk of dying by suicide than those who live in a home without guns. We also know that it is rare for a person to die by suicide using a firearm that is stored outside the home and people rarely go to the trouble of purchasing a gun with the specific intention of completing suicide.

The evidence suggests that restricting access to means has the capacity to reduce death and disability associated with suicide and suicidal behaviours. Young males facing stressful life events are particularly vulnerable to attempt suicide based on an impulse. So, if a gun or a lethal dose of medication is not readily available to them, the likelihood of an impulsive suicide attempt is reduced. Young people thinking about suicide also often show a certain degree of ambivalence towards ending their life. In other words, they do not necessarily want to die, they simply want the pain to stop. So, if a suicidal youth does not have immediate access to a gun or medications, additional time will be required to seek out an alternative method. This may provide an opportunity for family and friends, traditional healers, or other mental health workers in the community to intervene with the youth in crisis.

Suicide by firearm is a common reality in Aboriginal communities

Between 1989 and1993, data from the Medical Services Branch, First Nations and Inuit Health Program Directorate, showed that firearms were used by 31% of suicides among First Nations people in Canada, the second most common method after hanging. Among Alaska Natives, one study found that 78% of suicides during a two-year period were the result of gunshot wounds. A study of suicide among Aboriginal people from Manitoba found that between 1988 and 1994, 26% of the suicides were using a firearm, while hanging was used in 52% of suicides. In a study of deaths by suicide among the Inuit of northern Quebec, the most common methods of suicide were hanging (54.9%) and gunshot (29.6%) in victims 15 to 24 years of age.

How do we know that means restriction holds promise?

Research shows that reducing access to guns can make a difference

On a broader scale, stricter handgun control laws have been associated with lower suicide rates. In Canada, researchers found that the number of suicides by firearms dropped significantly immediately following the introduction of the Canadian gun control legislation in 1978, especially in Canadians under the age of 40. In these younger Canadians, the rate of deaths by suicide with firearms declined, and suicides with other methods did not increase to compensate, so the total suicide rate declined as well. In Britain, a sharp decrease in suicides was recorded when more lethal domestic gas made from coal was replaced by natural gas which has a much lower carbon monoxide content. These and other results strongly suggest that decreasing the availability of lethal means within the home environment can have a definite impact on the number of suicides.

Experts recommend this strategy

Although more research is needed in this area, the Canadian Association for Suicide Prevention, the American Association of Suicidology, as well as many suicide experts believe that the evidence is sufficiently powerful to recommend that communities undertake specific measures to restrict access to dangerous means. The Canadian Pediatric Society also strongly advocates restricting access to firearms for young people as a preventive measure towards reducing firearms deaths. The International Association for Suicide Prevention has endorsed the World Health Organization's six steps for the prevention of suicide, four of which pertain specifically to means restriction including: gun possession control; detoxification of domestic gas; detoxification of car emissions; and control of toxic substance availability.

There are a number of issues you should consider for the overall success of this strategy.

Setting up for success

1. **Familiarize yourself with the facts**
   Statistics related to deaths by firearms and medication overdoses tell a powerful story about the dangers associated with firearm and medication availability. By becoming familiar with such statistics, you will be able to make a strong case to others regarding the importance of the safe handling and storage of firearms and safe prescription and storage practices of potent medications. For more information, see the box *A place to start*.

2. **Educate yourself and your group about the safe handling and storage of guns**
   In order to plan a successful education campaign, you must first educate yourself and your group about safe handling and storage practices of firearms and medications. For this purpose, a number of organizations have developed helpful and user-friendly information kits for individuals and groups planning public education initiatives.

   For example, the Canadian Firearms Centre recommends the following storing practices for firearms:
   - store all firearms unloaded and unable to be fired by using a secure locking device, by removing the bolt or bolt carriers, or by locking in a sturdy, secure container or room that cannot be easily broken into
   - store in a place where ammunition for the firearms is not easy to obtain

   For more information, see *A place to start*.

3. **Encourage cooperation between community members and organizations**
   Educating community members, physicians, and other professionals about means restriction represents an ambitious undertaking. This will best be accomplished by encouraging cooperation between concerned individuals, relevant community organizations, local government decision-makers, and the media.

4. **Be prepared for potential resistance**
   Your group is likely to encounter a certain degree of resistance from certain groups like gun sellers and even gun owners themselves. It is important to remind ourselves, and those who will potentially oppose the effort, that the aim of this strategy is not to interfere with individuals' rights to possess firearms, but rather to ensure their safe storage so that they are inaccessible to potentially vulnerable children and adolescents.

Are there any concerns associated with this strategy?

Wouldn't a determined suicidal person seek out another method?
Some have pointed out that decreasing access to certain means of suicide will only make a determined suicidal person choose another method. However, it has been shown that a significant number of suicidal people may actually be discouraged from proceeding further. In the event that a youth is very determined to end their life, he or she may be forced to choose another method that is less lethal, allowing for a greater possibility of medical rescue. There have been several examples in which a reduction in access to a particular lethal method resulted in a reduction in suicide rates, without an increase in suicide by other methods.

How will we know if we're making a difference?

You will know that your means restriction program is making a difference if you can answer yes to questions listed in the table below under the headings *short-term*, *medium-term*, and *long-term indicators*. Please note that in order to detect changes over time we typically need to make a long-term commitment to the overall evaluation process. In other words, measuring success is not something you do at a single point in time and then forget about. The timelines that are included below are only guidelines, but they should give you a good sense about the need to measure the impact of our interventions at several points in time following the initial implementation of the strategy.

Short-term indicators: Short-term indicators are changes that the strategy itself is designed to produce and are usually measured right after, or up to two months following, the implementation of a program. Depending on the type of program being developed, short-term indicators can be measured using quantitative methods (e.g. pre-and-post tests measuring changes in skills or knowledge) or qualitative methods (e.g. interviews or focus groups designed to assess attitudes, opinions, and satisfaction).

Medium-term indicators: Medium-term indicators of success capture changes that you might expect further down the road and are usually measured three to six months after the implementation of a program. Medium-term indicators can be measured using methods such as surveys, questionnaires, interviews, or observations that look at changes in well-being, attitudes, or behaviours in young people or other groups/social environments targeted by the program.

Long-term indicators: Long-term indicators of success measure the ultimate goal of a program (usually a reduction in suicide and suicidal behaviours among youth) and are

usually measured on an annual basis, starting two to five years following the implementation of a program.

Keep in mind that the indicators listed in the table below represent examples only and we invite you and your group to develop indicators that are in line with the specific goals and activities of your own means restriction program. Identifying relevant indicators of success for your own program (and the methods by which these will be measured or monitored) represents one of the most important steps of your overall evaluation plan (see the section *Evaluate your community-wide suicide prevention efforts* in chapter 5).

Methods to evaluate

	Ask a Key Evaluation Question	Measure the Success
SHORT TERM*	Is the link between suicide and access to firearms being reinforced to community members using a variety of communication strategies (articles in newspapers, community information sessions, poster campaign, etc.)?	➢ keep track of the number of articles, community gatherings, and posters which address this issue and ensure that the correct information is provided to community members
	Are community members (including youth, parents, guardians, gatekeepers, and physicians) more knowledgeable about the role of firearms and other lethal means in youth suicide?	➢ measure community knowledge about the association between firearms in the home and gun deaths among youth before and after the implementation of the means restriction program and compare results to determine whether the program has made a difference
MEDIUM TERM**	Do community members and gun store owners have more favourable attitudes regarding the safe storage of firearms and medications?	➢ measure attitudes of community members regarding the safe storage of guns and medications
	Are community members practicing safe storage of firearms and medications?	➢ measure percentage of homes with safely stored guns and medications
LONG TERM***	Are suicide and suicidal behaviours among youth decreasing?	➢ measure the number of deaths by suicide and attempted suicides in the community and compare to previous statistics

**** Short-term** (measured immediately to 2 months following program implementation)*
***** Medium-term** (measured 3 to 6 months following program implementation)*
****** Long-term** (measured 2 to 5 years following program implementation)*

Shamattawa First Nation Central Storage Program

Location: RCMP detachment
General delivery
Shamattawa, Manitoba
R0B 1K0
Telephone: (204) 565-2351
Fax: (204) 565-2201

Contact person: Sgt Dario Cecchin

Program description: The community of Shamattawa is located along the north shore of the intersection of God's River and Echoing River, approximately 1,277 air kilometers north of Winnipeg and 365 air kilometers east of Thompson. The on-reserve population is approximately 900 and the native language is Cree. The economic base of the community is commercial fishing and trapping. The reserve is inaccessible by road, although a winter road may be constructed when heavy equipment is required in the area. The community maintains a gravel airstrip and is serviced by scheduled air flights out of Thompson. There is an RCMP detachment located on the reserve.

The Shamattawa Central Firearms Storage Program was started in 1988 in response to a very high number of shootings occurring the previous year. The Chief and Council passed a Band Council Resolution (BCR) stating that all firearms be placed in a central storage facility when they were not being used for hunting. The program is technically voluntary but the existence of the BCR provides a strong incentive for community members to use the program.

The firearms are stored in a locked room with barred windows located in a secure building within the RCMP compound. Numbered racks were installed to organize the stored firearms. Each user is assigned a number corresponding to the location in the rack where their firearms are stored. A registration form for each user listing name, address, number of firearms, and types of firearms is kept in a binder in the storage room. When the firearm is needed, the registered owner can sign it out of the storage facility between the hours of 10:00 a.m. and 2:00 a.m. (operating hours of the Shamattawa RCMP detachment). No one other than the registered owner may check out a firearm unless the owner gives permission in-person, or has provided a signed note indicating permission to release the firearm to another person. The only conditions on the release of firearms are that the person must be sober, and must not be prohibited from possessing firearms. There are approximately 250 firearms currently stored in the storage facility. It is estimated that over 90% of firearm owners use the central storage facility for their guns.

Target groups: All gun owners within the community of Shamattawa.

Partners involved: Shamattawa First Nation Band and local RCMP detachment.

Years in operation: The Central Storage Program was started in 1988.

Source of funding: There were almost no initial costs associated with the central storage program, since it was set up in an existing building. The only cost incurred was a minimal amount for the lumber used to construct the storage stalls. There are no personnel costs associated with the program since it is administered by the RCMP members as part of their duties. It is noted, however, that the members' workload increases significantly during hunting seasons.

Evaluation findings: A study done in 1998 revealed that participants believe the central storage program has benefits for the community including: safety, reduced break-ins, reduced accidents, fewer shootings, and the protection of children. The survey also showed that satisfaction with the central storage program was very high, with 93.5% if those respondents using the program reporting that they are satisfied with the way it works. A local RCMP officer reports that, since he has been in the community (the last two years), there have only been two minor incidents involving firearms, and these were not suicide-related.

Advice to others interested in starting this type of program:

- The existence of a BCR promoting central storage of firearms is a major factor in the high rate of use of the facility. In First Nation communities overall, BCRs carry a great deal of weight because they reflect the will of the community. The discussions leading up to the passage of a BCR serve to unite the community around the issue being considered. These discussions also serve to inform the public of the dangers of unsafe firearms storage and use, as well as the benefits to community peace and safety that central storage may yield.

- The central storage program needs to be well publicized, e.g. through notices in high traffic areas (Band office, nursing station, and local stores), announcements on local radio and television stations where available, and community information meetings.

- Convenience of the program in terms of broad hours of operation is also important in order to maximize success.

A Place to Start

Organizations

Centre for Suicide Prevention
Suicide Information & Education Collection (SIEC)
Suite 320, 1202 Centre Street S.E.
Calgary, Alberta
T2G 5A5
Telephone: (403) 245-3900
Fax: (403) 245-0299
E-mail: siec@suicideinfo.ca
Web site: www.suicideinfo.ca

This is the largest English-language suicide information resource and library in the world, with extensive information on suicide prevention, postvention, and intervention. SIEC offers an information kit called *Gun Control and Suicide* which can be ordered for a nominal cost.

American Association of Suicidology (AAS)
Suite 408, 4201 Connecticut Avenue, N.W.
Washington, DC
20008
USA
Telephone: (202) 237-2280
Fax: (202) 237-2282
E-mail: info@suicidology.org
Web site: www.suicidology.org

In 1996, the AAS developed a *Consensus Statement on Youth Suicide by Firearm* which has now been endorsed by 30 major organizations including national mental, public, and physical health associations; public policy organizations; and child and youth welfare advocacy organizations. You can order this document directly from the American Association of Suicidology.

The Brady Center to Prevent Gun Violence
1225 Eye Street, NW, Suite 1100
Washington, DC
20005
USA
Telephone: (202) 289-7319
Fax: (202) 408-1851
Web site: www.bradycenter.org

The Brady Center works to reform the gun industry and educate the public about gun violence. The Center has developed the following program, which is available by contacting the organization:

Steps To Prevent Firearm Injury In The Home (STOP2) is a counselling tool that prepares health care providers across a wide range of disciplines (nurses, social workers, psychologists, health educators, counsellors, etc.) to talk with their clients and their families about the danger of keeping a gun in the home. The STOP2 kit includes a Health Care Provider Reference Manual, family brochures, and posters.

Suggested reading

American Academy of Child and Adolescent Psychiatry (1996). *Facts for families: Children and firearms.*

Boothroyd, L.J., Kirmayer, L.J., Spreng, S., Malus, M. & Hodgins, S. (2001). Completed suicides among the Inuit of northern Quebec, 1982-1996: a case-control study. *Canadian Medical Association Journal*, 165(6),749-755.

Brent, D.A., Perper, J.A., & Allman, C.J. (1987). Alcohol, firearms, and suicide among youth. *Journal of the American Medical Association*, 257, 3369-3372.

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Centres for Disease Control and Prevention (1992). *Youth suicide prevention programs: A resource guide*. Atlanta: U.S. Department of Health and Human Services.

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Cree Trappers Association (1998). *James Bay Cree gun survey*. Ottawa, Ontario: Canadian Firearms Centre, Department of Justice.

Cummings, P., Grossman, D.C., Rivara, F.P., & Koepsell, T.D. (1997). State gun safe storage laws and child mortality due to firearms. *Journal of the American Medical Association*, 278(13), 1084-1086.

Gabor, T. (1994). *The impact of the availability of firearms on violent crime, suicide, and accidental death: A review of the literature with special reference to the Canadian situation*. Ottawa, Ontario: Department of Justice, Research and Statistics Directorate.

Hlady, W.G. & Middaugh, J.P. (1988). Suicides in Alaska: firearms and alcohol. *American Journal of Pubic Health*, 78(2), 179-180.

International Association of Suicide Prevention (IASP) (1997). *Adelaide declaration on suicide prevention*. Adelaide, Australia: IASP Executive Board.

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School Strategies

School Gatekeeper Training

What is school gatekeeper training?

School gatekeeper training is an educational and skill-building effort designed to improve the knowledge and competency of school personnel in the recognition and crisis management of potentially suicidal young people. In the field of suicide prevention, the term "gatekeeper" is usually used to refer to those individuals who typically come into contact with youth as part of their daily routine. By virtue of their existing relationships with young people, school personnel are naturally well-placed to detect changes in the behaviour of students that may signal distress or suicidal thinking.

Goals

More specifically, school gatekeeper training aims to achieve the following goals:

- increase attitudes favourable to intervention
- increase knowledge about depression and the problem of youth suicide
- improve competency in the identification and crisis management of potentially suicidal adolescents
- increase awareness of helping resources

Target population

All adults who work within the secondary and middle school systems, including teachers, guidance counsellors, administrators, coaches, and other school-based staff and volunteers.

Brief description

School gatekeeper training is typically provided within the educational settings where school personnel work. Training sessions vary in length from one to two-day workshops.

The following themes are usually covered:

1. **The problem of youth suicide**. School gatekeepers are provided with information about youth depression; the seriousness of the problem of suicide; risk and protective factors for youth suicide; warning signs; guidelines for responding; school policies; and community resources.

2. **Attitudes**. School staff is provided with an opportunity to explore their attitudes about the issue of youth suicide, and are helped to understand how certain attitudes can help or hinder an effective response. Helpful attitudes include willingness to initiate dialogue with a potentially suicidal adolescent; adopting a non-judgmental approach; openness to seeking consultation, taking responsibility for making referrals; and having a sense of optimism regarding the role of professional helpers.

3. **Identification of youth at potential risk**. School staff is provided with the opportunity to learn basic intervention skills for determining the level of risk and providing a rapid and effective response. Skills include how to initiate an intervention; how to estimate the level of suicide risk; how to develop an action plan for safety; how to respond to an acute crisis; and how to communicate with parents.

4. **Community referral sources**. School personnel are provided with information about available helping agencies in the community, how to access professional help for consultation purposes, and how to make a referral for a student-at-risk.

5. **School policies and procedures**. School staff are introduced to or reminded about the school's policy and procedures related to the management of suicidal youth. The roles and responsibilities of each staff member are reviewed.

Why should we provide school gatekeeper training?

It is consistent with the overall mission of the school

While the primary role of the school is to educate students, it is equally clear that students will not be able to learn if their overall health and well-being is compromised. Hence, any strategy that enables the adults to promote and protect the safety and well-being of their students will be consistent with the overall educational mission of the school system.

School staff have existing relationships with young people

Since school personnel will generally have regular (daily) contact with large numbers of students which typically lasts throughout the school year, they are in an ideal position to serve as gatekeepers. The ongoing contact with young people affords school-based staff with the opportunity to establish fairly enduring relationships with students which may in turn allow them to detect some of the more subtle changes, including signs of depression and emotional distress, in their students.

Further, since teachers and other school staff have so much contact with young people in general, they will often be better than parents at discriminating between behaviour that is typical or normative for a particular age group, or time period, and those student behaviours or attitudes which appear out-of-character or noticeably inconsistent over time. By providing school staff with the necessary knowledge and skills to recognize and assess potential risk, young people at-risk for suicide will be more easily detected and directed to the proper helping resources.

Adults working in the school system deserve to be supported

A sad reality of our times is that many young people feel suicidal in the face of unbearable stress and many of these students are coming to the attention of school-based personnel. It is essential that we enable school staff to become knowledgeable, skilled, confident and well-supported in their roles as gatekeepers. If the adults within the school system regard the topic of suicide with anxiety and fear, if they are reluctant to intervene

with a student who is suspected to be suicidal, and if they dismiss the importance of suicide prevention efforts in general, we will be missing a tremendous opportunity to reduce the number of adolescent deaths by suicide.

How do we know school gatekeeper training holds promise?

Gains in knowledge and improvements in attitude have been noted

Research studies have demonstrated that participants in school gatekeeper training have shown increased knowledge of warning signs, increased knowledge of community resources, as well as an increased willingness to make referrals to mental health agencies. Further, many gatekeepers report increased confidence in their ability to provide assistance to a suicidal youth following the training. Participants also report feeling satisfied with the training they have received.

More students have been referred for follow-up

Other researchers have reported an increase in the number of students referred for further evaluation following the gatekeeper training.

Experts recommend this strategy

The Centers for Disease Control included school gatekeeper training in their summary of recommended strategies for addressing the problem of youth suicide. Other experts have suggested that school gatekeeper programs could reduce youth suicide by about 12%. The Canadian Association for Suicide Prevention has also recommended suicide prevention training for school personnel as a key strategy for reducing youth suicide and suicidal behaviour.

Setting up for success

There are four steps that should be addressed in setting up a successful school gatekeeper training program.

1. **Use or adapt existing training programs**

   Several high-quality school gatekeeper training programs have already been developed (see *In our own backyard* and *A place to start).* While program modifications may be desirable, there is no need to develop a new program from scratch. In general, school gatekeeper training programs should be organized around specific, results-oriented goals, and program developers should be able to easily answer the following question, “What will participants do or understand differently as a result of the training?”

What areas should the training focus on?

At a minimum, training efforts should seek to achieve results in the following areas:

Attitudes

- *favourable to intervention*
- *non-judgmental*
- *willingness to make referrals/seek consultation*

Knowledge

- *warning signs*
- *risk factors*
- *role of school*
- *school policies*
- *referral sources*

Behaviours

- *initiate intervention (establish rapport; reflect back what you have noticed/understood; ask the question, "are things so bad that you are considering suicide?"; be specific, direct, and unambiguous)*
- *assess risk (actively explore and consider the following dimensions: specificity of plan; availability of method; lethality; and availability of support)*
- *develop action plan (share information; make referral; consult with others; contact parents; make a structured plan for safety; document)*

2. **Focus on knowledge and skills acquisition**
   The best approach to training for school gatekeepers should include the presentation of high quality information offered in the context of a safe environment where participants can watch and learn from others, practice their new skills, receive feedback, and have easy access to expert consultation once the training has been completed. Refer to the box *What areas should the training focus on?* for more information.

3. **Emphasize the specific prevention roles of school personnel**
   School gatekeeper training should include very practical, "how-to" information that focuses on the recognition and referral of potentially at-risk youth. School staff needs to be supported to understand how their role "on the front lines" can be pivotal in ensuring that students at-risk receive an appropriate and timely response through their own early detection efforts. School policies that support staff in their roles as gatekeepers should also be highlighted.

4. **Link school gatekeeper training with other suicide prevention strategies in the community**
   In order to develop a more comprehensive approach to addressing the problem of youth suicide, schools and community mental health organizations need to work together. To facilitate more collaboration between these two key sectors, schools are encouraged to participate in the development of joint protocols with community mental health agencies which specify the roles, expectations, and responsibilities of each system, should a student become suicidal (refer to the *Interagency communication and coordination* strategy).

Are there any concerns associated with this strategy?

Schools are responsible for educating students, not managing social problems

An area of tension that sometimes emerges in discussions about school gatekeeper training pertains to questions about the appropriate roles and responsibilities of school personnel, particularly in relation to distressed and potentially suicidal students. Many educators believe that the only role of the school is to teach students the required course content and they do not support efforts to prepare school personnel to respond to potentially suicidal students. Further, they argue that teachers, administrators, and, to a lesser extent, counsellors, are not trained to deal with issues of risk assessment and crisis management in their professional training programs, and thus should not be expected to perform these functions.

We do not live in an ideal world

While all of these assertions are true – schools should be held accountable for the provision of high quality education to their students and the management of social problems like substance abuse, violence, and suicide, should be left to qualified professionals – the reality is that we do not live in an ideal world where we can rigidly adhere to these beliefs. Despite what is specified in the school professional's job description, emotionally distressed students will often seek out their favorite teacher or

principal to talk with about their suicidal feelings and suicidal students will routinely be present in school hallways and classrooms throughout this country.

Being prepared is always best
At least by having some basic skills in the recognition and assessment of suicide risk and by knowing what to do to help a student in crisis, school gatekeepers will be ready to respond effectively, if and when such a situation arises.

How will we know if we're making a difference?

You will know that your school gatekeeper training program is making a difference if you can answer yes to questions listed in the table below under the headings *short-term*, *medium-term*, and *long-term indicators*. Please note that in order to detect changes over time we typically need to make a long-term commitment to the overall evaluation process. In other words, measuring success is not something you do at a single point in time and then forget about. The timelines that are included below are only guidelines, but they should give you a good sense about the need to measure the impact of our interventions at several points in time following the initial implementation of the strategy.

Short-term indicators: Short-term indicators are changes that the strategy itself is designed to produce and are usually measured right after, or up to two months following, the implementation of a program. Depending on the type of program being developed, short-term indicators can be measured using quantitative methods (e.g. pre-and-post tests measuring changes in skills or knowledge) or qualitative methods (e.g. interviews or focus groups designed to assess attitudes, opinions, and satisfaction).

Medium-term indicators: Medium-term indicators of success capture changes that you might expect further down the road and are usually measured three to six months after the implementation of a program. Medium-term indicators can be measured using methods such as surveys, questionnaires, interviews, or observations that look at changes in well-being, attitudes, or behaviours in young people or other groups/social environments targeted by the program.

Long-term indicators: Long-term indicators of success measure the ultimate goal of a program (usually a reduction in suicide and suicidal behaviours among youth) and are usually measured on an annual basis, starting two to five years following the implementation of a program.

Keep in mind that the indicators listed in the table below represent examples only and we invite you and your group to develop indicators that are in line with the specific goals and activities of your own school gatekeeper training program. Identifying relevant indicators of success for your own program (and the methods by which these will be measured or monitored) represents one of the most important steps of your overall evaluation plan (see the section *Evaluate your community-wide suicide prevention efforts* in chapter 5).

Methods to evaluate

	Ask a Key Evaluation Question	Measure the Success
SHORT TERM*	Is school personnel satisfied with the training program?	➢ measure participant feedback regarding the training and their overall satisfaction with the materials presented
	Are school gatekeepers more confident in their abilities to intervene with a potentially suicidal youth?	➢ measure perceived comfort and confidence before and after the training and compare results to determine whether the training has made a difference
	Do school gatekeepers hold more favourable attitudes?	➢ measure attitudes (e.g. favourable to intervention, non-judgmental, willingness to get help) before and after the training and compare results to determine whether the training has made a difference
	Are school gatekeepers more knowledgeable?	➢ measure knowledge (e.g. warning signs of suicide, available community resources) before and after the training and compare results to determine whether the training has made a difference
	Do school gatekeepers demonstrate appropriate intervention and referral skills?	➢ measure skills (e.g. "ask the question", assess the level of risk, make a plan for safety) before and after the training and compare results to determine whether the training has made a difference
MEDIUM TERM**	Are school gatekeepers retaining the skills learned?	➢ measure retention of skills over a period of time
	Are school gatekeepers correctly identifying and referring students at-risk for suicide?	➢ track the number of youths referred by school staff ➢ measure the appropriateness of these referrals
LONG TERM***	Are suicide and suicidal behaviours among youth decreasing?	➢ measure the number of deaths by suicide and attempted suicides in the community and compare to previous statistics

**** Short-term** (measured immediately to 2 months following program implementation)*
***** Medium-term** (measured 3 to 6 months following program implementation)*
****** Long-term** (measured 2 to 5 years following program implementation)*

School personnel training in suicide prevention

Location: Labrador School Board District 1
Labrador East Office
P.O. Box 1810, Station B
Happy Valley-Goose Bay, NL
A0P 1E0
Telephone: (709) 896-2431 ext. 237
Fax: (709) 896-9638
E-mail: dfeener@lsb.ca
Web site: www.k12.nf.ca/labrador

Contact person: Darryl Feener, Program Specialist

Program description: The Labrador School Board District #1 is responsible for a total of 19 schools located in 14 Labrador communities. Of these communities, there are two Innu communities (Sheshatshiu and Davis Inlet-Utshimassit) with a total population of approximately 1,500 people and five Inuit communities (Nain, Hopedale, Postville, Makkovik, and Rigolet) with a total population of approximately 4,000 people. There is one school (Kindergarten to grade 12) in each of these Aboriginal communities.

In the last few years, the Labrador School Board District has been sponsoring a number of suicide prevention initiatives which include: training of school personnel, suicide awareness education for students, youth leadership training (with an emphasis on suicide prevention), and youth gatherings (which include a suicide prevention component). The training of school personnel in the area of suicide prevention has been ongoing since 1998. To date, approximately 300 teachers have been trained and there are currently at least three people in each school who are fully trained in suicide prevention and intervention.

The trainer is a staff member of the School Board District who travels to each community twice a year or more, depending on the local needs. Participants in the training sessions include local school personnel as well as other individuals from various community groups (health sector, Band council, RCMP members, etc.). The two-day ASIST curriculum (for more information on this curriculum, see *A place to start*) is used and 15-20 participants are trained at a time. Recently, 15 individuals from various local communities participated in a Train-the-Trainer session and are now qualified to deliver the ASIST workshop.

Target groups: School personnel (administrators, teachers, assistants, counselors) as well as community members.

Partners involved: Labrador School Board District #1, Band Councils, as well as a number of local community agencies.

Years in operation: Training has been ongoing since 1998.

Source of funding: The following organizations have contributed funds to this initiative: Labrador School Board District #1, Band Councils, Labrador Inuit Association, Innu Nation, Health Labrador Corporation, RCMP, Aboriginal Policing (Ottawa), Torngasok Cultural Centre, provincial government, as well as major private corporations.

Evaluation findings: A feedback evaluation form is filled out by participants at the end of each workshop. This serves to highlight the strengths and weaknesses of each workshop. On a broader scale, staff of the Labrador School Board District monitors the program on an on-going basis.

Advice to others interested in starting this type of program:

- Include all relevant Aboriginal and non-Aboriginal organizations and groups from each community.
- Combine the training of school personnel with a suicide awareness education component for the student body (grades seven and up) and other young people involved in community youth groups.

A Place to Start

Curricula

ASK.ASSESS.ACT

While not specific to Aboriginal populations, ASK.ASSESS.ACT is a solid suicide intervention training program for school personnel developed and delivered by the BC Council for Families. The goal of the program is to improve the overall competency of school personnel in the recognition and crisis management of potentially suicidal youth.

ASK.ASSESS.ACT is a one-day workshop presented in three modules covering the following topics:

- Statistics on youth suicide
- Individual and societal attitudes towards youth suicide and intervention
- Teen stressors
- Suicide warning signs
- How to ASK about suicide
- How to ASSESS the risk of suicide
- Steps to ACT using your school suicide intervention protocol

Target groups for this training program include teachers, school counsellors, youth care workers, youth probation officers, youth correction officers, mental health workers, school administrators, and RCMP members. The workshop is presented by certified suicide intervention trainers using lectures, experiential exercises, viewing of a video, large and small group discussions as well as role plays. The BC Council for Families organizes the training workshops on a fee-for-service basis.

Results of a formal evaluation (1998) indicated that 100% of surveyed participants would recommend ASK.ASSESS.ACT to colleagues. An increase in knowledge about suicide intervention as well as observable appropriate suicide intervention skills during workshop simulations were also detected during the evaluation. Finally, as a direct result of the workshop, most of the participating school districts took a closer look at their suicide intervention protocols and wrote or rewrote their policies. In some cases, schools used this opportunity to begin developing this important policy.

For more information on the program, please contact:
BC Council for Families
#204 - 2590 Granville Street
Vancouver, BC
V6H 3H1
Telephone: (604) 660-0675 or 1-800-663-5638
Fax: (604) 732-4813
E-mail: bccf@bccf.bc.ca
Web site: www.bccf.bc.ca

ASIST – Living Works training

The ASIST workshop is the most widely used suicide intervention training workshop in the world. The goal of the ASIST workshop is to provide community caregivers with emergency "first aid" skills for helping persons at risk of suicidal behaviors. The workshop provides participants with an understanding of their own attitudes about suicide, how to recognize and assess the risk of suicide, effective suicide intervention techniques, and community resources for caregivers. As such, the workshop is divided into five modules: introduction; attitudes; knowledge; skills intervention; and resourcing / networking. Providing the basis for skill development are: mini-lectures, group discussions, simulations, role plays, and award-winning audio-visuals.

This workshop is designed for anyone who may come in contact with a person at risk of suicide. This may include mental health professionals, volunteers working in the community, physicians, nurses, police, teachers, counsellors, clergy, youth workers, and others. Aboriginal and Non-Aboriginal trainers come together to present this two-day workshop (14 hours). While the information presented is basically the same as workshops presented in non-Aboriginal communities, the trainers working with Aboriginal groups are experienced in adapting the material so that it is relevant to the group.

For more information about this workshop, contact:
Living Works Education, Inc.
4303D - 11 Street S.E.
Calgary, Alberta
T2G 4X1
Telephone: (403) 209-0242
Fax: (403) 209-0259
E-mail: info@livingworks.net
Web site: www.livingworks.net

Youth suicide awareness presentation package

The youth suicide awareness presentation is an 80-page instructional guide with a set of 32 overhead transparencies. The guide examines issues such as definitions of suicide, magnitude of the problem, warning signs, how to help, and community resources. The package also includes participant handout masters, organizer's guide, and reading lists. Although the presentation is designed to be delivered by trainers and caregivers with some familiarity with the subject, it can also be used by the novice. The presentation is designed for an audience consisting of adults who want to know about youth suicide (it is not specific to teachers). Materials included in the package can be covered in a two-hour period.

For more information, please contact:
Centre for Suicide Prevention
Suicide Prevention Training Programs (SPTP)
Suite 320, 1202 Centre Street S.E.
Calgary, Alberta
T2G 5A5
Telephone: (403) 245-3900
Fax: (403) 245-0299
E-mail: sptp@suicideinfo.ca
Web site: www.suicideinfo.ca

Suggested reading

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School Strategies

School Policy

What is a school policy?

A policy is a written statement that tells people what to do in certain situations by providing guidelines for action and by outlining various staff responsibilities. In the field of suicide prevention, a school policy mandates and guides the effective handling of crisis situations within the school environment.

The purpose of having a policy to guide the management of crisis situations is to ensure the safety of students at risk for suicide or a suicide attempt and to minimize the potentially negative consequences that could arise following a death by suicide. In addition, by developing such a policy, a school clearly communicates its commitment towards suicide prevention to staff, parents, and students.

Goals

The overall goals of a suicide prevention school policy are to:

- ensure that suicidal crises are handled in an appropriate, effective, and coordinated manner
- provide school personnel with clear guidelines as to their roles and responsibilities with regards to a suicidal student, a student returning to school after a suicide attempt, or a death by suicide
- ensure that students identified as potentially suicidal by peers or school personnel are promptly referred for assessment and treatment
- facilitate the re-integration of students returning to school following a suicide attempt
- minimize the levels of stress and bereavement in the student and staff population following a suicide
- reduce the risk for suicide contagion (imitative suicidal behaviour) among the student population, following a suicide

Target population

This strategy targets the school system, which includes members of the school community (faculty, staff, and students) and the school environment.

Brief description

This strategy involves the development and endorsement of a written school policy that will mandate and guide the effective handling of suicide crisis situations within the school environment.

Typically, a school suicide prevention policy (with accompanying procedures) should contain the following components:

- role and responsibilities of the school with respect to the problem of suicide in the student population
- detailed description of the steps that are to be taken when confronted with a suicidal student or a death by suicide
- directions on how the policy will be communicated, reviewed, and evaluated
- expectations regarding professional development, materials or other administrative measures
- list of names and telephone numbers of community emergency responses
- links with other school-based suicide prevention efforts

Guidelines related to intervention and postvention

A school policy should provide clear guidelines for intervention (to be activated once a suicidal student has been identified) as well as postvention (to be activated after a suicide has taken place).

1. ***Intervention.*** *Intervention activities include the following: early recognition of suicide potential, direct contact with the student involved, and referral to the appropriate mental health professional or other outside resources for assessment and care. Specifically, a school policy should address the following intervention issues:*

   - *person(s) to be contacted if a staff member learns or suspects a student may be suicidal*
   - *how to assess a suicidal student and determine the level of risk*
   - *what type of intervention should be initiated within the school*
   - *when should the parents be notified and by whom*
   - *guidelines for intervention*
   - *which community resources (e.g. suicide prevention agency, crisis centre, hospital emergency room, private psychiatrist or psychologist, police) can provide assistance and how these resources can be contacted*
   - *whether and how the student will be taken to an appropriate agency such as the hospital emergency room or mental health centre if necessary*
   - *how school staff will be informed about the incident*
   - *how the suicidal student's return to school will be coordinated*

Guidelines related to intervention and postvention

2. ***Postvention.*** *Postvention activities include a range of activities undertaken in a school or community following an adolescent suicide death with the aim of providing support to survivors and preventing suicidal contagion, i.e. imitative suicidal behaviour among vulnerable youth exposed to a suicide death. Specifically, a school postvention policy should include step-by-step procedures covering the following issues:*

Short-term

- *identification of a school-based (district-level) person in charge*
- *how to mobilize and receive outside help, if necessary*
- *who will communicate with the bereaved family and with the media*
- *how will support staff handle telephone calls and requests for information from the community*
- *how will information be communicated to all parents (and neighbouring schools) regarding the school's response*
- *how and by whom will staff and students be informed of a death by suicide*

Longer-term

- *how to provide support to staff for dealing with students' reactions*
- *how to inform staff and students regarding funeral arrangements*
- *how to reduce the sensational and emotionally-charged climate that surrounds a suicide death in the school community*
- *how to identify and manage students at high-risk following the suicide*
- *what type of support and counselling services will be provided for peers and school personnel and how will these be coordinated*

Why should we develop a school policy?

A suicidal crisis is usually a sudden and unexpected critical incident

Given what we know about the prevalence of suicidal behaviours among youth, it is very likely that a school community will be faced with a suicide crisis at some point or another. Due to the fact that crises are unpredictable, tending by definition to be sudden in their onset, and due to the strong emotions that are typically involved, it may be very difficult for school personnel to react and make decisions in a prompt and effective manner if they have engaged in no previous crisis response planning.

That is why it is important for schools to develop a detailed policy and procedures document prior to the onset of a crisis and for staff to thoroughly understand what is expected of them. Well-written guidelines can minimize the initial sense of helplessness and anxiety, increase the chances that students will receive the required support and assistance, and diminish the negative impact on the school community.

School staff deserves to be supported

Teachers and other school staff may have never been faced with a student in crisis before. In addition, many may view the prospect of having to intervene in such a crisis with anxiety and fear. It is therefore important to provide school staff with clear expectations about their roles-and the accompanying limitations-as well as detailed directions about how to carry them out. Finally, the development and existence of a school policy could potentially serve to protect the staff and school from lawsuits due to negligence.

Students in crisis should be recognized and referred in a prompt manner

Students who are experiencing a crisis and who are suspected to be at risk for suicide require immediate attention. These children and adolescents will most often need assistance beyond what the school system can offer and will need a referral to an appropriate mental health resource in the community. The presence of a clear school policy can facilitate an efficient process that is in the best interest of distressed youth.

After a suicide, peers need help too

Following the suicide of one of their peers, friends and acquaintances will feel intense shock and grief. There is also a real concern that adolescents exposed to a peer's suicide may be at increased risk to engage in suicidal behaviour themselves. Obviously, all children and adolescents exposed to a suicide will need some type of support, while those closer to the victim or those who were already emotionally vulnerable prior to the suicide may need more intense follow-up and counselling support. Well written school procedures will outline what needs to be done, and for whom, in order for peers to be supported in a timely and appropriate manner.

How do we know school policy development holds promise?

Policies and procedures represent effective tools to guide the actions of staff

The effectiveness of a school policy in reducing suicidal behaviours and completions has never been specifically evaluated. However, we do know that policies and procedures represent effective tools for guiding the behaviours and actions of an organization's staff members. So if a policy is well-written and communicated to all school staff, and if the staff is supported in their implementation efforts, we can reasonably expect that the policy will achieve its intended effects. Furthermore, if the contents of the policy are based on research findings about "what works," then we can be confident that the impact of the policy will be maximized.

Experts consistently recommend that every school should have a policy in place

There is a general consensus in the suicide prevention field that the development of school policy and procedures represents a very critical component of comprehensive school-based suicide prevention programs. The Canadian Association for Suicide Prevention has recommended the development of such policies at the school and district levels, especially when this strategy is combined with other suicide prevention efforts including trained faculty and staff, informed parents, informed students, and adequate linkages with community resources.

Setting up for success

There are five issues that you should address when developing a school policy.

1. **Use a participatory approach**

   Policy statements are written to serve the population of the school. Although the development of your policy will be led by a working group, you should ensure that there are ample opportunities for staff, students, parents, and community members to have input into the development, implementation, and evaluation of the policy.

2. **Base the contents of your school policy on "what works" in terms of intervention and postvention**

   The ultimate goal of developing a school policy is to help suicidal students get the necessary help and to support the peers of a suicide victim or attempter come to terms with their feelings in the most effective manner. As such, the contents of the policy (e.g. what steps should be taken and by whom) should be based on the recommendations of experts as to what works. Local mental health professionals possess the technical knowledge and have the clinical expertise to be of great help in the development of the policy. You can also review examples of policies that other schools or districts have developed. For more information, refer to the publications and sample policies highlighted in *A place to start.*

3. **Establish effective referral links with community resources**

   Dealing effectively with a highly suicidal student or managing in the aftermath of an actual suicide will usually require more assistance than schools can reasonably provide. Because of the emergency nature of most crises, rapid access to resources is required. It is important that resource links be developed with local hospitals,

emergency response units and mental health centres for assessment and treatment assistance prior to the emergence of a crisis. Such links with community resources must be described in the policy along with up-to-date contact persons and telephone numbers. The agencies must be made aware of the school's policies and programs, and written protocols for referral and follow-up assistance should be discussed (refer to the *Interagency communication and coordination* strategy).

4. **Disseminate the policy and provide training for staff members**
   It is important to ensure that the school policy is thoroughly disseminated to all school personnel. This may be accomplished by providing a copy of the policy to staff and faculty members and holding a meeting to discuss its contents. Staff members should thereafter be reminded of the policy and its contents on a yearly basis, preferably at the beginning of each school year.

   Staff members who are in direct contact with students will also require training (refer to the *School gatekeeper training* strategy). In addition, staff that is expected to perform a specific role in the event of a crisis, as outlined in a school policy, must have the necessary competencies to accomplish that role and should receive appropriate training.

5. **Ensure that the policy is reviewed on a regular basis**
   A school policy which highlights the management of crisis situations should be reviewed every 6 to 12 months to ensure that the contents and procedures are still appropriate and to update any changes related to emergency contact persons and telephone numbers.

How will we know if we're making a difference?

You will know that your school policy is making a difference if you can answer yes to questions listed in the table below under the headings *short-term*, *medium-term*, and *long-term indicators*. Please note that in order to detect changes over time we typically need to make a long-term commitment to the overall evaluation process. In other words, measuring success is not something you do at a single point in time and then forget about. The timelines that are included below are only guidelines, but they should give you a good sense about the need to measure the impact of our interventions at several points in time following the initial implementation of the strategy.

Short-term indicators: Short-term indicators are changes that the strategy itself is designed to produce and are usually measured right after, or up to two months following, the implementation of a program. Depending on the type of program being developed, short-term indicators can be measured using quantitative methods (e.g. pre-and-post tests measuring changes in skills or knowledge) or qualitative methods (e.g. interviews or focus groups designed to assess attitudes, opinions, and satisfaction).

Medium-term indicators: Medium-term indicators of success capture changes that you might expect further down the road and are usually measured three to six months after the implementation of a program. Medium-term indicators can be measured using methods such as surveys, questionnaires, interviews, or observations that look at changes in well-being, attitudes, or behaviours in young people or other groups/social environments targeted by the program.

Long-term indicators: Long-term indicators of success measure the ultimate goal of a program (usually a reduction in suicide and suicidal behaviours among youth) and are usually measured on an annual basis, starting two to five years following the implementation of a program.

Keep in mind that the indicators listed in the table below represent examples only and we invite you and your group to develop indicators that are in line with the specific goals and activities of your own school policy. Identifying relevant indicators of success for your own program (and the methods by which these will be measured or monitored) represents one of the most important steps of your overall evaluation plan (see the section *Evaluate your community-wide suicide prevention efforts* in chapter 5).

Methods to evaluate

	Ask a Key Evaluation Question	Measure the Success
SHORT TERM*	Has your school developed and adopted a policy in accordance with the guidelines described in this section?	➢ conduct a review to ensure that the policy includes the following elements: • role and responsibilities of the school with respect to the problem of suicide in the students population • detailed description of the steps that are to be carried out for difference scenarios (suicidal student, death by suicide) and by whom • list of names and telephone numbers of community emergency responses • expectations regarding professional development, materials, or other administrative measures • links with other school-based suicide prevention efforts • directions as to how the policy will be communicated reviewed and evaluated
	Has the policy been communicated to all school personnel?	➢ verify that the existence of the policy has been properly communicated to all school personnel
	Are all school staff aware of the policy, its purpose, and its contents and do they understand their respective roles and responsibilities?	➢ measure level of knowledge and understanding of the school policy among school gatekeepers ➢ measure understanding of respective roles and responsibilities
MEDIUM TERM**		➢ review the actions taken by school personnel during the incident and ensure that these are in accordance with the contents of the policy ➢ measure feedback from staff, students, and parents regarding the overall postvention efforts (e.g. satisfaction with communication, follow-through on referrals made for counselling, satisfaction with support provided by community resources or other outside experts)

**** Short-term*** *(measured immediately to 2 months following program implementation)*
***** Medium-term*** *(measured 3 to 6 months following program implementation)*

Methods to evaluate

	Ask a Key Evaluation Question	Measure the Success
MEDIUM TERM**	In the event of a student suicide, are any other suicide attempts or completions directly related to the first one?	➢ measure number of suicides and suicide attempts in your school following a student suicide
LONG TERM***	Are suicide and suicidal behaviours among youth decreasing?	➢ measure the number of deaths by suicide and attempted suicides in the community and compare to previous statistics

*** **Medium-term** *(measured 3 to 6 months following program implementation)*
**** **Long-term** *(measured 2 to 5 years following program implementation)*

A Place to Start

Organizations

Centre for Suicide Prevention
Suicide Information and Education Collection (SIEC)
Suite 320, 1202 Centre Street S.E.
Calgary, Alberta
T2G 5A5
Telephone: (403) 245-3900
Fax: (403) 245-0299
E-mail: siec@suicideinfo.ca
Web site: www.suicideinfo.ca

SIEC is the largest English language suicide information resource and library in the world, with extensive information on suicide prevention, postvention, and intervention. SIEC offers two information kits to help schools develop policies and procedures: *School Postvention* and *School Intervention and Prevention.* SIEC also has copies of several existing school policies that you can use as a starting point. SIEC will send you the materials for a nominal cost.

Suggested reading

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White, J. (1994). After the crisis: Facilitating the suicidal student's return to school. *Guidance and Counselling*, 10(1), 10-15.

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School Strategies

School Climate Improvement

What is school climate improvement?

This strategy aims to organize the educational setting in ways that will enhance the well-being and health of students and staff. The climate of a school refers to all the physical and social qualities of a school that affect how staff and students feel and behave while they are there. Each school has a unique atmosphere and it is never neutral. While a positive school climate can contribute to the growth and adaptation of children and adolescents, a negative school climate may have the opposite effect.

Goals

More specifically, school climate improvement concentrates on the following goals:

- focus attention on what students, teachers, administrators, and parents think about key issues related to the climate of the school
- provide a solid basis for the development of strategies to overcome deficiencies
- improve certain factors of the school climate
- provide a wholesome, stimulating, and productive learning environment conducive to the academic and personal growth of students

Target population

This strategy targets the entire school system, which includes members of the school community (faculty, staff, and students) as well as the school environment.

Brief description

School climate improvement is a deliberate and planned process whereby a school takes an in-depth look at certain elements of its climate and then takes steps to positively influence these. The strategy of school climate improvement involves an orderly process, usually headed by a project team, which typically includes representation from the following groups: administration, guidance and counselling staff, teachers, parents, and students. Typically, the project team will: raise the awareness of staff, students, and parents; assess the current climate; identify improvement priorities and develop an action plan; and accomplish the tasks identified in the action plan.

What does school climate mean?

The concept of school climate may, at first, seem rather abstract. So it may be useful to think about school climate as encompassing four main areas:

1. ***Personal growth and development.*** *This area refers to the extent to which the school fosters continuous personal growth and self-enhancement for both students and staff. Important elements include:*

   - *degree of emphasis on academic achievement*
   - *degree of emphasis on personal skill-building*
   - *degree of emphasis on cooperation vs. competition among students*
   - *level of freedom and safety for students to take risks and learn equally from their failures as well as their achievements*
   - *level of teacher autonomy*
   - *opportunities for staff development*

2. ***Communication and participation****. This area refers to the intensity and nature of personal relationships within the school environment, the extent to which people are involved in creating change in their surroundings, and the degree to which people support and help one another. This area includes elements such as:*

   - *quality of relationships among students*
   - *quality of student relationships with teachers (personal and instruction related)*
   - *quality of relationships among staff*
   - *quality of relationships between staff and the administration*
   - *quality of relationships between staff and parents*
   - *degree of parental involvement and support*
   - *degree of participation of students and staff in decision-making*

What does school climate mean?

3. ***Maintenance.*** *This area refers to the extent to which the environment is able to support and convey clear expectations and maintain control over individuals as necessary. This area includes elements such as:*
   - *clarity of rules*
   - *student level of awareness regarding the consequences of rule infractions*
   - *consistency in assigning consequences*
   - *degree of emphasis on behaving in an orderly and polite manner*

4. ***Physical environment.*** *This area refers to the extent to which physical surroundings contribute to a pleasant school environment. Important elements include:*
   - *attractive surroundings*
   - *safety of surroundings*
   - *adequacy of instructional resources for teaching/ learning*

Why should we be concerned with school climate?

Environments shape the way in which people feel and behave

There is a relationship between the characteristics of environments and the way in which people feel and behave in these environments. For example, we know that people tend to be more satisfied and have higher self-esteem when they live in environments characterized by a high degree of interpersonal involvement and mutual support. This is not to say that every person reacts the same way to a particular environment. However, it is clear that the quality of our social environments-those places where we live, work, and play-has a lot to do with how we feel about ourselves, our relationships with others, and our overall sense of well-being.

Schools play an important role in young people's lives

The way youth develop and adapt is shaped especially by the settings in which they spend the majority of their time, namely the family and the school. In fact, school climate has been shown to be related to student achievement, student behaviours, and the way students feel about their schools, themselves and others. Because children and

youth spend a great deal of their formative years in school, improving the climate within schools becomes a key strategy for the prevention of maladjustment and the enhancement of well-being in youth.

The negative impact of an unhealthy climate is related to risk for suicide

The characteristics of an unhealthy school environment are relevant to the problem of youth suicide. School settings that do not create opportunities for youth to be involved, where academic performance is valued to the exclusion of all other student efforts, where school staff make no time for cultivating meaningful, caring relationships with students, and where staff themselves feel unsupported, can all contribute to youth-especially those who are already vulnerable-feeling devalued, isolated, and at risk for a range of high-risk behaviours, including suicide. So, by improving the climate within a school, the educational system can make a meaningful contribution to reducing suicide risk among youth.

How do we know that school climate improvement holds promise?

School climate improvement efforts can influence key risk and protective factors of youth suicide

The specific effects of classroom restructuring (which is one example of a school climate improvement effort) have been investigated to determine how environmental modifications within the school might reduce risks for a range of youth problems, including youth suicidal behaviour. For example, an evaluation of an American program designed to help students make the transition from one school environment to another showed that participating students were less likely to show declines in academic performance, decreases on indicators of positive mental health, and increases in emotional and behavioural difficulties when compared with non-participating students.

In addition, a number of large and long-term school climate initiatives have been found to have an impact on several of the contributing and protective factors related to youth suicide. The Yale-New Haven primary prevention project, which focused on creating a desirable social environment in schools, found improved academic achievement and attendance, reduced incidence of behaviour problems, improved staff attendance, reduced staff turnover, and markedly improved parent involvement in school activities.

A follow-up study of the same project found that there were long-term positive effects associated with school climate improvement. Students who had attended a school where the project had been implemented showed improved school performance as well as perceived school competence. In addition, students reported higher levels of self-competence, which meant that they felt better about themselves and their functioning, both in and out of school, than did students who were not part of the intervention.

Suicide prevention experts are recommending this type of intervention

Several experts in suicide prevention have noted that our efforts will be limited if we focus exclusively on changing individual behaviours. They recommend that the

educational system has a key role to play in youth suicide prevention by improving the quality of the social environments in which youngsters interact on a day-to-day basis. Many experts have urged program planners to direct attention to the organization of the school itself within which many of these environmental risk factors manifest themselves. "Students are not high risk, circumstances are" (Felner, et al., 1993). In addition to reducing the negative impact of social and environmental risk factors for suicide, many have noted that school climate improvement initiatives can contribute to positive growth enhancement.

Setting up for success

The following issues are important to the success of a school climate improvement initiative.

1. **Set up a project team to lead your school climate improvement project**
   A school climate improvement project will have a better chance of succeeding if a core group of committed individuals takes overall responsibility for the project. As such, it is recommended that a "school climate improvement project team" be set up before any activities are undertaken. This team should not act as an advisory group that simply studies a problem and then makes recommendations. Rather, the team should function as a working group that, together with school administration, plans and coordinates the school climate improvement activities in the school. The team should be composed of staff, parents, and students, who are willing to work to make the school a better place for everyone.

2. **Follow a step-by-step process in the development of your project**
   It is recommended that your working group follows the following step-by-step guide to project development:

   a. *Raise the awareness of staff, students, and parents*. People first need to understand what school climate is, how it affects them and others, and what can be done to make a difference. So to start, it is important to plan a series of awareness-raising workshops or other activities where staff, students, and parents can learn about the proposed climate improvement project and become convinced that the initiative can benefit their school.

   b. *Assess the current school climate*. Once key groups have been informed about the project, the next step involves assessing the current school climate. To this end, the project team must first decide which elements of the school climate will be assessed. Then, an assessment survey is developed that asks how well the school is doing with respect to these elements. Major groups to be surveyed include parents, students, faculty, and other school staff. Options for surveying these groups include written questionnaires, interviews, focus groups, staff meetings or some combination of these. Assessment results are then analyzed, interpreted, and communicated to staff, students, and parents.

c. *Identify improvement priorities and develop an action plan*. Based on the results of the assessment, the top priorities for improvement are selected. For each priority, the project team, in consultation with the key stakeholder groups, then determines what they would like to see happen (goals and objectives) and proceeds to develop an action plan.

The action plan spells out how the goals will be met, and who will do what and when. Finally, the written action plan is shared with students, parents, school staff, and the community.

d. *Accomplish the tasks identified in the action plan*. The next step involves the implementation of the action plan. There must be sufficient commitment on the part of administration and staff to free up the necessary time and resources. During the implementation phase, it is important to schedule regular meetings with the project team and key interest groups in order to make sure that all components of the action plan are being implemented correctly.

e. *Review your efforts*. The last step of a school climate improvement project should be an evaluation of the results. This involves ensuring that the project has met the goals and objectives that your group identified in the beginning. In addition, you should take the time to find out whether participants in the project were satisfied with the experience and whether there were any unforeseen positive or negative outcomes of the project.

3. When in doubt, start small

The prospect of analyzing and attending to your school's climate may at first seem like an overwhelming and difficult undertaking. If circumstances at your school do not allow for a school-wide and comprehensive climate improvement project, why not begin small by focusing on one element of the environment that seems particularly problematic? You may even opt to hand over the process to a group of dedicated and enthusiastic students. A successful small improvement project may just pave the way for more or larger undertakings in the future.

How will we know if we're making a difference?

You will know that your school climate improvement program is making a difference if you can answer yes to questions listed in the table below under the headings *short-term*, *medium-term*, and *long-term indicators*. Please note that in order to detect changes over time we typically need to make a long-term commitment to the overall evaluation process. In other words, measuring success is not something you do at a single point in time and then forget about. The timelines that are included below are only guidelines, but they should give you a good sense about the need to measure the impact of our interventions at several points in time following the initial implementation of the strategy.

Short-term indicators: Short-term indicators are changes that the strategy itself is designed to produce and are usually measured right after, or up to two months following, the implementation of a program. Depending on the type of program being developed, short-term indicators can be measured using quantitative methods (e.g. pre-and-post tests measuring changes in skills or knowledge) or qualitative methods (e.g. interviews or focus groups designed to assess attitudes, opinions, and satisfaction).

Medium-term indicators: Medium-term indicators of success capture changes that you might expect further down the road and are usually measured three to six months after the implementation of a program. Medium-term indicators can be measured using methods such as surveys, questionnaires, interviews, or observations that look at changes in well-being, attitudes, or behaviours in young people or other groups/social environments targeted by the program.

Long-term indicators: Long-term indicators of success measure the ultimate goal of a program (usually a reduction in suicide and suicidal behaviours among youth) and are usually measured on an annual basis, starting two to five years following the implementation of a program.

Keep in mind that the indicators listed in the table below represent examples only and we invite you and your group to develop indicators that are in line with the specific goals and activities of your own school climate improvement program. Identifying relevant indicators of success for your own program (and the methods by which these will be measured or monitored) represents one of the most important steps of your overall evaluation plan (see the section *Evaluate your community-wide suicide prevention efforts* in chapter 5).

Methods to evaluate

	Ask a Key Evaluation Question	Measure the Success
SHORT TERM*	Is there increased satisfaction among members of the school community in general?	➢ measure student and teacher satisfaction with respect to the school in general before and after implementation of the program and compare results to determine whether the program has made a difference
	Is one or more of the following indicators are showing improvements?	
	a) student academic achievement	➢ measure percentage of students earning high/ low grades before and after implementation of the program and compare
	b) student participation in extra-curricular activities	➢ measure percentage of students involved in at least one extra-curricular activity before and after implementation of the program and compare
	c) attendance of students and staff	➢ record total year and monthly attendance rates for staff and students before and after implementation of the program and compare ➢ record attendance at school sponsored events (cultural, athletic, or social events) before and after implementation of the program and compare
	d) level of vandalism and theft	➢ calculate total and monthly repair and replacement costs before and after implementation of the program and compare
	e) number of discipline problems	➢ count records of suspensions before and after implementation of the program and compare ➢ record and analyze the numbers of students referred to the office for disciplinary action before and after implementation of the program and compare
	f) alcohol and drug use	➢ measure alcohol and drug use before and after implementation and compare

**** Short-term** (measured immediately to 2 months following program implementation)*

Methods to evaluate

	Ask a Key Evaluation Question	Measure the Success
MEDIUM TERM**	Is the general student population is experiencing improved emotional well-being?	➢ measure student mental well-being (e.g. depression, self-esteem, perceived competence, level of stress)
LONG TERM***	Are suicide and suicidal behaviours among youth decreasing?	➢ measure the number of deaths by suicide and attempted suicides in the community and compare to previous statistics

***** Medium-term** (measured 3 to 6 months following program implementation)*
****** Long-term** (measured 2 to 5 years following program implementation)*

Native Pride Program

Location: Ernest Morrow Junior High School
1212 - 47th St. S.E.
Calgary, AB
T2A 1R3
Telephone: (403) 777-7800
Fax: (403) 777-7809
E-mail: lauriee@epals.com

Contact person: Laurie English, Coordinator

Program description: The purpose of the Native Pride Program is to provide academic and cultural support to Aboriginal and Métis children while exposing the Aboriginal culture to non-Aboriginal students. Ernest Morrow Junior High School has a student population of 600, of which approximately 50 students are of Aboriginal or Métis background. The program coordinator estimates that 35 students regularly use program services.

The activities sponsored by the program include: regular cultural activities and teachings for Aboriginal students, on-going academic support and tutoring for Aboriginal students, outreach work with families, and cultural awareness events involving the whole school.

Cultural activities and teachings take place every Wednesday afternoons at the school or on field trips. The program often invites guests (representatives of the Rediscovery Program, Elders, Addictions Counsellors, etc.) to come in and teach students various topics such as drumming, Aboriginal games, wilderness survival, and arts and crafts.

The academic support component of the program takes place in the program office. Students can come in at any time to receive one-on-one support from the program coordinator or the program aide. Teachers will often refer their students to the program when they need extra help.

The program coordinator is also responsible for the outreach component of the program. She does home visits when families or students are in need of more support or referrals to other services.

Finally, the final component of the program involves exposing the non-Aboriginal student population to the Aboriginal culture in an effort to raise awareness and promote understanding. This can be done, for example, by organizing a school-wide drumming performance presented by the Aboriginal students.

Target groups: All Aboriginal and Métis children enrolled in the school. Non-Aboriginal children are also welcomed to participate in the activities organized by the program.

Partners involved: None.

Years in operation: The program has been in operation since 1995.

Source of funding: Costs related to this program include salaries (one full-time coordinator and one part-time aide) as well as administrative costs. The program is entirely funded by the United Way.

Evaluation findings: In-house evaluations are performed every year. In 2000, a survey was distributed to all participating students and to school teachers. The results from the student survey were overwhelmingly positive. Approximately 60% of the teachers thought that the program was extremely positive.

Advice to others interested in starting this type of program: The program coordinator recommends that programs such as the Native Pride program should always welcome non-Aboriginal students to participate in program activities.

A Place to Start

Organizations

BC Healthy Schools

The aim of the BC Healthy Schools program is to get students involved in learning and practicing skills for decision making towards health. Through a five step process, students are involved in creating action plans that will make their school a healthier place. Since its inception in 1990, hundreds of schools and thousands of students in British Columbia have developed ways to create school environments that are supportive of health.

The Healthy Schools Resource Guide is available for downloading (PDF document) at www.mcf.gov.bc.ca/publications/ecd/healthy_schools_website.pdf or by contacting:

BC Healthy Schools
c/o Ministry of Children and Family Development
716 Courtney Street
Victoria, BC
V8W 1C2
Phone: (250) 356-2489
Fax: (250) 356-0580
Web site: www.gov.bc.ca/mcf

Suggested reading

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Youth/Family Strategies

Self Esteem Building

What is self-esteem building?

Self-esteem building programs aim to foster positive self-esteem in children and adolescents, which in turn may decrease the likelihood of suicide completions and suicide attempts. Such programs increase youth's awareness of how they feel about themselves and help them value their own unique sense of self, where they come from, and the things that they do.

Although there are many ways to describe self-esteem, it basically refers to how we feel about ourselves. Positive self-esteem has been described as feeling good about one's self on the basis of perceived strengths. Related to the concept of self-esteem is self-acceptance, which means to value oneself regardless of perceived weaknesses. In the most basic terms, self-esteem is the disposition to experience oneself as competent, to cope with the challenges of life and to be deserving of happiness.

Goals

More specifically, the goals of self-esteem building are to:

- help youth understand, build, and maintain their self-esteem
- help youth build a sense of self-acceptance and purpose
- facilitate the development of a sense of identity in youth
- promote understanding and acceptance of differences between people

Target population

Self-esteem building programs are directed towards ALL children within a particular age group. This strategy is proactive in that it targets as yet unaffected children and adolescents in order to strengthen their adaptive capacities.

Brief description

There are an extensive number of existing programs that aim to enhance self-esteem in youth, mostly developed for the general population. Most programs focus on all or some of the following components to achieving healthy self-esteem:

1. *Trust*. A sense of security is the first prerequisite to positive self-esteem. Individuals need this sense of security before they can look at themselves realistically or risk the possibility of failure. A sense of security means understanding limits, knowing what to expect, and feeling comfortable and safe. In order for an individual to develop trust in others, he/she must have a series of positive encounters with the people who share his/her world.

2. *Self*. Children begin to mold their self-image early in life. By creating environments in which children can feel secure about themselves and develop their strengths, adults can help children have those positive experiences.

3. *Belonging*. Belonging is the feeling of being accepted by others. When an individual feels like they belong to a group, they gain security. That security and the acceptance they feel help nurture their own self-esteem.

4. *Purpose*. Purpose is an important part of one's self-esteem development. Every individual needs to have a feeling of purpose or a mission in life.

5. *Success*. The statement, "success breeds success," is true in the development of healthy self-esteem in people. By identifying a problem or goal, by developing a plan of action, and by accomplishing an objective, children develop problem-solving skills, as well as a sense of pride.

Self-esteem programs are most often taught in schools but can also be presented in other youth friendly settings including community centres, recreational facilities, friendship centres, and family resource centres. The sessions are usually led by volunteers or staff who has been properly trained. A variety of teaching methods can be used including lectures, small group discussions, presentations by guest speakers, modelling, and role plays.

Why should we offer self-esteem building programs?

Self-esteem is important to a healthy development

Self-esteem is important to normal, psychological development. To adequately cope with the challenges of growing and developing, a person needs to believe that they have the capacity to achieve what they want to and that they are deserving of happiness and joy in life.

Self-esteem programs can impact on known risk and protective factors for suicide

Strong self-esteem acts as a protective factor against suicide as it provides youth with the knowledge that they can cope with problems and feel able to meet the challenges and downturns of life. With positive self-esteem, youth may become less vulnerable to depression and all the other symptomatology of suicide ideation. This may ultimately lead to a decrease in the number of times suicide is even considered as a solution to a negative situation.

On the other hand, studies link low self-esteem with disturbed body image, curtailed physical activity, eating disorders, substance abuse, abusive relationships and interpersonal problems. People who have low self-esteem tend to feel isolated and worthless and low self-esteem can eventually lead to anxiety disorders, depression and suicide. There is therefore a role for self-esteem programs to counteract the negative impact of the risk factors while enhancing the positive power of the protective factors.

Building self-esteem is particularly important for Aboriginal youth

It is becoming more and more evident that self-esteem is an important factor in the lives of Aboriginal youth. Recent research found that a common experience for Aboriginal youth who kill themselves is the recurrent and destructive assault of their self-esteem. An example of a destructive factor on the self-esteem of Aboriginal youth is the constant negative cultural portrayal of Aboriginal people by their non-Aboriginal counterparts. Aboriginal children often grow up with images of themselves as an inferior race and are treated with extreme prejudice by the rest of Canada.

In addition, the process of having their community assimilated into a foreign culture to which they cannot always relate diminishes their sense of belonging. Many youth experience a strong feeling of cultural ambivalence in which they do not have a sense of belonging to either the majority or minority culture. Low self-esteem is usually the consequence of this alienation and assimilation process. As a result of chronic and inter-generational low self-esteem, these youth will experience great difficulty envisioning their future. It is therefore important for Aboriginal youth to develop healthy self-esteem, a sense of self-control over their destiny, as well as self-reliance and a feeling of personal power.

How do we know self-esteem building holds promise?

Although there is not, to date, any evaluative research clearly demonstrating a decrease in youth suicide following the implementation of self-esteem programs, there is enough indirect evidence to suggest that this strategy has potential for success.

Enhancing self-esteem has been shown to help suicidal youth

Aboriginal youth who have recovered from suicidal ideation assign great importance to the process of building one's self-esteem. A recent study investigating what type of strategies had helped a group of 25 Aboriginal youth from British Columbia recover from suicidal tendencies found that acquiring self-esteem/self-acceptance was *the most important successful healing strategy identified by these young people*.

Experts recommend this strategy

In the general literature, a number of authors have called for the implementation of programs that specifically target self-esteem in children and adolescents. Additionally, support can be found for this strategy in the literature on suicide prevention amongst Aboriginal youth.

Aboriginal youth recommend this strategy

Aboriginal young people participating in suicide prevention conferences often call for programs aimed at enhancing Aboriginal youth self-esteem as a means to reducing suicide rates. In a recent focus group of Aboriginal youth held in Thunder Bay, participants felt that low self-esteem, whether due to racism, language differences, learned helplessness, or taking on the victim's role, was the primary cause of the problems facing Aboriginal youth today. Participating youth indicated that improving self-esteem in youth was crucial element of any suicide prevention program.

Setting up for success

1. **Decide how you and your group will organize and structure your self-esteem building program**

   Self-esteem building can be offered to the youth in your community in a number of ways. First, you may choose to implement an established self-esteem curriculum in schools or other community setting. This usually involves purchasing the curriculum and then having local professionals or trained volunteers deliver the curriculum to the students over a period of a few weeks or longer. Second, you may opt to organize a self-esteem workshop or offer a presentation of self-esteem as part of a larger event such as a youth gathering. One-time workshops or presentations can be facilitated by local or outside professionals, but be aware that in general, one-time-only workshops or presentations are not particularly effective and we recommend the implementation of a series of self-esteem building efforts/ workshops which can be offered to young people over a longer period of time. Please refer to *A place to start* and *In our own backyard* for examples of curricula and workshops.

2. **Be aware of the findings from recent research**
   The literature stresses that efforts to improve self-esteem need to be approached from both traditional and modern perspectives. A recent study examined the link between ethnic identity and Aboriginal adolescents' self-esteem by surveying a group of 164 Canadian Aboriginal adolescents in grades 10 and 11. Researchers found that self-esteem was not related to the strength of their identification with the Aboriginal culture, but instead to the strength of their identification with the non-Aboriginal culture. It was concluded that in order to foster self-esteem in Aboriginal adolescents, efforts should focus on helping young Aboriginal people cope with the demands and prejudice that may be inflicted by the non-Aboriginal culture.

How will we know if we're making a difference?

You will know that your self-esteem building program is making a difference if you can answer yes to questions listed in the table below under the headings *short-term*, *medium-term*, and *long-term indicators*. Please note that in order to detect changes over time we typically need to make a long-term commitment to the overall evaluation process. In other words, measuring success is not something you do at a single point in time and then forget about. The timelines that are included below are only guidelines, but they should give you a good sense about the need to measure the impact of our interventions at several points in time following the initial implementation of the strategy.

Short-term indicators: Short-term indicators are changes that the strategy itself is designed to produce and are usually measured right after, or up to two months following, the implementation of a program. Depending on the type of program being developed, short-term indicators can be measured using quantitative methods (e.g. pre-and-post tests measuring changes in skills or knowledge) or qualitative methods (e.g. interviews or focus groups designed to assess attitudes, opinions, and satisfaction).

Medium-term indicators: Medium-term indicators of success capture changes that you might expect further down the road and are usually measured three to six months after the implementation of a program. Medium-term indicators can be measured using methods such as surveys, questionnaires, interviews, or observations that look at changes in well-being, attitudes, or behaviours in young people or other groups/social environments targeted by the program.

Long-term indicators: Long-term indicators of success measure the ultimate goal of a program (usually a reduction in suicide and suicidal behaviours among youth) and are usually measured on an annual basis, starting two to five years following the implementation of a program.

Keep in mind that the indicators listed in the table below represent examples only and we invite you and your group to develop indicators that are in line with the specific goals and activities of your self-esteem building program. Identifying relevant indicators of success for your own program (and the methods by which these will be measured or monitored) represents one of the most important steps of your overall evaluation plan (see the section *Evaluate your community-wide suicide prevention efforts* in chapter 5).

Methods to evaluate

	Ask a Key Evaluation Question	Measure the Success
SHORT TERM*	Are children and adolescents who have attended the sessions satisfied with the information presented?	➢ measure participants' feedback regarding the self-esteem workshops and their satisfaction with the materials presented
MEDIUM TERM**	Are children and adolescents who have attended the sessions showing healthy adjustment in the following areas?	
	a) Emotional well-being	➢ measure depression, self-esteem, and stress levels
	b) Social network	➢ measure perceived social support from peers, family, teachers, and other significant adults
	c) School performance	➢ measure attendance, academic performance, and antisocial behaviour
LONG TERM***	Are suicide and suicidal behaviours among youth decreasing?	➢ measure the number of deaths by suicide and attempted suicides in the community and compare to previous statistics

**** Short-term** (measured immediately to 2 months following program implementation)*
***** Medium-term** (measured 3 to 6 months following program implementation)*
****** Long-term** (measured 2 to 5 years following program implementation)*

Youth gathering in Fort Albany

Location: Peetabeck Health Services
P.O. Box 181
Fort Albany, Ontario
P0L 1H0
Telephone: (705) 278-1131
Fax: (705) 278-1069
E-mail: luc32edwards@hotmail.com

Contact person: Lucy Edwards, Health Director

Program description: Fort Albany First Nation is located 450 kilometers north of Timmins, Ontario on the shore of the Albany River. The community has a population of approximately 1000 on-reserve and is accessible only by air, winter road, and, during the summer season, by barge.

The Peetabeck Health Centre, in collaboration with Community Education Services, organizes a yearly youth gathering which takes place in the month of August. The 4-day event takes place on a site approximately a half-hour ride from the reserve where the youth and supervising adults camp out. Last summer, the youth gathering attracted over 100 young people from the reserve and it is expected that this number will be higher this year.

Although this wellness event also touches on drugs and alcohol prevention and cultural teachings, the main goal is to strengthen youth's self-esteem and self-confidence. Through workshops, speeches, activities, and games, the youth are encouraged to focus on the positive and are taught healthy and positive behaviors. Local as well as outside speakers, facilitators and role models are invited to address the youth during the event. For example, the Self-Improvement Course has been one of the cornerstones of the event in the past (see *A place to start* for more information on that workshop). During the year, a youth committee participates in the planning and fund-raising for the event.

Target groups: The target group for this event includes all youth 11 years of age and older.

Partners involved: Peetabeck Health Centre and the Community Education Services

Years in operation: The youth gathering has been a yearly event since 1999.

Source of funding and costs per year: The youth gathering is funded through: Health Services, various donations from local and outside organizations, and local fund-raising activities (e.g. bake sales, bingo, rummage sales)

Resources: Staff from Health Services and Education Services organizes the event and supervise the events.

Evaluation findings: Participating youth provide feedback by completing evaluation questionnaires following each workshop as well as at the end of the gathering. Participating youth also get a chance to offer suggestions related to future topics and speakers as well as the overall organization of the gathering. Feedback collected from past gatherings has consistently been very positive.

Advice to others interested in starting this type of program:

- Be prepared to listen to the young people and what they want for their gathering. Include youth in the planning of the event through some form of youth committee.
- Be committed to keep the gathering going year after year.
- Don't underestimate the fund-raising component, as it can be a long process to get the necessary funds to produce a successful gathering.

A Place to Start

Workshops

Community Leadership Workshop

Designed specifically for First Nations youth, the community leadership workshop offers an opportunity for youth to better understand, build, and maintain their self-esteem while developing their sense of identity. The three-day workshop focuses on the following topics: Understanding Leadership, Leadership and You, Leadership and Self-esteem, Leadership and Communication, Leadership in Action, and Self-care for Leaders. The workshop format includes many exercises, practice-circles, small and large-group discussions, and role-plays in order to encourage the participating youth to share their experiences and skills and to build on their own strengths.

The workshop is geared to accommodate 25 participants or less and is facilitated by Darien Thira of Thira Consulting. Darien offers a number of workshops in a variety of fields to Aboriginal and non-Aboriginal professionals and community members.

For more information, contact:
Thira Consulting
2837 Yale Street
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V5K1G8
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The Self-Improvement Course

This workshop focuses on self-esteem building for First Nations people and can be adapted to all ages. It was developed and is being offered by Dave Jones, an Ojibway of the Garden River First Nation through his company, *Turtle Concepts: Options for People*, located in Garden River, Ontario. The Self-Improvement Course is the end product of many years of training and observation of techniques to help build self-esteem in youth.

The workshop is based on the premise that "it is okay to feel good about one's self." The full workshop spans over five weeks but its length can be adjusted to fit a community's needs. The sessions focus on four major components:

- Emotional: feelings, issues, positive vs. negative, etc.
- Spiritual: pride, culture, heritage, role-models, etc.
- Physical: exercise, fitness, hygiene, foot care, oral hygiene, etc.
- Social: skill development, group dynamics, manners, conversational development, etc.

The workshop uses the fashion industry as the catalyst to empower youth to look at themselves and to bring about self-development. The notion that beauty comes from within is stressed throughout. However, each participant learns how to make the exterior look great. Each participant takes a photo shoot and looks at who they are. The course culminates with a fashion presentation known as "An Esteemed Extravaganza." This is a night to celebrate and share in one's new-found confidence, a chance to be appreciated for what they are, and a chance to be applauded for taking a healthy risk. For many, this is their only "claim to fame."

Throughout the workshop, participants are taught how to praise one another, and how to accept compliments because they are worthy of them. The workshop promotes acceptance of every participant, no matter who they are and what they look like. It teaches that First Nation People, like others, are on the move. Participants are encouraged to make the necessary changes in their life so that they will be happier. It is hoped that each individual will come to realize that only they can control their own destiny. Copies of the course overview are available.

For more information, contact:
Turtle Concepts: Options for People
580B, Highway 17 East
Garden River First Nation, ON
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E-mail: info@turtleconcepts.com
Web site: www.turtleconcepts.com

Curricula

I'm Thumbody

"I'm Thumbody" is a self-esteem curriculum originally developed in Alberta and adapted by the New Brunswick chapter of the Canadian Mental Health Association. Since the early 1990's, this curriculum has been offered within the public school system of New Brunswick and it is estimated that 80 to 85% of all schools currently use the program. The program is offered in a number of schools that are attended by Aboriginal students who live in neighbouring Aboriginal reserves. In the past, the program has also been offered in an Aboriginal school on-reserve. In fact, certain materials have been translated in Micmac to better serve the needs of that particular school.

The "I'm Thumbody"program:

- promotes healthy self-concepts
- stimulates the development of self confidence
- instills feelings of self worth, individuality and responsibility
- generates an understanding of each person's uniqueness and focuses on the value of their individual differences and strengths
- enhances self-awareness

The curriculum is designed for use at the grade three to four level. The material is presented in the classroom by trained volunteers over two one-hour sessions, with a one week interval between sessions (Session I: Awareness of the uniqueness of self and others and Session II: Identification, recognition, and acceptance of feelings). Each session has a range of activities, from the examination of thumbprints to group discussions about different types of feelings. In addition to the classroom experience, parents and teachers are provided with material to assist them in reinforcing the development of self esteem and good mental health in children. Evaluation forms are completed by teachers and volunteers to evaluate both the program delivery and content, and the volunteer training session.

Volunteers who deliver the program in the schools are selected and trained by the local CMHA chapter. They are selected for their personal suitability to the program and are requested to provide character references. Volunteers usually include retired teachers, parents, or university students. Volunteers are dispatched to the schools from the central office as well as from a number of satellite offices across the province.

For more information about this curriculum, contact:
Canadian Mental Health Association
78 Weldon St.
P.O. Box 11
Moncton, New Brunswick
E1C 8R9
Telephone: (506) 852-3270
Fax: (506) 859-9581
E-mail: cmharcwl@nb.aibn.com

Suggested reading

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Stivers, C. (1991). Promotion of self-esteem in the prevention of suicide. In A.A. Leenaars & S. Wenckstern (Eds.), *Suicide prevention in schools*. New York: Hemisphere.

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Youth/Family Strategies

Life Skills Training

What are life skills training programs?

Life skills training programs are intended to teach children and adolescents the social competencies and life skills needed to support positive social, emotional, and academic development. The aim of this strategy is to enhance young people's personal capabilities so that they may be able to adapt and deal effectively with daily tasks, challenges, and stresses.

In the context of suicide prevention, life skills programs aim at enhancing certain factors that are known to protect against suicide such as: creative problem-solving, healthy coping, and interpersonal competence, which in turn contribute to positive self-esteem.

Goals

More specifically, the goals of life skills training programs are to:

- provide children and adolescents with life-long skills that they can apply in a variety of situations
- facilitate the development of meaningful relationships with peers, family members, teachers, and other adults
- teach youngsters to recognize unhealthy social influences in the environment and make choices about those influences
- develop self-management skills for depression and anger
- increase the repertoire of health-promoting skills
- enhance personal resources such as a sense of well-being, self-esteem, and competency

Target population

Life skills training programs are directed towards ALL children within a particular age group. This strategy is proactive in that it targets children and adolescents who have never shown signs of early risk for suicide in order to strengthen their adaptive capacities.

Brief description

There are a wide variety of life skills training programs in existence. Although the programs may vary in terms of specific objectives, settings, and types of skills emphasized, they are all based on the assumption that training children and adolescents in basic life skills will have a positive impact on their ability to adapt and deal with the pressures in their lives.

Life skills programs usually focus on imparting one or more of the following sets of skills:

Social skills. The social skills component consists of a complex set of relationship and communication skills which allow children and adolescents to have successful and satisfying interactions with peers, parents, teachers, and other adults.

Problem-solving skills. Problem-solving skills include the ability to identify and define a problem, explore potential options, assess the merits and limitations of each, choose an effective means of resolving the problem and be resourceful in seeking help from others.

Decision-making skills. Decision-making skills are especially important in terms of recognizing unhealthy social influences, such as peer pressure related to smoking and drinking and making positive choices about those influences.

Coping and stress management skills. This set of skills relates to the ability to deal with stressful situations and manage anger.

Life skills training programs can be offered to children of all ages from very young children to young adults. Successful life skills programs tend to be relatively structured, with an emphasis on participants practicing specific behaviours and skills in a classroom-type situation and then transferring them to real-life settings. This is important because if this transfer does not occur, the training serves little or no purpose. The following steps are generally followed:

- a peer or adult trainer models the desired behaviour (and acts as a positive role model)
- youth practice the behaviour in role-play situations similar to ones in which the skills might be used
- the trainer or other participants provide feedback to the people participating in the role play situation about how successful they were in demonstrating the use of the behaviour
- youth are supported in their efforts to transfer the skill to real life situations

Because this strategy targets all young people, the most common setting for implementation is the school, although this type of program can also be offered in any other youth-friendly settings including community centres, recreational facilities, friendship centres, and family resource centres. Sessions or workshops are usually led by volunteers or staff who has been properly trained.

Why should we provide life skills training?

Aboriginal youth experience significant stresses and challenges

As they grow up, all young people experience a number of real physical and emotional changes. On top of these changes - which are a normal part of growing up -young people are regularly confronted with various life stressors like peer pressure, parental expectations, and school-related issues. While Aboriginal youth are faced with the same normal changes associated with adolescence, they are thought to be facing, *on average*, more numerous or more intense life stressors than their non-Aboriginal peers. Poor housing, family abuse of drugs and alcohol, and unemployment are examples of problems that are statistically known to be more prevalent in Aboriginal communities. In addition, Aboriginal youth may have observed and internalized a number of unhealthy life skills and coping mechanisms from their own family, neighbours, or peers.

There is a relationship between a lack of life skills and youth suicide

In general, young people who possess and use basic life skills in their daily lives seem to deal better with daily hassles and pressures. On the other hand, young people who are lacking or deficient in these skills are seen as being maladjusted and often experience difficulties such as social relationship problems, failure to achieve in school, involvement in health-damaging behaviours, and low self-esteem. Being deficient in life skills therefore constitutes a high risk condition that increases the probability of later maladjustment and ultimately increases the risk for suicide or suicide attempts.

Life skills programs can help young people adjust and thrive

There is therefore a strong argument to be made for implementing programs that are designed to provide children with the life skills that will allow them to deal effectively with challenges and stress so that they can experience a healthy transition into adulthood. The current consensus in the literature on youth suicide prevention is for schools and organizations to provide a health curriculum that strengthens basic skills useful for managing a variety of health and social issues instead of teaching children and adolescents exclusively about the topic of suicide. Although implementing skill-building programs will not remove the problems that are inherent in many Aboriginal communities, it can provide Aboriginal youth with useful tools that will help them address the negative consequences of adversity and build on the positive prospects for living a healthy life.

How do we know life skills training holds promise?

Extensive research has been done in the general population

Research conducted in the general population suggests that programs that teach generic, broadly applicable personal and social competencies (e.g. problem-solving skills, decision-making skills, interpersonal skills, self-control, stress management, and assertiveness) have yielded significant benefits at least one year following the training, in broad areas such as social adjustment, assertive behaviour, non-aggressive behaviour, peer sociability, and coping with stressors.

A recent American study also reported a decrease in the rate of suicide attempts and completions (but not in suicidal ideation) in a large school district with a long-standing suicide prevention program that combines life skills training (pre-kindergarten to grade 12) and a suicide awareness education curriculum.

Evidence is also emerging within the context of Aboriginal populations

One study that evaluated the impact of a life skills program on Aboriginal youth found that the program was effective in reducing hopelessness and suicide probability as well as improving anger management and problem-solving. The life skills program evaluated in that study was the American Indian Life Skills Development Curriculum (described in *A place to start*). This curriculum focuses on the following areas: self-esteem building, identifying emotions and stressors, communication and problem-solving, recognizing and eliminating self-destructive behaviour, suicide information, suicide intervention, and personal and community goal-setting.

Experts recommend this strategy

Because skill-building programs have been shown to influence a number of factors known to protect against suicide and suicidal tendencies, experts in child and adolescent mental health recommend the widespread implementation of this strategy, especially when it is combined with other strategies that enhance and strengthen the environments most common to youth (e.g. families, schools, and communities) and educate students about suicide. Additional support for this strategy can be found in the literature on suicide prevention amongst Aboriginal youth.

Setting up for success

There are two steps that should be addressed in setting up a successful skill-building program.

1. **Decide how you will organize and structure your life skills training program**
   Many of the coping, communication and decision-making skills that we use on a daily basis are learned naturally (or informally) at home, at school, and in the company of peers and other community members. Teaching new social/life skills in a formal setting is not easy, especially when the skills to be learned are not getting reinforced or practiced by other people in the community. It would probably be to your advantage, therefore, to select an existing and proven curriculum (see *A place to start*) that you may then adapt to meet the needs of your group of young people. You may also decide to sponsor a series of workshops where local or outside qualified people can be invited to speak to the youth about a particular set of skills.

Regardless of the type of training provided, it is important to keep the following in mind:

- Early is better. Life skills programs will achieve maximum benefits if they are provided as early as possible in a child's life. It makes sense to build a strong base of healthy life skills before the development of maladjustment and/or social problems, or when these problems are not so entrenched and may be easier to modify.

- Age-appropriate contents and teaching methods are a must. Children of various ages differ in their capacity to comprehend or integrate certain life skills. It is therefore important to match the level of skills as well as teaching methods to the developmental capacity of the group.

- Focus on the practice of skills. As mentioned earlier, it is important that the training curriculum uses training methods or techniques that are known to produce change in youth behaviour. For example, we know that a program will be much more effective if it includes a practice and feedback component. Therefore, the training should encourage active student engagement by using methods like modelling, role plays, performance feed-back, dialoguing, and positive reinforcement.

2. Combine life skills training with other strategies that focus on strengthening the settings where youth interact

For maximum benefit, this strategy should be combined with efforts aimed at positively influencing the environments most common to youth (e.g. families, schools, and communities). Children who grow and develop in environments that are caring, supportive and respectful will be more likely to use their newly acquired skills, especially if they receive constant positive reinforcement for their positive behaviors.

For example, a school-based skill training effort focusing on interpersonal skills will have more of an impact on students if the school itself is a place where student opinions are valued, teachers and administrators are easily accessible and friendly, and there are plenty of social activities where students can interact and form friendships. This manual highlights a number of strategies aimed at creating positive changes in the key settings where youth spend most of their time. We invite you to check out the following strategies: *Family support*, *School climate*, and *Community development*.

How will we know if we're making a difference?

You will know that your life skills training program is making a difference if you can answer yes to questions listed in the table below under the headings *short-term*, *medium-term*, and *long-term indicators*. Please note that in order to detect changes over time we typically need to make a long-term commitment to the overall evaluation process. In other words, measuring success is not something you do at a single point in time and then forget about. The timelines that are included below are only guidelines, but they should give you a good sense about the need to measure the impact of our interventions at several points in time following the initial implementation of the strategy.

Short-term indicators: Short-term indicators are changes that the strategy itself is designed to produce and are usually measured right after, or up to two months following, the implementation of a program. Depending on the type of program being developed, short-term indicators can be measured using quantitative methods (e.g. pre-and-post tests measuring changes in skills or knowledge) or qualitative methods (e.g. interviews or focus groups designed to assess attitudes, opinions, and satisfaction).

Medium-term indicators: Medium-term indicators of success capture changes that you might expect further down the road and are usually measured three to six months after the implementation of a program. Medium-term indicators can be measured using methods such as surveys, questionnaires, interviews, or observations that look at changes in well-being, attitudes, or behaviours in young people or other groups/social environments targeted by the program.

Long-term indicators: Long-term indicators of success measure the ultimate goal of a program (usually a reduction in suicide and suicidal behaviours among youth) and are usually measured on an annual basis, starting two to five years following the implementation of a program.

Keep in mind that the indicators listed in the table below represent examples only and we invite you and your group to develop indicators that are in line with the specific goals and activities of your own life skills training program. Identifying relevant indicators of success for your own program (and the methods by which these will be measured or monitored) represents one of the most important steps of your overall evaluation plan (see the section *Evaluate your community-wide suicide prevention efforts* in chapter 5).

Methods to evaluate

	Ask a Key Evaluation Question	Measure the Success
SHORT TERM*	Are the youth satisfied with the information presented?	➢ measure participants' feedback regarding the life skills lessons and their satisfaction with the materials presented
	Did the youth acquire the skills emphasized in the training?	➢ measure skills (e.g. problem-solving, stress management, communication skills - depending on the type of life skills training) before and after the training and compare results to determine whether the training has made a difference
MEDIUM TERM**	Are the youth showing healthy adjustment in the following areas?	
	a) Emotional well-being	➢ measure depression, self-esteem, and stress levels
	b) Social network	➢ measure perceived social support from peers, family, teachers, and other significant adults
	c) School performance	➢ measure attendance, academic performance, and antisocial behaviour
	d) Leisure and recreation	➢ measure involvement in healthy leisure activities
LONG TERM***	Are suicide and suicidal behaviours among youth decreasing?	➢ measure the number of deaths by suicide and attempted suicides in the community and compare to previous statistics

**** Short-term** (measured immediately to 2 months following program implementation)*
***** Medium-term** (measured 3 to 6 months following program implementation)*
****** Long-term** (measured 2 to 5 years following program implementation)*

A Place to Start

Curricula

Miyupimaatisiiuwin Wellness Curriculum

The Miyupimaatisiiuwin Curriculum is a holistic and Cree-specific preventive program with an emphasis on wellness through health promotion for children in kindergarten to grade 8. It was developed for the Public Health Module of the Cree Board of Health and Social Services of James Bay by SWEN Productions, Educational Consultants, Montreal (Quebec).

The Miyupimaatisiiuwin Curriculum is comprehensive, covering a wide range of wellness issues in a practical and teacher-friendly format. There are four units in the curriculum built around the concept of the Wellness Circle. Units one (Strong Self) and two (Strong Relations) focus primarily on strengthening self-concept and interpersonal skills while units three (Strong Body) and four (Strong Future) present factual information and practical experience. The learning activities are designed to promote four aspects of health: personal effectiveness, emotional balance, physical energy, and mental clarity.

A different lesson objective is identified for each theme at each grade level. Objectives develop across grade levels from being simple language-based to more complex and thought provoking. Each year, students revisit the same themes related to different health issues, as well as traditional values. Accompanying resources include: books, music tapes, videos, games, activity sheets. The information also reaches parents through a planned parental informed consent component built into each lesson. Barbara Reney, from SWEN Productions, explains that the curriculum encourages bringing in community members (especially elders) to talk to the youth as wellness is a community issue and it is based on traditions. The curriculum was developed in 1999 and there has been no formal overall evaluation to date. Teachers participate in on-going evaluation.

The Miyupimaatisiiuwin Curriculum was recently selected by the Institute of Community & Family Psychiatry (1999) as one of nine programs they most highly recommend for suicide prevention and mental health promotion activities. This group conducted a systematic review of suicide prevention and mental health promotion programs developed for or potentially applicable to Aboriginal populations. Although there is no suicide-specific theme in the curriculum, it represents a comprehensive school-based approach to building life skills and promoting health, and, by extension, to the long-term goals of suicide prevention.

For more information, contact:
Barbara Reney
SWEN Productions
3622 rue De Bullion #2
Montreal, Quebec
H2X 3A3
Telephone: (514) 849-8478
Fax: (514) 849-2580

Learning for life: A social skills training program for young adolescents
This 100-page manual draws on three prevention strategies: influencing normative values; teaching skills that help Aboriginal youth counter social pressures; and teaching general personal and social skills such as problem-solving, decision-making, effective interpersonal communication, assertiveness, and coping with stress. Ideas are presented to help schools cooperate with other community agencies in addressing broad-based societal concerns.

This curriculum can be ordered from:
Four Worlds International Institute for Human and Community Development
347 Fairmont Boulevard
Lethbridge, Alberta
T1K 7J8
Telephone: (403) 320-7144
Fax: (403) 329-8383
E-mail: 4worlds@uleth.ca
Web Site: www.uleth.ca/~4worlds

American Indian Life Skills Development Curriculum
The American life skills curriculum was developed to teach American Indian secondary school students coping and suicide prevention skills. One of the goals is to help students feel comfortable talking about issues such as depression, stress, anger, sexuality, and grieving.

The curriculum consists of seven major units that include a total of 37 lesson plans. Sections cover the following topics: building self-esteem; identifying emotions and life stressors; communication and problem-solving skills training; recognizing and eliminating self-destructive behaviour; suicide information; and personal and community goal-setting. Lesson plans include objectives, instructional materials, suggested time frames, lesson content, and learning activities. Learning activities focus on developing social skills and include information on the rationale and components of a particular skill, modeling and demonstration of a skill, skill practice, and feedback on individual skill performance. The curriculum was designed to be culturally compatible with the norms of Zuni traditions but is easily adaptable to other communities.

The developers of this life skills curriculum explain that Aboriginal people have potential facilitative cultural values and beliefs for coping with adversity. These were incorporated into the curriculum to help Aboriginal youth to cultivate cognitive coping strategies and better understand the coping resources within their traditional tribal culture. As Aboriginal adolescents understand the process of coping, they can become more adept at regulating their own behaviours. They begin to exercise a range of coping options which they may not have previously considered and they start to experience greater freedom than those who have more limited coping repertoires. As they feel more effective, they become less interested in self-destructive forms of coping and more involved in determining their own futures.

In an evaluation, the life skills training was found to be effective in reducing hopelessness and suicide probability as well as improving anger management and problem-solving.

The curriculum (ISBN 0299149242) is available from the distributor of the University of Wisconsin Press:
Customer Service Department
The University of Wisconsin Press
c/o Chicago Distribution Center
11030 S. Langley Ave.
Chicago, IL
60628
USA
Telephone: (773) 568-1550
Fax: (773) 660-2235
Web site: www.wisc.edu/wisconsinpress

Lions-Quest Canada

Lions-Quest Canada is a charitable organization representing the Canadian Branch of the partnership between Lions Club International and Quest International. The tri-level curriculum is designed to:

- help young people develop positive social behaviours, such as self-discipline, responsibility, good judgment, and the ability to get along with others.
- help young people develop strong commitments to their families, schools, positive peers, and communities, including a commitment to lead healthy, drug-free lives.

Although the programs are not Aboriginal-specific, they have been widely implemented and evaluated in Canadian schools, as well as schools around the world, since 1984.

Skills for Growing (ages 5-10): This program is a comprehensive life skills program that reinforces traditional civic values and focuses on the development of important skills (self-discipline, communication, respect for others, and resistance to alcohol and other drugs) within a caring and consistent environment.

Skills for Adolescence (ages 11-13): This comprehensive life skills and drug prevention curriculum helps adolescents develop key competencies in communication, problem solving, goal setting, and resisting the use of alcohol and other drugs.

Skills for Action (ages 14-17): Personal and social responsibility are the focal points of this program. By taking part in service-learning projects, participants learn life skills that include: interpersonal communication, cooperation, proactive learning and thoughtful citizenship.

For more information on these programs, contact:
Lions-Quest Canada
515 Dotzert Court, Unit 7
Waterloo, ON
N2L 6A7
Telephone: (519) 725-1170 or 1-800-265-2680
Fax: (519) 725-3118
E-mail: qbear@lions-quest.ca
Web site: www.lions-quest.ca

Programs/ workshops

White Stone: An Aboriginal Youth Suicide Prevention Program

White Stone: An Aboriginal Youth Suicide Prevention Program trains youth from First Nations communities to deliver life skills sessions to other youth in their own community. The White Stone Program was developed in a partnership between the RCMP National Aboriginal Policing Services and the Suicide Prevention Training Programs (SPTP), Calgary, Alberta. The vision for and the curriculum of the White Stone Project was informed by Aboriginal youth focus groups, current literature, participant feedback, and a review of programs in Canada, the United States and Australia. The term White Stone comes from an Ojibwa concept: one who teaches others how to grow old.

Aboriginal and Inuit youth 18-25 years of age who have been identified as natural leaders by their community and community-based service providers (youth worker, teacher, nurse, police etc.) are invited to take part in a *Training for Youth Educators* workshop. The five-day workshop is divided into two components: youth suicide prevention training (16 hours) and leadership training (19 hours). The suicide prevention training component focuses on: exploration of beliefs around suicide, dynamics of suicidal behaviours, discussions around the role of culture of origin, risk and protective factors, intervention skills as well as practice through simulations. The leadership skills component of the training concentrates on enhancing knowledge and experience in: group dynamics; planning and preparation of a Youth Education Session; presentation and leadership skills; working with vulnerable youth; as well as self-care and community implementation.

Following the training, youth leaders return to their community and work in partnership to offer Youth Education Sessions to other youth. The Youth Education sessions are intended to be presented to youth over the age of 16 who are not known to be actively at risk of suicide. The sessions are designed to be flexible and responsive to local needs. The sessions are life skills based and focus on self-esteem, problem solving, goal setting, as well as communication and coping skills. Most of the content for these sessions was adapted from the American Indian Life Skills Development Curriculum (see above for more information). It is expected that the Youth Education Sessions would be offered as part of a larger community suicide prevention strategy.

For more information about this program, contact:
Suicide Prevention Training Programs (SPTP)
Suite 320, 1202 Centre Street S.E.
Calgary, Alberta
T2G 5A5
Telephone: (403) 245-3900
E-mail: sptp@suicideinfo.ca
Web site: www.suicideinfo.ca

The First Nations Cadet Corps

The First Nations Cadet Corps (FNCC) is an Aboriginal version of "Air Cadet/Army Cadet" program designed to assist youth in making the right choices and to stay out of trouble and away from negative influences. Participating youth learn about respect, discipline, self-pride, and team work and are given the knowledge and strength to overcome obstacles they may encounter from day to day. Program activities include: drill classes, organized sports, life skills, and other activities (first aid, firearm safety, community service, competition shooting, traditional skills such as trapping, hunting and fishing, drug/alcohol education, cultural and language lessons). The program is open to boys and girls between the ages of 12 to 18 years who are attending school on a full time basis. The cadets are rewarded for their accomplishments through awards and uniform pins which are distributed to cadet corps throughout Canada from the FNCC headquarters. The program is delivered by Cadet leaders (civilians or RCMP members) who are volunteers from the local community. Costs for the program are usually covered by Band or Community funding as well as the Cadets' parents. All the information and materials necessary to start the program are available from the FNCC headquarters in Regina.

Communities interested in starting a First Nations Cadet Corps program should contact:
National Coordinator, FNCC
"F" Division Aboriginal Policing Services
Regina, Saskatchewan
S4P 3K7
Telephone: (306) 780-7778
Fax: (306) 780-8567

Suggested reading

Botvin, G.J., Baker, E., Dusenbury, L., Botvin, E.M., & Diaz, T. (1995). Long-term follow-up results of a randomized drug abuse prevention trial in a white middle-class population. *Journal of the American Medical Association*, 273(14), 1106-1112.

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Youth/Family Strategies

Suicide Awareness Education

What is suicide awareness education?

This well-known youth suicide prevention strategy involves talking directly with young people about suicide. The main purpose of suicide awareness education is to provide youth with the necessary attitudes, knowledge, and skills to be able to self-refer or identify and help a friend who may be thinking about suicide.

Goals

The goals of suicide awareness education are as follows:

- raise awareness about the problem of youth suicide and the behavioural signs, physical symptoms, and stress indicators
- encourage identification of at-risk youth
- teach youth how to seek help; provide information about mental health services and referral procedures
- promote the development of competencies such as coping and stress management skills, as well as interpersonal and communication skills

Target population

All youth can benefit from suicide awareness education. This type of education is most often offered at the junior and senior high level.

Brief description

Suicide awareness education is a popular suicide prevention strategy that has been implemented around the world for decades. Although individual programs may vary slightly, the following topics are usually addressed:

- *The issue of suicide*. Youth are presented with statistics, myths and facts, as well as information about risk factors of adolescent suicide. This part of the presentation serves to make them aware of the problem and help them understand why their peers may become suicidal. Youth are also invited to explore how they feel about the topic.

- *Warning signs*. Youth are taught to recognize the warning signs of suicide in their peers so that they may be in a position to help them by seeking help.

- *How to seek help.* Youth are taught how to talk with a suicidal peer and how to get help from a responsible adult or service organization. Concerns relating to confidentiality and breaking a friend's trust are usually addressed.

- *Mental health services.* Youth are given information about available mental health resources in their own community, how they operate, and how to contact them.

- *General competencies*. Youth are taught coping and stress management skills to help them deal with their own personal problems. Other competencies such as interpersonal and communication skills can also be taught and practised with the group environment. A suicide awareness education curriculum is typically offered in the classroom as part of an existing health or social studies course. However, this type of curriculum can also be provided in places where out-of-school youth congregate, such as street youth programs, group homes, shelters, and youth employment centres.

Suicide awareness education can be presented in schools, community centres, recreational facilities, friendship centres, and family resource centres. Sessions or workshops are usually led by volunteers or a staff who has been properly trained over a period of two to four hours. A combination of teaching methods is often used and these include lectures, role plays, group discussions, and videotapes. Many programs distribute small, printed wallet cards or pamphlets to the youth attending the session. These summarize, in a user-friendly format, the facts about suicide, warning signs, steps to take if one suspects that a friend is suicidal, and telephone numbers of local help-lines and other emergency services in the community.

Why should we provide suicide awareness education?

Young people talk to each other about their personal problems

In general, young people who want to share their personal feelings and problems will turn to their own peers. In addition, disturbed youth (depressed, substance abusers) prefer peer supports over adults more than their non disturbed peers. This may be because peers are seen to be more understanding and more likely to maintain a confidence than adults. It is also known that youth who are suicidal often do communicate their intent to someone before proceeding to end their life.

A recent study found that when asked, young people often report having recently talked to or known a peer who was suicidal or potentially suicidal. However, very few of them report having told an adult. This may be because they find it difficult to break the promise of secrecy, have not taken their friend seriously, or simply do not know what to do. In fact, young people often report that they simply do not know what services and resources are available to provide assistance to their friends or even themselves.

For these reasons, youth need to know how to recognize the warning signs of suicide and need to know when, how, and where to get professional assistance for a peer or for themselves. They also need to understand the myths and misconceptions about suicide, to take warning signs seriously, and to break the confidence to save a life.

How do we know suicide awareness education holds promise?

Encouraging results have been noted in the general population

Research on the effectiveness of this strategy in the general youth population has been relatively limited. Research in non-Aboriginal settings indicates that young people generally receive the materials favourably and believe that the information is important.

Participating youth have increased their knowledge about suicide warning signs and mental health referral sources, although it is not clear whether this knowledge lasts over time. Results regarding attitude change are mixed, although positive results have been noted. Again in the general population, the effectiveness of suicide awareness education on peer helping skills has yet to be proven. Finally, there is evidence suggesting that suicide education programs result in more referrals to community mental health services. We did not find any research (related to the effectiveness of this strategy) that specifically addressed Aboriginal youth.

Suicide prevention experts recommend this strategy

Suicide awareness education is a strategy that has received a lot of attention in the general literature. It has been recommended for the general youth population by a number of experts and organizations (e.g. Canadian Association for Suicide Prevention and the U.S. Centers for Disease Control). Experts writing about Aboriginal youth have also supported this strategy, especially when implemented within the school system.

Setting up for success

There are six steps that should be addressed when setting up a suicide awareness education program in a school system or elsewhere.

1. **Gain entry into the relevant youth-serving systems.**
   Suicide is an emotional and anxiety-producing topic for many community workers, youth leaders, school administrators, teachers, and even parents. Efforts to introduce a suicide awareness education program into a school or other organization may therefore be met with varying degree of resistance. This may be due, in part, to a lack of information and knowledge about suicide and its prevention. It is therefore important for these groups to be thoroughly informed about the issue and involved in the development and implementation of the program.

2. **Select a suicide awareness education curriculum for the school system or organization**
   There are many established and well-accepted suicide awareness education programs in existence that can be readily implemented or modified to meet the needs the schools or organizations within your community (please refer to the box *A place to start* for more information). As you will see, most but not all of these curricula have been written for the general youth population. They can, however, be modified to suit the particular needs of the Aboriginal youth.

   When selecting a suicide awareness education curriculum for your school system or organization, keep in mind that the curriculum should:
   - be appropriate for the developmental level and age of the youth you are targeting
   - be aimed at youth as potential helpers, not victims
   - present information that is clear, up-to-date, and “user friendly”

- include elements that teach skills, not just knowledge, such as certain opportunities for youth to practice and receive feedback
- ensure active youth engagement through learning methods including role modelling, role plays, performance feedback, small group discussion, and positive reinforcement
- provide plenty of opportunity for discussion

If you decide to adapt a curriculum that has been written for the general population, you may want to consider including certain topics that are relevant to Aboriginal youth such as: self-esteem and identity, the impact of alcohol and drugs on suicide risk, multi-generational grief and cultural losses, as well as the identification of relevant community-based resources beyond suicide specific resources, e.g. traditional healers, extended family members, elders. It may also be important to challenge the notion that suicide is a heroic gesture and point to alternative responses to interpersonal crises and despair.

3. Provide suicide prevention training for school and community workers

If teachers are to be the primary providers of the suicide awareness curriculum, then they need to be provided with the right training and preparation in the form of an in-service. Similarly, the staff of a community organization implementing this type of program also needs to receive adequate training. In addition to reviewing the lesson plans and material to be presented to the youth, the in-service should provide them with the opportunity to explore their own attitudes toward suicide and gain the skills to recognize and help potentially suicidal youth or any youth who may react negatively to the presentation.

4. Develop up-to-date school or organizational policies and procedures

Schools as well as community organizations should have in place policies and procedures that will help guide staff responding to at-risk youth who have been identified by their peers or other individuals. The written guidelines should clearly describe what personnel are to do and how at-risk youth are to be referred to the appropriate community mental health resources. There should also be a procedure for handling youth who may be upset by the materials presented. For more information on writing policies and procedures, refer to the *School policy* strategy.

5. Develop and maintain linkages with the community mental health system

Schools as well as other community organizations are not expected to deal with suicidal adolescents on their own. It is therefore important to develop and maintain effective communication and referral procedures with the broader mental health system for the management of the at-risk youth. Professionals within the mental health system should be made aware of the implementation of a suicide awareness education program in a school or other organization. For more information on developing such linkages, refer to the *Interagency communication and coordination*

strategy. In small or remote reserves, where professional mental health services may not be available, links should be forged with community "natural helpers" such as elders or extended family members.

6. **Combine suicide awareness education with other prevention strategies**
   The Royal Commission for Aboriginal People and other experts have suggested that suicide awareness education programs are most likely to contribute to prevention when they are tied to skills development around help-seeking behavior, self-esteem enhancement, problem-solving, and general life skills. We invite you to check out the following strategies: *Life skills training* and *self-esteem building*.

Are there any concerns associated with this strategy?

This strategy has received some criticism in the literature

You should be aware that conventional suicide awareness lectures have been criticized in the literature, following the work done by David Shaffer and his colleagues in the late eighties. These researchers conducted a systematic evaluation of classroom-based suicide prevention programs and found them to be generally quite limited in their effectiveness. Perhaps the most damaging misperception that has arisen as a result of Shaffer's study is that school-based education programs are somehow harmful to students because classroom discussions about suicide can prompt suicidal behaviour, especially in young people who are considered "high risk" for suicide.

Recently, the Royal Commission for Aboriginal People reported that there is indeed some need for caution in relation to suicide education programs that consist of a brief, one-time-only information lectures for young people, as these may be ineffective and may even be upsetting to certain groups. Other authors have written that suicide awareness programs may be less useful in many Aboriginal communities, where the population is all too aware of suicide. In particular, for some Aboriginal youth, suicide may even be viewed positively as a heroic gesture or a means of protest against social wrongs and injustices.

We need to be clear about our program and evaluation goals

Unfortunately, the conclusions of Shaffer's work were given widespread media attention without being placed within the proper light. Most importantly, the work of Shaffer and his colleagues was valuable for highlighting the need to be clear about the goals (as well as the most appropriate target groups) for these types of programs and the constant need to evaluate our efforts. In a recent review of school-based youth suicide prevention programs, Kalafat argues that evaluations of early suicide awareness education programs showed mixed results because these "first generation programs" lacked focus regarding their target audience (e.g. at-risk youth, potential peer helpers, or all youth) and they also lacked clarity regarding their instructional objectives (e.g. changes in suicidal feelings, understanding suicide and depression, or intervention issues). More recent findings, based on research undertaken in the United States, found positive program effects with some of the newer, "second generation programs," which have been developed to bring a

more concentrated focus to the goal of preparing young people to respond to encounters with at-risk peers and seeking adult help.

We need to be prepared to deal with potentially vulnerable audience members

The other major criticism that was raised with respect to suicide awareness education programs is that they may be damaging to vulnerable young people. Again, Kalafat argues that this criticism arose based on two early "first generation programs" that may not have been particularly well implemented. He also points out that these findings simply raised the need for caution concerning students' reactions to programs.

Kalafat suggests that the concern about upsetting vulnerable youth through the presentation of suicide awareness education programs, is generally appropriate. In fact, there will always be the possibility of negative reactions, particularly on the part of students who have some personal experience with suicide. Therefore, carefully designed programs need to clearly anticipate this kind of reaction and the facilitators of these programs should be prepared to react appropriately.

We also need to be realistic in our expectations

Another key recommendation arising from Shaffer's studies was that classroom-based suicide prevention efforts should specifically target those at highest risk for suicide. This recommendation, however, presupposes that the ultimate goal of such programs is to reduce the risk status among those who are most vulnerable (i.e. depressed, isolated, or lonely). Given the educational nature of the programs themselves, this is a very unrealistic expectation.

Young people who are currently at risk for suicide require an individual clinical assessment and perhaps a referral to receive more intensive follow-up, including individual or group counselling. These young people do not need, nor would one expect them to benefit from, short-term education and information sessions. In contrast, the general youth population, who will likely come into contact with a potentially suicidal peer, are the more appropriate target of these efforts. Through increased knowledge and by enlisting the help of an adult, these students can provide more effective assistance to a potentially suicidal peer.

How will we know if we're making a difference?

You will know that your suicide awareness education program is making a difference if you can answer yes to questions listed in the table below under the headings *short-term*, *medium-term*, and *long-term indicators*. Please note that in order to detect changes over time we typically need to make a long-term commitment to the overall evaluation process. In other words, measuring success is not something you do at a single point in time and then forget about. The timelines that are included below are only guidelines, but they should give you a good sense about the need to measure the impact of our interventions at several points in time following the initial implementation of the strategy.

Short-term indicators: Short-term indicators are changes that the strategy itself is designed to produce and are usually measured right after, or up to two months following, the implementation of a program. Depending on the type of program being developed, short-term indicators can be measured using quantitative methods (e.g. pre-and-post tests measuring changes in skills or knowledge) or qualitative methods (e.g. interviews or focus groups designed to assess attitudes, opinions, and satisfaction).

Medium-term indicators: Medium-term indicators of success capture changes that you might expect further down the road and are usually measured three to six months after the implementation of a program. Medium-term indicators can be measured using methods such as surveys, questionnaires, interviews, or observations that look at changes in well-being, attitudes, or behaviours in young people or other groups/social environments targeted by the program.

Long-term indicators: Long-term indicators of success measure the ultimate goal of a program (usually a reduction in suicide and suicidal behaviours among youth) and are usually measured on an annual basis, starting two to five years following the implementation of a program.

Keep in mind that the indicators listed in the table below represent examples only and we invite you and your group to develop indicators that are in line with the specific goals and activities of your own suicide awareness education program. Identifying relevant indicators of success for your own program (and the methods by which these will be measured or monitored) represents one of the most important steps of your overall evaluation plan (see the section *Evaluate your community-wide suicide prevention efforts* in chapter 5).

Methods to evaluate

	Ask a Key Evaluation Question	Measure the Success
SHORT TERM*	Are youth satisfied with the information presented?	➢ measure participants' feedback regarding the suicide awareness classes and their satisfaction with the materials presented
	Are youth more knowledgeable?	➢ measure participants' knowledge (e.g. about warning signs and available community resources) before and after the lesson and compare results to determine whether the program has made a difference
	Are youth showing more favourable attitudes?	➢ measure participants' attitudes (e.g. helping a friend in a non-judgmental manner, willingness to get help/break a confidence)
	Are youth demonstrating appropriate helping skills?	➢ measure participants' skills (e.g. asking directly about suicide, telling an adult)
MEDIUM TERM**	Are youth retaining the knowledge and skills gained?	➢ measure retention of knowledge and skills over a period of time
	Are youth correctly identifying and referring peers at-risk for suicide?	➢ track the number of youths referred by their peers or self-referred to professionals/ organizations ➢ measure the appropriateness of these referrals
LONG TERM***	Are suicide and suicidal behaviours among youth decreasing?	➢ measure the number of deaths by suicide and attempted suicides in the community and compare to previous statistics

**** Short-term** (measured immediately to 2 months following program implementation)*
***** Medium-term** (measured 3 to 6 months following program implementation)*
****** Long-term** (measured 2 to 5 years following program implementation)*

Suicide Prevention: Let's Talk About It

Location: Kativik School Board
2055 Oxford
Montreal, Quebec
H4A 2X6
Telephone: (514) 482-8220
Fax: (514) 482-8278

Program description: In the early 1990's, alarmed by the number of suicides and suicide attempts as well as the misconceptions people had about suicide, the Kativik School Board staff recognized the need to develop a suicide prevention program for implementation in the school system. The School Board decided to offer a suicide awareness education curriculum for the students as well as organize training sessions in suicide prevention for school staff.

After reviewing a number of suicide awareness education programs, Kativik School Board staff decided to adapt a program originally developed in Laval (Quebec). The Laval program was revised to reflect the reality of the Nunavik Regions and re-named "Suicide Prevention: Let's Talk About It". At the time the program was launched, several professionals and other individuals from 14 communities were trained in program implementation as well as basic intervention skills. The curriculum is currently being taught in community schools as well as other community settings. In the schools, the curriculum is usually taught by school counsellors as part of the Personal and Social Development curriculum.

The overall goal of the program is for students to develop an understanding about the issue of suicide. The specific goals of the program are as follows:

- develop a better understanding of the magnitude of the problem of suicide
- express knowledge, ideas, reactions, and beliefs about suicide
- distinguish between the myths and the realities surrounding suicide
- learn to recognize the risk factors
- learn to recognize the warning signs
- understand the stages of the suicidal process
- become familiar with the intervention steps in the prevention of suicide
- identify available resources and the importance of using them

The curriculum materials are presented over the course of 5 sessions. Methods of instruction include: lectures, group discussion, brainstorming, role playing, and reading on the topic. Schools implementing the curriculum are provided with a Presenter's guide, booklets on suicide awareness (for distribution to the students), and pamphlets (for

distribution to the parents). The Presenter's guide is intended for school staff members (or community members) who will be leading the sessions. The Presenter's guide provides all the necessary information to carry out the implementation.

The Presenter's guide warns that the curriculum should not be used for 3-6 months following a suicide in the school or community. As well, it is recommended that the program be discontinued immediately if a suicide occurs during the course of program implementation.

Target groups: The program is intended to be used with adolescents (from about 15 years of age) and adults.

Partners involved: Kativik School Board.

Years in operation: The curriculum was developed in 1993 and has been used in the schools since 1994.

Source of funding and costs per year: Funding for the development of the suicide awareness program was provided by the following organizations:

- Kativik School Board
- Kativik Regional Government
- Nunavik Regional Board of Health and Social Services
- Ungava Tulattavik Health Centre

There is no direct cost to the schools as all the materials are provided by the Kativik School Board.

Resources: The only school resource associated with this program is the time commitment required of the professionals who will prepare for and deliver the curriculum to the youth.

Evaluation findings: The program has never been formally evaluated.

Advice to others interested in starting this type of program: One of the developers of the program strongly suggests that this type of program should not be implemented in isolation. Professionals and other adults in frequent contact with youth should be adequately trained in intervention and postvention skills. Furthermore, it also is important to focus on raising children's self-esteem and to develop activities that celebrate life.

Available reports and materials:

- Presenter's guide Let's Talk About It!
- Booklet on suicide awareness for students
- Pamphlet for parents

A Place to Start

Programs

CHOICES: Youth suicide awareness program

CHOICES is an internationally award-winning youth suicide awareness program designed to teach young people (grades 8-12) about the warning signs of suicide as well as how to best help a suicidal peer. The CHOICES program includes a 16-minute video and a facilitator's manual. The video tells the story of an adolescent at risk, interspersed with real-life experiences from teenage suicide attempters and a family who lost their adolescent son to suicide. The facilitator's manual includes background information on youth suicide; pointers for teaching suicide education; a video transcript; a suggested seminar outline; an optional facilitator's "script" along with all visuals; and a brochure which can be photocopied and handed out to participating youth. The one-hour CHOICES program can be facilitated by suicide prevention professionals, trained crisis centre volunteers, teachers, counsellors, mental health professionals, or other committed community members. The content of the program can also be adapted for younger children.

For more information, contact:
Crisis Intervention and Suicide Prevention Centre of B.C.
763 East Broadway
Vancouver, BC
V5T 1X8
Telephone: (604) 872-1811
Fax : (604) 879-6216
E-mail: info@crisiscentre.bc.ca
Website: www.crisiscentre.bc.ca

Suggested reading

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Youth/Family Strategies

Family Support

What are family support programs?

Family support programs provide a variety of services designed to help parents fulfill their childrearing responsibilities. These services, such as parent support groups, parenting classes, family counselling, or emergency assistance, empower and strengthen parents with the aim of enhancing the overall health and well-being of family systems.

In the context of suicide prevention, family support programs act to strengthen a number of protective factors within the family unit. Examples of such protective factors include warm and caring parent-child relationships, healthy adult modelling, and the establishment of high and realistic parental expectations. At the same time, family support programs work to reduce the negative impact of certain risk factors for youth suicide, such as social isolation, family instability, and a family history of depression or other psychiatric disorder. Providing parents with the tools and skills to create a home where children can succeed is at the heart of family support programs.

Goals

More specifically, the goals of the family support strategy are to:

- enhance parental knowledge, self-esteem, and problem-solving capabilities
- enhance parenting skills
- promote healthy physical, emotional, and social development of children
- improve family functioning including family cohesion, communication, and joint problem-solving ability
- prevent various child and family dysfunction such as abuse and neglect
- strengthen family and community support networks
- facilitate access to community resources

Target population

Most family support programs target families within a community that may be “at-risk” or in need of active support and assistance. However, family support services are also very valuable in strengthening families in general, even in the absence of any specific or identifiable risk.

Brief description

There are hundreds of programs in Canada that are found under the umbrella of family support. These programs all vary in terms of their objectives, settings, and types of services offered. This diversity is not surprising given the fact that family support programs are usually structured to meet the specific needs of families within a community and are designed to complement existing community services and resources. The common theme running through all of these programs, however, is that they are based on the assumption that the provision of information, emotional support, and

practical assistance to families will have a positive impact on parents, and children, as well as family systems.

Family support programs can be planned and operated by a number or organizations including Band offices, service agencies, recreation centres, mental health offices, schools, health centres, service clubs, or cultural organizations. Providers of family support services include professionals and other trained individuals as well as volunteers. Services can be provided from a central location, such as a family resource centre, or may be offered in settings where families and parents naturally gather, such as schools or even their own homes. Finally, families may use available services for a short time period or for several years, depending on their own situation.

There are a number of services that family support programs offer. Here are some examples:

- parent education classes focusing on child development and traditional parenting concepts and techniques
- life skills training that may include employment and vocational training, or personal development skills such as problem-solving, stress reduction, and communication
- support groups that provide opportunities for parents to share their experiences and concerns with peers
- preventive health care that may include education in health and nutrition for parents, and developmental checks or health screening for infants and children
- parent-child groups and family activities that promote healthy family relationships
- a drop-in centre that offers unstructured time for families to be with other families and program staff, time away from challenging home responsibilities, and a network for finding playmates, referral sources, or parenting information
- educational day care or preschool for infants and toddlers
- information and referral service to other services in the community
- practical assistance such as clothing exchanges, emergency food, and transportation
- advocacy for individual families or for all families within the community
- critical support for parents when a youth is in trouble but is refusing treatment or help

Why should we provide family support programs?

Aboriginal families are facing many challenges

In Aboriginal society, the family unit has always been regarded as the main institution of the community where networks of parents, grand-parents and other community members provided a safe place for children to find comfort and identity. Today, however, many would agree that the Aboriginal family is under threat mainly as a result of the residential school system and other oppressive forces that were imposed on Aboriginal people. Other significant issues facing today's Aboriginal families include single parenthood (single parents are found twice as often among Aboriginal people), high rates of teenage pregnancies, family violence, sexual abuse, as well as drug and alcohol abuse. The institution that once protected children is now one that poses a potential risk for suicide.

There is a link between family distress and risk for suicide

With few exceptions, unhealthy families cannot support the healthy development of young people. Youth who grow up in homes where emotional and physical nurturance is lacking, where parental care is inconsistent and where marital relationships are strained, are often at greater risk for a range of social problems, including suicide. Mental health problems suffered by family members can also heighten the risk. The result of ineffective parenting is young people who suffer from low self-esteem, poor attachments skills, and the unwillingness or inability to trust.

Suicide is also associated with a history of childhood physical and sexual abuse and with a family history of violence or assault, imprisonment, and harmful use of alcohol or other drugs. More specifically, it is estimated that young people who had been physically abused in childhood were almost 5 times more likely to attempt suicide than other young people who were not abused and 9 times more likely if the abuse was both physical and sexual. Growing up in an abusive or alcoholic family leads to the internalization of anger and conflict, marked difficulties in expressing feelings, and a lack of effective interpersonal skills.

There is a need to reconnect children with their parents and improve parenting skills

In many Aboriginal families, the ability to parent effectively must be re-established or else the negative legacy will be passed on to the next generation. This begins by supporting and helping parents who are themselves in tremendous pain and may have little to give to their children, and it continues by taking steps to break the cycle of abuse and violence. Clear and consistent parenting expectations that blend traditional values and problem-solving approaches with contemporary community realities are also needed in order to encourage the development of appropriate family bonds. The need to improve parenting skills is especially relevant for that generation of adults who missed learning these lessons naturally at home because they were sent away to residential schools.

Family support programs can help meet some of these goals

By working with the extended family unit, family support programs aim at reducing these risk factors, while enhancing important protective factors such as warm and caring parent-child relationships and the modelling of healthy adjustment by parents and other adult caretakers. Whether focusing on parents themselves or on the parent-child relationship, family support programs work to heal and strengthen the family unit in order to create a healthy environment for children to live in. Family support programs represent a timely approach to suicide prevention since 40-60% of the population living on reserves is below the age of 21 years old and Aboriginal Canadians represent one of the fastest growing segments in this country.

How do we know family support holds promise?

Family support programs have shown positive results in the general population
Evaluations of existing family programs have found a number of positive effects on children, parents, parent-child relationships, as well as family functioning. This mounting evidence suggests that family support programs can be effective in influencing the development of children as well as the familiar environments they live in. Having said that, it is important to note that the impact of any program will depend, of course, on the types of services it provides.

For example, programs specifically aimed at enhancing the healthy development of children have found positive cognitive outcomes, increased social competence, and reduced delinquent behaviour in later years. Programs with a strong focus on parental education and support have found positive parental outcomes including enhanced self-esteem and coping, greater sense of control and competence, and enhanced problem-solving. These programs have also observed better care giving behaviours and better communication from parent to child. Finally, a number of intensive and long-term family support programs have even reported a significant impact on family demographic variables such as quality of housing, educational advancement, and economic self-sufficiency.

Experts recommend family support programs as a strategy to prevent suicide
In the context of suicide prevention, many have called for increased primary prevention efforts that focus on improving parental capabilities and practices, strengthening family support networks, and improving the stability and continuity of children's relationships. These goals are embodied in the family support movement and research findings suggest that these programs are indeed capable of promoting these protective factors. So although family support programs have not been explicitly evaluated in terms of their effectiveness on the prevention of youth suicide, the evidence is compelling enough for experts to recommend this approach as a potentially effective prevention strategy.

Setting up for success

To maximize the success of a family support program, you should consider the following steps:

1. **Learn more about how to develop and operate a family support program**
   As a first step, you should familiarize yourself with the issues involved in planning, implementing, and operating a successful family support program. To this end, we invite you to consult *A place to start* which highlights a number of publications dealing with the "how to" of family support programs. It is also a good idea to read about or visit actual family support programs as you prepare to develop your own (see *In our own backyard*).

2. **Learn more about your own community**
   As mentioned before, family support programs typically structure their services according to the needs and priorities of the communities they serve. Assessing a community's needs and resources is therefore an essential component of program

planning. Begin by researching the characteristics of the population in your community. Then, map out the resources and services that are already serving families in one way or another within your community. This exercise should allow you and your group to find out about any gaps in service delivery.

3. **Involve families**
   The heart of family support programs is the recognition that families can identify their own needs, design solutions to address these needs, and mobilize resources. Recognize the special role that extended family members – aunts, uncles, cousins, and in-laws – play in promoting the health and well-being of Aboriginal children and youth and make sure to consider them in your planning. Programs utilizing families in planning and development are typically richer and have services that encompass the diverse populations they serve.

4. **Recognize that setting up a successful program may take time**
   The program implementation literature indicates that new family support programs require significant amounts of time to reach a stable level of operation, generally from one to three years.

How will we know if we're making a difference?

You will know that your family support program is making a difference if you can answer yes to questions listed in the table below under the headings *short-term*, *medium-term*, and *long-term indicators*. Please note that in order to detect changes over time we typically need to make a long-term commitment to the overall evaluation process. In other words, measuring success is not something you do at a single point in time and then forget about. The timelines that are included below are only guidelines, but they should give you a good sense about the need to measure the impact of our interventions at several points in time following the initial implementation of the strategy.

Short-term indicators: Short-term indicators are changes that the strategy itself is designed to produce and are usually measured right after, or up to two months following, the implementation of a program. Depending on the type of program being developed, short-term indicators can be measured using quantitative methods (e.g. pre-and-post tests measuring changes in skills or knowledge) or qualitative methods (e.g. interviews or focus groups designed to assess attitudes, opinions, and satisfaction).

Medium-term indicators: Medium-term indicators of success capture changes that you might expect further down the road and are usually measured three to six months after the implementation of a program. Medium-term indicators can be measured using methods such as surveys, questionnaires, interviews, or observations that look at changes in well-being, attitudes, or behaviours in young people or other groups/social environments targeted by the program.

Long-term indicators: Long-term indicators of success measure the ultimate goal of a program (usually a reduction in suicide and suicidal behaviours among youth) and are usually measured on an annual basis, starting two to five years following the implementation of a program.

Keep in mind that the indicators listed in the table below represent examples only and we invite you and your group to develop indicators that are in line with the specific goals and activities of your family support program. Identifying relevant indicators of success for your own program (and the methods by which these will be measured or monitored) represents one of the most important steps of your overall evaluation plan (see the section *Evaluate your community-wide suicide prevention efforts* in chapter 5).

Methods to evaluate

	Ask a Key Evaluation Question	Measure the Success
SHORT TERM*	Are participants in the program satisfied with the services received?	➢ measure satisfaction with the various components of the program
	Are participating parents showing improvements in the following areas (depending on the type of family program)?	
	a) knowledge related to parenting options and strategies, and child development	➢ measure knowledge (e.g. effective discipline techniques, normal and abnormal child behaviour) before and after participation in the program and compare results to determine whether the program has made a difference
	b) life skills	➢ measure skills (e.g. problem-solving, communication, anger management) before and after participation in the program and compare results to determine whether the program has made a difference
	c) use of social support	➢ measure perceived social support (e.g. from family member and group members) before and after participation in the program and compare results to determine whether the program has made a difference
	d) willingness to seek help	➢ measure help-seeking patterns before and after participation in the program and compare results to determine whether the program has made a difference
MEDIUM TERM**	Are the children and youth of participating families being referred appropriately for professional help as needed?	➢ measure number of youth being referred as a result of the program ➢ measure the appropriateness of these referrals
	Are parents appropriately being referred to professional help when needed?	➢ measure number of parents being referred as a result of the program ➢ measure the appropriateness of these referrals

**** Short-term** (measured immediately to 2 months following program implementation)*
***** Medium-term** (measured 3 to 6 months following program implementation)*

Methods to evaluate

	Ask a Key Evaluation Question	Measure the Success
MEDIUM TERM**	Are participating parents showing improvements in emotional well-being?	➢ measure depression, self-esteem, stress level, and marital satisfaction in parents
	Are the children of participating families showing improvement in emotional well-being?	➢ measure healthy adaptation among youth (e.g. school performance, peer relationships), depression, self-esteem, and stress
	Is the quality of parent-child interactions showing improvement?	➢ measure parent-child interactions (e.g. observations, self-report) and family functioning (e.g. adaptability, cohesion)
LONG TERM***	Are suicide and suicidal behaviours among youth decreasing?	➢ measure the number of deaths by suicide and attempted suicides in the community and compare to previous statistics

***** Medium-term** (measured 3 to 6 months following program implementation)*
****** Long-term** (measured 2 to 5 years following program implementation)*

Big Cove Family Workshop

Location: Child and Family Services
Big Cove Indian Band
P.O. Box 1078
Rexton, NB
E4W 5N6
Telephone: (506) 523-8224
Fax: (506) 523-8226

Contact person: Evangeline Francis, Family Wellness Coordinator

Program description: In the late 1980's, the community of Big Cove, New Brunswick, was experiencing high numbers of youth suicide. Concerned Child and Family Services staff started looking for innovative and proactive ways to address this problem. Support of families was identified as an important goal and staff began searching for a family program to implement. After reviewing a few different programs, the group settled on a program called Parents and Problems Parenting Program, which was developed in the United States by Fred Streit. Although the curriculum is not Aboriginal-specific, it was to be presented in the local language.

The goals of the program are to enable parents to better understand their own behaviour towards each other and their adolescent(s), how adolescents perceive the behaviour of their parents, and what makes adolescents behave as they do. In this way, the program aims to prevent mental health problems, drug and alcohol abuse, and criminal activity among adolescents. A total of seven topics are covered:

- Through the Eyes of Youth
- Do Adults Understand Me?
- Do my Parents Love Me?
- But They're My Friends
- Adolescent Sexuality
- Why Can't I Do It My Way?
- I Don't Have Two Parents (for single parents)

Participants in the program (both parents and adolescents) meet weekly for three hours to discuss one of the program topics. A maximum of three or four families take part in the training at a time (for a total of 9-14 participants). Sessions begin with a discussion of the materials covered the previous week, a review of the new session materials, and continue with a group discussion and exercises. Reading materials for the next topic (at the junior high school level) are distributed to the families who can then prepare for the next session.

The community hired a psychologist who was familiar with the Parents and Problems Parenting Program to train approximately 20 community members (social workers, teachers, and other health care workers) in the delivery of the program. Following the training, which took place in Big Cove, the participants began to deliver the curriculum to local parents in workshops. The trained community members were also asked to reach out to their own extended family and friends by using the program materials.

Over the years, the number of trained community members who were willing to facilitate workshops began to drop and the workshop has not been offered in the last few years. The community recently hired a psychologist and a Parenting Committee has been formed. One of the goals of the Parenting Committee is to revive the Parents and Problems Parenting Program and perhaps implement other initiatives in an effort to support parents. Harry Sock, Director of Child and Family Services would like to see workshops like the Parents and Problems Parenting Program being offered throughout the year.

Target groups: The target groups of the Parents and Problems Parenting Program workshop include parents and their teenagers.

Partners involved: Child and Family Services

Years in operation: Began implementation in early 1990's.

Program costs: The main costs include the fee of the psychologist who trained the community members and the costs to copy the materials.

Resources: Financial resources come from the Family Wellness budget.

Evaluation findings: The program was never formally evaluated. Satisfaction questionnaires were completed by participants at the end of workshops.

Advice to others interested in starting this type of program: Harry Sock, Director of Child and Family Services mentions that a family support curriculum should be presented by trained community members.

Available reports and materials: The following Parents and Problems Parenting Program materials are available from the Big Cove Child and Family Services office for a small cost (to cover printing costs):

- Leader's manual
- Seven Parents and Problems pamphlets (for each topic)

A Place to Start

Programs

Kise Wa To Ta To Win Aboriginal Parenting Program

The Kise Wa To Ta To Win Parenting Workshop outlines the principles of traditional parenting methods and offers discussions on how to apply these guiding principles in contemporary society. The goal of this program is to enhance parenting skills, which strengthens family units and the community. Parenting workshops lead to discussions regarding the impact of Residential Schools and the devastating effect this legacy has on First Nations people. The workshop is always conducted with the guidance of Elders. The manual used during the workshop was developed from an Aboriginal perspective in 1993 and is available from the Aboriginal Parenting Program. This program is suitable for individuals with limited educational background.

The Aboriginal Parenting Program also offers Facilitator Workshops geared toward teaching participants how to run Parenting Workshops. The Facilitator Workshop runs for 5 days and is guided by the Kise Wa To Ta To Win handbooks and manuals.

For more information on the Parenting Workshop or the Facilitator Workshop, contact:
Aboriginal Parenting Program
#216, 335 Packham Avenue
Saskatoon, Saskatchewan
S7N 4S1
Telephone: (306) 665-3337
Fax: (306) 665-3299
E-mail: aboriginalparenting@shaw.ca

Kishawehotesewin: A Native Parenting Approach

This seven-session program targets First Nations parents and expecting parents and conforms to the seven traditional teachings. The sessions can be presented weekly or as a three-day workshop. Activities include sharing in a circle, readings, videos, role playing, discussion and assignments. The program assists and supports parents in identifying and realizing their goals, helps them listen to their children, encourages them to share their knowledge about First Nations traditions, provides general information on resources, allows parents to reappraise their parenting styles and situations, and provides culturally relevant materials. Resources required are a trained facilitator. The materials have been presented in First Nations languages with the use of a translator. The manual can be obtained from the Canadian Public Health Association.

To order manual (order number: 3-1BK01011), contact:
Canadian Public Health Association
Health Resources Centre
1565 Carling Avenue, Suite 400
Ottawa, Ontario
K1Z 8R1
Telephone: (613) 725-3769 (ask for the Health Resources Centre)
Fax: (613) 725-9826
E-mail: hrc@cpha.ca
Web site: www.cpha.ca/english/hrc/hrc.htm

Nobody's Perfect

Nobody's Perfect is a parenting education and support program for parents of children from birth to age five. It is designed to meet the needs of parents who are young, single, socially or geographically isolated, or who have low income or limited formal education. However, the program is not intended for families in crisis or those with serious problems. Participation is voluntary and free of charge.

Nobody's Perfect is offered as a series of 6 to 8 weekly group sessions. The program is built around 5 colourful, easy-to-read books which are given to the parents free of charge. The books address the body (health and illness), safety, mind (child development), behaviour, and needs of parents. During the meetings, trained facilitators support participants as they work together to discover positive ways of parenting. The program is offered in a broad range of settings in every Canadian province and territory. Although the program was developed for the general population, it has been used extensively with Aboriginal families. Across Canada, over 5,000 community workers, parents and public health nurses have been trained as Nobody's Perfect facilitators.

To obtain further information regarding the Nobody's Perfect or to find your provincial coordinator, contact:
Canadian Association of Family Resource Programs
National Office
707-331 Cooper Street,
Ottawa, ON
K2P 0G5
Telephone: (613) 237-7667
Fax: (613) 237-8515
E-mail: np-yapp@frp.ca
Web site: www.frp.ca

Workshops

The family: Going at it together

In order to move as families toward wellness, we need to know what a healthy family is like and more specifically, what our family would be like if it were truly healthy. Then we need to know exactly what our strengths and weaknesses are (mental, emotional, physical, spiritual) as families. Finally we need a plan for how to become healthier, and a process of learning to get us there.

This four day workshop is for families (grandparents, parents and children – or any combination that you consider "family") who want to take the wellness journey together. This workshop is limited to six to eight families per session (about 40 people) including children. Four Worlds trainers will travel to interested communities to deliver this workshop.

Working together with other families through a program of workshop and recreational challenge activities, families will:

- develop a working vision of what their family would be like if it were truly healthy
- complete a process of assessment to determine the actual levels of wellness of your family in all key wellness areas
- learn new skills, models, strategies and tools for growth
- develop new, healthier patterns of interaction between family members
- begin to address key healing issues
- make a one-year plan for continuing family development after the workshop that includes continued learning, family activities and outside support for continued development in all key wellness areas.

For more information, contact:
Four Worlds International Institute for Human and Community Development
347 Fairmont Boulevard
Lethbridge, Alberta
T1K 7J8
Telephone: (403) 320-7144
Fax: (403) 329-8383
E-mail: 4worlds@uleth.ca
Web Site: www.uleth.ca/~4worlds

Leading The Way To Becoming A Better Parent

This workshop was developed and is being offered by Dave Jones, an Ojibway of the Garden River First Nation through his company, *Turtle Concepts: Options for People*, located in Garden River, Ontario. The sessions focus on the need to understand the level of maturity and the level of development that children are at throughout their lives. Importance is stressed on how each child may follow the example that may have been set as "normal" behaviour. This normal behaviour then becomes acceptable and a routine is developed until new behaviour is introduced. The workshop focuses on three critical

areas: positive communication, setting positive boundaries and establishing positive routines. Each area is examined in detail, clarified, and applied to everyday situations. Role playing and activity-based learning are applied throughout the workshop. Discussion is promoted amongst participants to share their experiences, both positive and negative, and solutions are suggested.

For more information, contact:
Turtle Concepts: Options for People
580B, Highway 17 East
Garden River First Nation, ON
P6A 6Z1
Telephone: (705) 945-6455 or 1-877-551-5584
Local: Fax: (705) 945-7798
E-mail: info@turtleconcepts.com
Web site: www.turtleconcepts.com

Resource

Parenting Today's Teens: A Survey and Review of Resources (1999). This resource is published by Health Canada. The document is designed to help professionals who work with parents of teens or parents themselves to identity and locate resources specifically designed to help families at this stage of parenting. You can view the document (in pdf) at www.hc-sc.gc.ca/dca-dea/publications/pdf/teens_e.pdf . To order a copy, contact:

Publications
Health Canada
Postal locator 0900C2
Ottawa, Ontario
K1A 0K9
Telephone: (613) 954-5995
Fax: (613) 941-5366

Organizations

Canadian Association of Family Resource Programs
This organization promotes the well-being of families by providing national leadership, consultation and resources to those who care for children and support families. The organization assists new and existing family resource programs by providing up-to-date information and resource materials, making available regional lists or existing family resource programs and related services, and organizing workshops and conferences. A number of useful publications can be ordered online through the organization's web site. For example, the document *Caring About Families: the "How To" Manual for Developing Canadian Family Resource Programs* contains all the information you need to develop a family resource program in your community.

For more information, contact:
Canadian Association of Family Resource Programs
707 - 331 Cooper Street
Ottawa ON
K2P 0G5
Telephone: (613) 237-7667 or (613) 728-3307
Fax: (613) 237-8515
E-mail: info@frp.ca
Web site: www.frp.ca

Suggested reading

Adams, D.M., Overholser, J.C., & Lehnert, K.L. (1994). Perceived family functioning and adolescent suicidal behavior. *Journal of the American Academy of Child & Adolescent Psychiatry*, 33(4), 498-507.

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Youth/Family Strategies

Support Groups for Youth

What are support groups for youth?

This strategy brings together vulnerable youth in a caring and comfortable group environment where they receive the support of peers and practice valuable life skills. Support groups serve the purpose of counteracting a number of early risk factors experienced by vulnerable youngsters, while enhancing important protective factors.

It is important to note that these programs should not be confused with those that are more clinical in nature. Psychotherapy groups and the provision of services to young psychiatric patients-while often key components in the prevention of youth suicide-are more appropriately classified as "treatment" efforts and these types of clinical strategies are not included in this manual.

Goals

The goals of support groups for youth are to:

- extend the social support available to at-risk youth both within and outside of the group
- assist youth to develop decision-making, interpersonal, and coping skills
- provide opportunities for youth to develop personal skills to reduce the negative impact of various suicide risk factors such as unresolved and accumulated losses, anger and alienation, impulsive behaviour, and substance misuse

Target population

The target population for this strategy is youth who may be at early risk for suicide based on a variety of potential risk factors and conditions including depression, recent or recurrent loss, prior suicidal ideation, alcohol and drug use, and exposure to a suicide of a friend or family member. Low risk youngsters can be referred by parents/guardians, teachers, community members, mental health professionals, or themselves. This strategy is not recommended for high risk youth who are more appropriately assisted by on-going treatment and/or crisis intervention services.

Brief description

Support groups can be conducted in a variety of settings common to at-risk youth including schools, community centres, youth centres, young offender centres, shelters for homeless/runaway youth, and organizations serving gay and lesbian youth.

Typically, the groups are small (10-15 individuals) and meet on a regular basis over a relatively short period of time ranging from six weeks to six months. Group leaders include counsellors, teachers, nurses, social workers, or other health professionals. Youth who have "graduated" from a support group can work alongside the group

facilitator, serving as peer leaders of future on-going groups. Support groups for youth typically incorporate two key program components:

1. **Social support.** This component is designed to provide group participants with a greater and improved social support network consisting of peers, supportive and caring adults, and family members. The group environment provides youngsters with an opportunity to share their feelings and experiences in an atmosphere of trust and friendship.

2. **Skill-building.** This component is designed to enhance personal resources in the form of life skills which may include decision-making, personal control, coping, and communication. In many cases, participating youth will also acquire the knowledge and skills to seek help and access the physical and mental health systems. The life skills component can be made more relevant by providing participants with the opportunity to apply the skills to current problems and concerns being experienced by the group members.

Why should we provide support groups for youth?

Young people at-risk for suicide tend to exhibit a number of risk factors, including depression, hopelessness, unresolved losses, alcohol and other drug use, family distress, and other stresses related to school. In addition, lack of coping skills (e.g. problem solving) or maladaptive coping strategies (e.g. withdrawal) are also considered major risk factors. On the other hand, certain factors such as positive self-esteem, a sense of personal control, peer and family support, and school bonding are known to protect children and adolescents against suicidal tendencies.

By enhancing personal resources, increasing social support networks, and decreasing maladaptive behaviours, this strategy aims at reducing the negative impact of a number of risk factors for suicide, while bolstering important protective factors.

How do we know support groups for youth hold promise?

Promising results have been noted

Evaluation of skilled-based support groups has demonstrated very promising results. Participants in these programs have consistently shown improvements in emotional well-being. More specifically, youngsters show a decrease in depression, hopelessness, stress, anger, and an increase in self-esteem and personal control. These gains have also been shown to be maintained or to increase over time.

This type of strategy has also been successful in the prevention of other adolescent problems such as drug abuse, delinquency, school failure, and school dropout. Among adolescents, these high-risk behaviours (including suicidal behaviours) are often interrelated. The success of support groups in reducing the risks for other maladaptive behaviours adds to the evidence that this strategy holds very promising potential in reducing risks for youth suicide.

Experts recommend this strategy

The available evidence has prompted a number of suicide prevention experts and organizations such as the U.S. Centers for Disease Control & Prevention (CDC) to recommend the implementation of this strategy for the prevention of suicide among at-risk youth.

Setting up for success

There are three steps that should be addressed in setting up a support group for youth.

1. **Decide how you will organize and structure your support group program**
   When planning a support group for youth, you may decide to design your own program or implement a tested curriculum that is available for purchase. If you opt to develop your own program, it may be useful to consult with existing support programs (even if designed for adults) to see how they are structured and what makes them successful. We also invite you to consult *In our own backyard* for a description of one such program. Finally, remember that community mental health workers can be of great assistance in the development phase of a support group for youth.

   On the other hand, there are a number of tested curricula that you can purchase and implement to fit your own needs. One support group curriculum that has proven to be very effective is highlighted in *A place to start*. Above all, remember that a support group should address, as much as possible, a number of suicide risk and protective factors.

2. **Involve the family or guardians of high-risk youth**
   Families of participating youth should be well informed about the purpose and content of a support group. It is also recommended that a component designed to strengthen family support be incorporated into all support group programs. Family members or guardians should be engaged as "partners" from the onset so that they may understand the process, be prepared for any interim negative impact on family life, contribute where appropriate, and reinforce and reward the youth's participation and successes. If handled delicately, involving families may also provide an opportunity to address certain risk factors in the family such as alcoholism and lack of family support.

3. **Ensure that high-risk youth do not feel "labeled" because of their participation**
   Efforts must be made to ensure that youngsters do not feel negatively "labeled" because of their participation in support group programs. This may be especially relevant when the support groups are organized within a school setting where it may be easy for the general student population to find out who is attending. For example, you may consider giving the group a non-stigmatizing or fun name that reflects its primary focus on well-being and health promotion.

How will we know if we're making a difference?

You will know that your support group for youth is making a difference if you can answer yes to questions listed in the table below under the headings *short-term, medium-term*, and *long-term indicators*. Please note that in order to detect changes over time we typically need to make a long-term commitment to the overall evaluation process. In other words, measuring success is not something you do at a single point in time and then forget about. The timelines that are included below are only guidelines, but they should give you a good sense about the need to measure the impact of our interventions at several points in time following the initial implementation of the strategy.

Short-term indicators: Short-term indicators are changes that the strategy itself is designed to produce and are usually measured right after, or up to two months following, the implementation of a program. Depending on the type of program being developed, short-term indicators can be measured using quantitative methods (e.g. pre-and-post tests measuring changes in skills or knowledge) or qualitative methods (e.g. interviews or focus groups designed to assess attitudes, opinions, and satisfaction).

Medium-term indicators: Medium-term indicators of success capture changes that you might expect further down the road and are usually measured three to six months after the implementation of a program. Medium-term indicators can be measured using methods such as surveys, questionnaires, interviews, or observations that look at changes in well-being, attitudes, or behaviours in young people or other groups/social environments targeted by the program.

Long-term indicators: Long-term indicators of success measure the ultimate goal of a program (usually a reduction in suicide and suicidal behaviours among youth) and are usually measured on an annual basis, starting two to five years following the implementation of a program.

Keep in mind that the indicators listed in the table below represent examples only and we invite you and your group to develop indicators that are in line with the specific goals and activities of your own support group for youth. Identifying relevant indicators of success for your own program (and the methods by which these will be measured or monitored) represents one of the most important steps of your overall evaluation plan (see the section *Evaluate your community-wide suicide prevention efforts* in chapter 5).

Methods to evaluate

	Ask a Key Evaluation Question	Measure the Success
SHORT TERM*	Are youth satisfied with the program?	➢ measure participant feed-back regarding the support group, their satisfaction with the materials presented, and the teaching methods used
	Are participating youth demonstrating that they are capitalizing on available support?	➢ observe peer interactions before and after participation in the program and compare ➢ measure perceived social support from friends, family members, and other adults before and after participation in the program and compare
	Are participating youth showing increased use of personal resources?	➢ measure skills for managing mood, stress, and anger before and after the implementation of the program and compare results to determine whether the program has made a difference ➢ measure life skills competencies (e.g. skills in decision-making, personal control, communication, coping) before and after participation in the program and compare results to determine whether the program has made a difference
MEDIUM TERM**	Are participants showing improvement in the following areas?	
	a) emotional well-being	➢ measure depression, self-esteem, stress and suicide ideation
	b) school performance	➢ measure attendance, academic performance, and antisocial behaviour
	c) reduced alcohol and drug abuse	➢ measure alcohol and drug use
LONG TERM***	Are suicide and suicidal behaviours among youth decreasing?	➢ measure the number of deaths by suicide and attempted suicides in the community and compare to previous statistics

**** Short-term** (measured immediately to 2 months following program implementation)*
***** Medium-term** (measured 3 to 6 months following program implementation)*
****** Long-term** (measured 2 to 5 years following program implementation)*

A Place to Start

Programs

The Breakfast Club

The Breakfast Club, which began in 1992, is part of the Suicide Prevention Resource Centre of Grande Prairie, Alberta. It is a support program for adolescents 12 to 17 years of age who are having trouble coping with problems in their lives. This includes teens that are depressed, involved in drugs or alcohol, having suicidal thoughts or behaviours, at risk for criminal behaviour, or making poor decisions. The goals are for adolescents to identify and express their feelings, understand their personal circumstances, develop coping skills, improve communication with others, and make healthier choices.

The program includes an initial interview, a weekend group retreat, a four to six week follow-up support group, monthly recreation support meetings, and individual support with the Program Coordinator. The support group that meets once a week (for four to six weeks) concludes with a Parent Appreciation Night for parents and guardians. The adolescent is also involved in individual testing and assessment by qualified facilitators and the Program Coordinator. Referrals can be made by anyone in the community: school counsellors, teachers, principals, community agencies, physicians, pastors, parents, concerned friends and family members or adolescents themselves.

The Program Coordinator reports that local Aboriginal youth often participate in the Breakfast Club program. There are usually two or more Aboriginal young people involved in each retreat and follow-up support group, so every effort is made to ensure that at least one of the facilitators is of Aboriginal background. In addition, Aboriginal activities are often integrated in the retreat and follow-up support group.

For more information, contact:
The Breakfast Club
202, 10118-101 Avenue
Grande Prairie, Alberta
T8V 0Y2
Telephone: (780) 539-7142
Fax: (780) 539-6574
E-mail: cispp@telusplanet.net
Web site: www.telusplanet.net/public/cispp

Youth Net

Youth Net/Réseau Ado is a bilingual, community based, youth mental health promotion and early intervention program run by youth for youth. The core program has been operating since 1994 throughout Eastern Ontario and Western Quebec. Based on the

success of the program, the Youth Net Satellite program has recently been set up to facilitate the expansion of this program to other communities across Canada.

The main goal of Youth Net is to provide a forum for young people to express, explore and discuss their views and concerns about mental health. The program works to develop strategies for making current mental health services more youth-friendly and empowering and to help youth develop connections with a safety net of youth-friendly professionals. The program focuses on two main activities:

- **Focus groups**
  Youth Net holds focus groups (90 minutes long), which are run by two older youth facilitators (aged 20 to 30), and involve 8-12 youth who are between the ages of 13 and 20. Through these focus groups, youth can discuss the mental health issues they are facing, their views about the mental health system, and how the system could better meet their needs. Youth are reached in schools, community centres, treatment centres, detention centres, drop-ins, and any place where youth are found in rural and urban areas. Although this program was developed to meet the needs of the general youth population, focus groups have also been held with Aboriginal youth at the Odawa Native Friendship Centre in Ottawa. In addition, the Youth Net satellite program located in the Owen Sound area (a few hours from Toronto) has trained an Aboriginal youth facilitator and plans to hold focus groups on the Saugeen Reserve in the near future.

- **Therapeutic support groups**
  Youth Net also provides longer-term therapeutic support groups for youth having difficulties. These groups were initiated as a result of youth expressing a need for more practical supports delivered through a continuing group format where they could explore and discuss their life issues and problem-solve together to find solutions. Support groups are led by young graduate students and/or experienced Youth Net facilitators, who are supervised by a clinical psychologist and a child psychiatrist. Two distinct models have been implemented:

  The **"depression model group"** targets those youth with significant depressive symptomatology and include individual pre and post-assessments. This group runs for 12 weeks and addresses a variety of issues related to depression and suicide.

  The **"support group model"** is more general in focus and participants discuss problematic life issues in a supportive environment. The length of this support group varies depending on the needs of the youth.

For more information on setting up a Youth Net program, contact:
Lynn Chiarelli
Youth Net Satellite Coordinator
Children's Hospital of Eastern Ontario
401 Smyth Road
Ottawa, Ontario
K1H 8L1
Telephone: (613) 738-3239
E-mail: chiarelli@cheo.on.ca
Web site: www.youthnet.on.ca

Resources

Reconnecting Youth: A Peer Group Approach to Building Life Skills

Reconnecting Youth (written by Leona Eggert, Liela Nicholas, and Linda Owen) is a step-by-step leader's guide designed for use by a facilitator in a small group setting, with high-risk students from grades 7-12. The curriculum is based on the integration of two key components: social support and life-skills training. Four life skills areas are emphasized: self-esteem, decision-making, personal control, and interpersonal communication. The guide contains 80 lessons that can be presented in sequence, selectively, or integrated into other curricula. Each lesson contains key concepts, learning objectives, preparations, materials, activities, reproducible handouts, overheads, and step-by-step suggestions for presentation.

This curriculum has proved effective in helping high-risk youth achieve in school, manage their anger, and decrease drug use, depression, and suicide risk. The program was piloted for five years with over 600 public high school students in Seattle, WA and has since been successful in alternative schools, private schools, and many other educational settings.

To order this curriculum (quoting item number: BKF00034), contact:
National Educational Service
304 West Kirkwood Avenue, suite 2
Bloomington, IN
47404
USA
Telephone: (812) 336-7700 or 1-800-733-6786
Fax: (812) 336-7790
E-mail: nes@nesonline.com
Web site: www.nesonline.com

Youth helping youth: A guide to starting a self-help group
This 30-page guide was created specifically to meet the needs of youth who want to start their own self-help group. As such, the guide was written with input from youth who participated in a focus group. Following a description of self-help and the benefits of self-help groups for youth, the guide describes the necessary steps in setting up such a group. Here are some of the topics that are explored in the guide: Where to start; Building your team; How a meeting might go; Ground rules; Space; Avoiding burn-out; Money; and Forming an organization. The guide can be purchased from the Self-Help Connection for a small cost.

The Self-Help Connection also produces the Starter's Kit: Tips for starting a self-help group. This 6-page document provides a number of tips for starting a self-help group but is not specific to youth.

For more information on either of these resources, contact:
Self-Help Connection
63 King Street
Dartmouth, NS
B2Y 2R7
Telephone: (902) 466-2011
Fax : (902) 466-3300
E-mail: selfhelp@att.ca

Suggested reading

Centers for Disease Control and Prevention (1992). *Youth suicide prevention programs: A resource guide*. Atlanta: U.S. Department of Health and Human Services.

Eggert, L.L. & Thompson, E.A. (1994). Preventing adolescent drug abuse and high school dropout through an intensive school-based social network development program. *American Journal of Health Promotion*, 8(3), 202-215.

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Morano, C.D., Cisler, R.A., & Lemerond, J. (1993). Risk factors for adolescent suicidal behavior: Loss, insufficient familial support, and hopelessness. *Adolescence*, 28(112), 851-865.

Orbach, I. & Bar-Joseph, H. (1993). The impact of a suicide prevention program for adolescents on suicidal tendencies: Hopelessness, ego identity, and coping. *Suicide and Life-Threatening Behavior*, 23(2), 120-129.

Thompson, E.A., Horn, M., Herting, J.R., & Eggert, L.L. (1997). Enhancing outcomes in an indicated drug prevention program for high-risk youth. *Journal of Drug Education*, 27(1), 19-41.

Washington State Department of Health (1995). *Youth suicide prevention plan for Washington state*. Olympia, WA: Washington State Department of Health.

Wassef, A., Mason, G., Collins, M., O'Boyle, M., & Ingham, D. (1996). In search of effective programs to address students' emotional distress and behavioral problems. Part III: Student assessment of school-based support groups. *Adolescence*, 31(121), 1-16.

White, J. & Jodoin, N. (1998). *Before the fact interventions: A manual of best practices in youth suicide prevention*. Vancouver, BC: Suicide Prevention Information & Resource Centre of British Columbia, Co-operative University-Provincial Psychiatric Liaison (CUPPL), University of British Columbia.

Chapter 5: A Community-Wide Approach to Suicide Prevention

A comprehensive, community-wide approach to youth suicide prevention that recognizes the complexity of the problem and capitalizes on the skills and talents of a broad range of community partners, professional disciplines, organizations, and government departments, has the greatest likelihood for success.

While each community is unique and each will be at a different stage of organizational readiness for developing a community-wide approach to suicide prevention, there are some key broad level considerations that can guide program development and community organization in this area.

The step-by-step guidelines presented in this chapter are designed to assist communities in the development or enhancement of a community-wide approach to youth suicide prevention, reflecting a coordinated approach to implementing the 17 promising strategies. The seven guidelines are as follows:

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

Remember our focus

on "before-the-fact" suicide risk prevention

It is important to be reminded that the promising strategies that have been included in this manual are all "before-the-fact" in nature (see chapter 3). As such, this chapter on community-wide organization does not specifically refer to any clinical or treatment strategies designed to be implemented with individuals at clear risk for suicide, even though these are obviously essential components in any comprehensive youth suicide prevention effort. Suffice it to say that individual assessment, treatment, and other clinically-based efforts take place in a range of settings including mental health centres, hospitals, treatment facilities, and private practitioners' offices, and the planning and delivery of these services should obviously be well-linked to the "before-the-fact" promising strategies.

1. Check out your community's assets

What is your community's current status with respect to the articulation, development, and implementation of a community-wide plan for suicide prevention? This could range from having no current plans or strategies in place to the presence of a well-established, highly organized community-wide approach to suicide prevention. Most communities fall somewhere in between these two extremes.

The following checklist can serve as a reference point for assessing your community's current status in the development of a community-wide suicide prevention effort, based on the 17 promising strategies. Please indicate below the key elements of your community's current suicide risk prevention effort (check all that apply):

Community renewal efforts

- cultural enhancement
- traditional healing practices
- community development
- interagency communication and coordination

Community education efforts

- peer helping
- youth leadership
- community gatekeeper training

- public communication and reporting guidelines
- means restriction

School Efforts

- school gatekeeper training
- school policy
- school climate improvement

Youth/Family Efforts

- self-esteem building
- life skills training
- suicide awareness education
- family support
- support groups for youth

2. Capitalize on the expertise of a range of community partners

What community partners, organizations, and agencies are committed to participating in your community-wide suicide prevention effort?

a) Generate a list that reflects the current situation

These may include the agency and individual representatives who are currently participating in a suicide prevention effort, but could also include those professionals working within the community who have a specific mandate for responding to at-risk individuals.

b) Who is missing?

Use the list below to identify key groups/representatives with which you would like further involvement.

- tribal administrators
- council members
- mental health professionals
- child, youth and family serving agencies
- schools
- youth
- parents
- survivors (family members or friends who have lost a loved one to suicide)
- emergency personnel
- police/RCMP
- spiritual leaders
- clergy
- physicians
- crisis/distress centres
- hospitals/health centres

- public health
- media
- policy makers/government
- volunteer associations
- other (specify)_____

3. Gather pertinent information

a) What does the available information reveal about the needs of your community?

Gathering information about the specifics of your community will help you tailor your community suicide prevention initiative. The kind of information that is useful includes: demographics of the community, health status, as well as suicide statistics (deaths by suicide and attempts by age group). Remember that death by suicide is a relatively rare occurrence within a particular community, so do not rely exclusively on mortality data to guide your planning efforts. You can use a variety of information sources to determine the unique profile and particular needs of your community including:

- regional suicide statistics (Vital Statistics)
- health determinants data
- community-wide survey data; stakeholder consultation feedback

b) What are the strengths of your community?

You should take the time to analyze and outline the strengths found in your community (e.g. commitment to upholding family and cultural values) that may be utilized in program activities. It may also be important to identify some potential barriers to the development of a suicide prevention program (e.g. denial of suicide among community members).

c) Consider holding a community consultation meeting

Ask members of your community what they think about the issue or undertake a survey of caregivers in the community regarding their perceptions about the problems and potential solutions, to build further commitment and fill in potential gaps in information (see box, *Community consultation guidelines*).

Community consultation guidelines

Provide an opportunity for broad public input and solicit the opinions and perceptions of a broad range of community members. For example hold public meetings, establish small focus groups or conduct a telephone survey, in order to receive feedback from a variety of groups within your community.

Questions to consider include:

- *Do they perceive suicide and self-destructive behaviour among youth to be a problem?*
- *If so, what leads them to believe this, or according to them, what is the evidence?*
- *If it is not perceived to be a problem for this community, what is a more pressing or urgent problem that needs to be addressed?*
- *Can the issue of youth suicide be approached from another perspective or through the efforts of other prevention initiatives (e.g. youth violence, injury prevention, substance abuse prevention, health and well-being promotion)?*
- *What are community members' perceptions about what needs to be done?*
- *What are the strengths/capacities of the community in responding to this problem or issue?*
- *What gets in the way?*
- *Can some consensus be reached regarding what are perceived to be community priorities?*

If the issue of suicide it is not viewed as a priority area for the community at present, and cannot be integrated with other current initiatives, then it is not advisable to "force the issue." This does not mean, however, that the work of suicide prevention needs to be abandoned altogether.

Community consultation guidelines

Work on those areas that the community perceives to be the most important and pressing concern. Meanwhile, continue to be strategic by taking advantage of opportunities to educate and heighten awareness about the issue of youth suicide; by helping others to make the links between suicide prevention and other prevention/ health promotion efforts; and by lending your explicit support to community-based efforts that seek to enhance the protective conditions within the community, including increasing social support and reducing isolation; building opportunities for youth to become involved in decisions that affect them; strengthening families; and creating supportive school environments.

4. Do your front-end work

Based on responses to the issues identified earlier, take the time to think through some of the following questions, prior to sketching out a preliminary workplan:

a) Which of the 17 promising strategy areas which have been described throughout this manual does your community want to develop or enhance? *Ideally*, a community should be developing and implementing efforts in all of the strategy areas simultaneously, but given the reality of limited resources, strategies may need to be developed and undertaken more slowly, with an aim towards building them up over time.

b) How does the available information, knowledge of your community, and current literature support or justify strategy development in this area?

c) In order to undertake further strategy development, which community partners need to be involved? How can you increase the likelihood of their commitment? What information or data could help you to "build a case" for their continued involvement?

d) Can the community-wide suicide prevention mandate be advanced through an existing interagency body by forming a sub-committee?

e) Who will take responsibility for providing the local leadership for this effort? A core working group? A particular agency? A rotating chairperson?

5. Set up an interagency planning body

While the overall goal of any community-wide suicide prevention effort must necessarily be the reduction of suicides and suicidal behaviours among youth, this is not a goal that can be achieved by any one particular agency acting in isolation. Reducing suicides and suicidal behaviour is not something that can be achieved overnight, nor will one single strategy be enough. It is therefore ideal to establish an interagency body that can coordinate specific results-oriented suicide prevention strategies, which are designed to be implemented across an array of settings and maintained over time.

For communities interested in establishing a formal interagency body for suicide prevention, some key considerations should be kept in mind:

Build on the existing structure

Build on the existing community infrastructure wherever possible. It is neither necessary nor efficient to create a new organizational structure for every particular youth problem or issue, including suicide. Rather, create a youth suicide prevention sub-committee from an existing intersectoral body.

Work with the local governing bodies

The community-wide approach to suicide prevention is more likely to be successful if it is part of an established and legitimate body that has been given an explicit mandate to promote the well-being of youth and reduce risks to their overall health. Furthermore, by including the work of suicide prevention in broader youth health promotion and prevention efforts, some important links between youth suicide prevention and other related issues will be fostered, for example substance abuse prevention, school drop-out prevention, or youth participation projects.

Advocate and coordinate

The role and corresponding duties of the local suicide prevention interagency group include:

- providing a strong voice for suicide prevention
- spearheading key initiatives
- ensuring the coordination of various suicide prevention efforts
- sharing and collecting key information
- establishing functional links across agencies
- advocating for services/community approaches that are known to reduce suicide
- monitoring the effectiveness of the combined community efforts

Facilitate key linkages

Individual agencies, hospitals, and mental health professionals will clearly be contributing to the overall goal of reduced suicidal behaviour through the provision of assessment, crisis intervention, and treatment services. While it will be up to each of these organizations/practitioners to monitor the effectiveness of their own

individual efforts, the interagency body can facilitate important linkages, assist with identifying community priorities, and coordinate/aggregate information across organizations.

What's been said so far

At this stage, if you have attended to each of the above considerations, it is assumed that:

- *an interagency planning body has been established to provide the direction and leadership for a community-wide suicide prevention initiative*
- *the interagency planning body is ideally a sub-group of a larger community-wide planning structure which has been given a specific mandate to improve the health and well-being of youth and/or improve the coordination of services to this population*
- *priorities for action have been identified based on the information available*
- *the "right players" and community partners are on-board*
- *the interagency body understands its role*
- *an organizational structure has been established for "getting on with the work"*

6. Develop an interagency action plan

a) It is wise for the interagency planning body to set some long-range goals as well as some more intermediate targets, always keeping in mind that the ultimate goal is the reduction of fatal and non-fatal suicidal behaviour.

b) Try to plot out your workplan according to a timeline (e.g. one to three year workplan).

c) Whatever strategy does get implemented, ensure that it is results-oriented. For example, what would you expect to change as a result of your intervention: individual attitudes, knowledge, behaviours; agency practices; level of community coordination; media reporting; policies, etc.

d) Identify who is going to take responsibility for what, by agency and/or by individual.

e) Monitor your results based on previously identified indicators of success (see *How will we know if we are making a difference?* for each of the 17 strategies).

f) Share your findings with a broad range of community partners and stakeholders as well as those implementing suicide prevention strategies in other areas of the province.

g) Refine and build on previous efforts, based on the results achieved.

h) Celebrate your successes and learn from those things that did not work.

Please keep in mind that these ideas are meant to serve as broad planning guidelines only. Hopefully they will enable you to begin planning or will enhance the efforts you already have underway. Be aware, however, that there is no one single approach that will work best for every community. Draw on the expertise of your community to determine what will be the best course of action or "best fit."

7. Evaluate your community-wide suicide prevention efforts

Evaluation is a way of measuring whether a program is doing what it is supposed to do and it provides an opportunity for you to improve the program. It means asking questions and gathering information in order to: assess how a program is coming along (process evaluation) and compare the program objectives with the actual results (outcome evaluation).

It's not easy to evaluate prevention programs...

Community-wide efforts that have as their ultimate goal the prevention of suicide and suicidal behaviour are difficult to evaluate for a number of reasons:

1. *Deaths by suicide are fairly infrequent events when considered at the local or community level, which makes it difficult to detect changes that may be due to specific program efforts or strategies.*
2. *It is very difficult to measure a "non-event," in this case the prevention of suicide.*
3. *Many of the promising strategies described in this manual are designed to target children and youth and their environments through such efforts as building their social competencies, strengthening their families, and improving conditions within the school and community. The effects of such programs on later suicidal behaviour may not be known for several years after the intervention.*
4. *Suicide and suicidal behaviour are not outcomes that follow a straight line or simple path, with specific markers leading predictably to a suicidal crisis or death. This makes it challenging to identify the appropriate intermediate targets for change and the corresponding outcome measures that would be most suitable for evaluation purposes.*

...but it's not impossible

As we have already noted, suicidal behaviour is multiply determined, and there are a wide range of risk conditions that interact with one another, serving to create a vulnerability for suicidal behaviour. Evaluating the effectiveness of youth suicide prevention efforts means having an appreciation for the complexity of the behaviour, understanding the multiple paths that lead to conditions of risk or vulnerability among youth, and identifying appropriate short, intermediate and long-term indicators of success (as described for each strategy in Chapter 4). By identifying the traits, events and conditions that increase suicide risk or enhance competencies in youth across a range of settings, and by explicitly measuring those things, we are no longer faced with having to place exclusive reliance on suicide rates as our only outcome measure.

Here are five steps that you can follow when evaluating your program:

1. **Identify the purpose of the evaluation**
   In this first step, you should clarify what you need and expect from the evaluation process to ensure that the evaluation will be useful to you and your group. Begin by answering the following questions: Why do you want to evaluate? Who is the evaluation intended for? What do you want to evaluate? How will the evaluation be carried out? and Who will carry out the evaluation?

2. **Prepare your evaluation plan**
   This is the opportunity to develop a more specific evaluation plan. At this stage, you will use what was decided in the first step to finalize your evaluation goals and objectives, prepare the evaluation plan, decide on the evaluation method, and prepare a timetable. Remember to refer back to the examples of short, medium, and long-term indicators of success that were presented for each strategy in chapter 4 (see the box below).

Short, medium, and long-term indicators of success

Short, medium, and long-term indicators of success
In chapter 4, examples of short, medium, and long-term indicators of success were presented for each of the 17 promising strategies (see the sections titled How will we know if we're making a difference?). While these do not represent the only measures of progress for each strategy, they should give you a good sense of some of the key areas to monitor in your evaluation plan.

In reading through each of the 17 strategies, you will have noticed the following:

- *short-term indicators are those changes that the strategy itself is designed to produce, (for example, increased knowledge);*
- *medium-term indicators of success capture changes that you might come to expect further down the road (for example, increased help-seeking among adolescents or referrals of their at-risk peers);*
- *the ultimate outcome or long-term indicator of success is a reduction in suicidal behaviour and death by suicide.*

3. Gather the appropriate information

You now have a more precise idea of what you need to know and you also know how you will gather that information. Begin by reviewing existing information which might help answer your evaluation questions by talking to people and reviewing project documents and other sources of information. If your review of existing materials does not answer all of your evaluation questions, you may need to gather new information to get a complete picture. This may involve the use of information-gathering tools like questionnaires, interviews, and observation.

4. Make sense of the information

By now, you have gathered all the information you need to answer your evaluation questions. Your next step will be to compile and analyze that information and draw conclusions from it. Your conclusions may deal with the process (how things are going in the program) or they may deal with the outcome (the extent to which the expected results or program objectives were achieved).

5. Use the results

In this step, you will go ahead and make recommendations, write the report, make the results known, and take appropriate action. People involved in the program as well as community members will be interested in knowing and talking about the results of the evaluation. You may want to organize a feedback session to give people a chance to learn about and comment on the findings. Don't forget that you may want to use part of your report in funding requests. Depending on the evaluation results, you will now go ahead and strengthen or modify certain components of your program to make it even more successful.

Check these out...planning and evaluation resources

Check these out…planning and evaluation resources
Several books and manuals have been prepared to assist communities to develop high-quality proposals, secure funding, and establish sound evaluation practices. Naturally, some are more "user-friendly" than others. Noteworthy resources that provide good solid advice in a very practical and easy-to-read format are:

- *Health Funding Arrangements Division (n.d.).* A guide for First Nations on Evaluating Health Programs, *Ottawa, Ontario: Health Funding Arrangements Division, Program Policy Transfer Secretariat and Planning Directorate, Medical Services Branch (MSB), Health Canada. You can view or download this document at: www.hc-sc.gc.ca/msb/pptsp/hfa/publications/evaul_e.htm*

- *Health Canada (1999).* Community Action Resources for Inuit, Métis and First Nations: Evaluating. *Ottawa, Ontario: Health Canada. You can view this document (in PDF) on the Health Canada web site at: www.hc-sc.gc.ca/hecs-sesc/cds/pdf/evaluating.pdf*

- *Holt, J. (1993).* How about…Evaluation: A handbook about project self-evaluation for First Nations and Inuit communities. *Ottawa: Medical Services Branch, Department of National Health and Welfare Canada*

- *Ewles, L. & Simnett, I. (1992).* Promoting health: A practical guide. *London: Scutari Press*

The final word

The value of generating specific, results-oriented findings through the systematic monitoring and evaluation of our community-wide suicide prevention efforts cannot be overestimated. Committing to such a process will allow us to learn from each other and will allow us to focus our energies on those areas that hold the greatest chance for success. By increasing our commitment to evaluating our youth suicide prevention efforts we will also be adding value to our existing knowledge base, which in turn will refine our understanding about what constitutes best practice in youth suicide prevention.

Suggested Reading

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Appendix A

Aboriginal youth: Suicide risk and protective factors

In this Appendix, the suicide risk and protective factors most relevant to Aboriginal youth are highlighted. For the purpose of this discussion, the risk factors have been organized into four categories: individual factors; family/peer-related factors; community/societal factors; and cultural factors.

How good is the best available evidence?

It is important to mention that while scientific studies can identify the factors that contribute to suicide, no scientific study can explain why a particular person acts to end his or her life. The literature on suicide identifies and discusses many risk factors for suicide and suicide behaviour, but almost all of the assumptions made about causality are based on "association factors." Therefore, we remain on shaky ground when we try to use this information to actually predict which particular individuals will go on to die by suicide. In spite of the imperfection of our present knowledge, the information that has been accumulated to date regarding the risk and protective factors for suicide among youth is very useful and can serve to guide our ongoing prevention efforts.

1. Risk factors at the individual level

Summary of the risk factors at the individual level:

- *mental health issues*
- *personality traits (e.g. impulsivity)*
- *low self-esteem*
- *absence of personal purpose*
- *previous history of a suicide attempt*
- *alcohol and substance abuse*
- *sexual orientation or two-spirited issues*
- *conflict with the law*

Mental health issues

There is very strong evidence that having a mental disorder places a person, regardless of their age, at considerably higher risk for suicide than the general population. "Psychological autopsy" studies (investigations done following suicides) have found that a significant proportion of people who died by suicide had a mental disorder. In the case of Aboriginal people, a recent case-control study of death by suicide among the Inuit of Northern Quebec showed that case subjects were 4.3 times more likely to have had a psychiatric diagnosis in their lifetime, the two most common being depression and personality disorder.[1] Another study of a small Arctic Inuit community found a strong association between anxiety disorders and suicidal behaviour.[2]

The prevalence of mental disorders in the Canadian Aboriginal population has been poorly documented, making it difficult to determine what proportion of suicides are associated with major mental disorders. The few studies examining mental disorders in North American Aboriginal populations have reported varying rates from levels comparable to those found in the general population to levels twice those found in the general population.[3] Reports from clinicians working in Aboriginal communities suggest high rates of depression in many communities. Schizophrenia, bipolar disorders, and possibly panic

[1] Boothroyd, Kirmayer, Spreng, Malus & Hodgins, 2001
[2] Manzer, 2001
[3] Kirmayer, Brass & Tair, 2000

disorder, may also be important contributors to suicide in Aboriginal communities.[4] It is important to mention, however, that Aboriginal people in general, and youth in particular, rarely seek out mental health services and, when they do, their condition is often misdiagnosed or under-diagnosed.

Personality traits

Studies in the general population have shown that certain temperaments may contribute to suicide risk. More specifically, there is evidence that social withdrawal, hypersensitivity (being extremely sensitive to others' anticipated judgments and being highly self-critical), personal rigidity (having difficulty generating alternatives when faced with problems and being very fixed in one's perspectives), and impulsivity (acting or reacting with no thought or attention paid to the consequences) are common temperamental traits of people who die by suicide. Individuals who die by suicide but who have no apparent mental health problems tend to show excessive performance anxiety and perfectionism along with a poor response to stress.

Substance abuse

Studies show that suicide and suicidal behaviours are clearly linked with substance abuse (including alcohol) in Aboriginal and non-Aboriginal people. A high blood alcohol level at the time of death may reflect an association between acute alcohol intoxication and suicidal behaviour. Alternatively, the association may be due to a relation between sustained alcohol use and psychological distress (for example, depression). Studies of adult Aboriginal suicides in British Columbia., Alberta, and Manitoba have estimated that between 75% and 90% of the victims are intoxicated at the time of their death.[5] [6] Among non-Aboriginal adults, measured rates of intoxication in those who attempt or die by suicide can vary from a low of 25% to a high of 66%.

Substance abuse also represents a relevant factor in Aboriginal youth suicide. A study done in Manitoba found that alcohol was involved in 60.7% of the young Aboriginal/Métis suicides and 42.9% of the young non-Aboriginal suicides. The study also found that substance abuse was a higher risk factor among Aboriginal/Métis (44.4%) than among non-Aboriginal suicides (23.8%).[7] Another study of solvent abuse in Inuit youth found that individuals who had used solvents were eight times more likely than non-users to have made a suicide attempt.[8]

Alcohol and drug consumption by young people remains a significant problem in many Canadian Aboriginal communities. Compared to the general population of youth,

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[4] Kirmayer, 1994
[5] Cooper, Karlsberg, & Pelletier, 1992
[6] Malchy, Enns, Young, & Cox, 1997
[7] Sigurdson, Staley, Matas, Hildahl, & Squair, 1994
[8] Malus, Kirmayer, & Boothroyd, 1994

Aboriginal youth report that they begin drinking earlier and that they drink more heavily.[9] They are also more likely than their counterparts to consume alcohol on their own, away from the company of peers. Aboriginal youth also abuse other substances such as gasoline and glue more frequently than non-Aboriginal youth.

Sexual orientation or "two-spirited" issues

Traditionally, two-spirited persons (lesbian, gay, transgendered and bisexual) were valued in many Aboriginal communities as they were considered to have a great gift of vision that went beyond most people's abilities. Two-spirited people were not only considered normal, but a crucial and much needed part of the natural world and of the community as a whole. Like the non-Aboriginal community, First Nations, Inuit and Métis communities have grown to fear and reject members who are sexually different. As a result, most two-spirit and transgendered Aboriginal young people live with high levels of discrimination and intolerance which often prompts them to leave their community and move to a larger urban setting where they experience loneliness, isolation and are vulnerable to victimization.

We know that gay, lesbian, and bisexual youth are at greater risk for suicide problems than their heterosexual counterparts.[10] Recent studies in Canada and the United States suggest that homosexuality issues are involved in up to one third of young men under 24 who die by suicide. Relevant data also suggest that Aboriginal gay youth are often subjected to high levels of homophobia and have serious suicidality problems.[11]

2. Risk factors at the family and peer levels

Summary of the risk factors at the family and peer levels

- *friends or family members attempting or completing suicide*
- *change of caretaker during childhood or adolescence, history of non-parental caretakers, chronic family instability, or disrupted relations (e.g. multiple foster placements or adoptions, arrest or hospitalization of caretakers)*
- *family or caretaker history of mental health problems, including alcoholism, drug abuse, or depression*
- *physical or sexual abuse*
- *interpersonal isolation*

[9] Gotoweic & Beiser, 1994
[10] Remafedi, 1999
[11] Bagley & Tremblay, 1997

Suicide in family members or friends

There is a proven link between losing a friend or family member to suicide and a higher risk for subsequent suicidal behaviours. A recent study found that the most powerful risk factor for a past suicide attempt among American Indian and Alaska Native male and female youth was having a friend who attempted or died by suicide. The study also found that having a family member who attempted or died by suicide was also a significant risk factor for a past suicide attempt among both male and female adolescents.[12] An earlier study conducted with Navajo adolescents found the same associations.[13] Tragically, a high number of Aboriginal young people are confronted to at least one, if not several suicides in the course of their young lifetimes, because of the high rates experienced by many Canadian Aboriginal communities.

Childhood separation and loss

Suicide is associated with a history of early separations, losses, and emotional deprivation. Examples include the early loss of important nurturing figures in the family through death, divorce, or desertion. Children living with their parents also suffer if the parents have a serious alcohol or chemical dependency problem and are unavailable to provide a nurturing environment for their children. Studies have also found that youth who die by suicide are more likely to have had a change of caregiver during their childhood or teenage years.

Childhood separation and loss is an issue for Aboriginal children and adolescents as many live in single parent families (32%) or with adult caregivers that are not their natural parents (11%).[14] This is not to say that all children coming from single parent families or living in foster care are at risk for suicide. The degree of support by extended family, relatives, elders and other members of the community will also have an impact on the emotional well-being of these young people.

Family violence

A number of studies have shown that a history of physical and sexual abuse represent risk factors for suicide attempts among American male and female Aboriginal youth.[15] [16] Although it is difficult to know the full extent of physical and sexual abuse in Aboriginal communities, most agree that it is a serious intergenerational problem occurring both on and off reserves in many communities across the country.

Suicide in young people is also associated with a family history of violence or assault, imprisonment, and harmful use of alcohol or other drugs. Unfortunately, it is often difficult to disclose and confront family violence and abuse in small communities. This

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[12] Borowsky et al., 1999
[13] Grossman, Milligan, & Deyo, 1991
[14] Data obtained from Statistics Canada
[15] Borowsky et al., 1999
[16] Grossman, Milligan, & Deyo, 1991

can contribute to the stress level and distress of the victims. Mental health problems suffered by family members can also heighten the risk for suicide in the young people living in the same household. Many Aboriginal adults have faced a series of losses, forced separations from their families, and physical and sexual abuse as a result of their attendance at residential schools, leaving many members of this particular generation ill-equipped for parenting their own children.

3. Risk factors at the community and societal levels

Summary of risk factors at the community and societal levels:

- *access to methods with high lethality (i.e. firearms)*
- *poverty*
- *community instability or lack of prosperity*
- *limited opportunities for employment*
- *lack of proper housing and inadequate sanitation and water quality*
- *isolated geographic location*

Access to lethal methods of self-injury

Between 1989 and 1993, data from the Medical Services Branch, First Nations and Inuit Health Program Directorate, indicated that firearms were used by 31% of suicides among First Nations people in Canada, the second most common method after hanging. We know that the availability of a lethal method, particularly firearms, increases the likelihood of that method being used for self-destructive purposes. In the general population, studies have shown that the risk of suicide is five times higher in homes with guns than in those without them and guns are twice as likely to be found in the homes of suicide victims and attempters.[17] [18] Although data regarding firearm ownership among Aboriginal people in Canada is scarce, it is probably safe to suggest that it is high.

Poverty

In studies of Native Americans in the U.S. and Aboriginal people living on reserves in Alberta, suicide rates have been shown to be strongly correlated with the percentage of population living below the poverty level. A recent study of American Indians found

[17] Brent, Perper, & Allman, 1987
[18] Brent, Perper, Allman, Moritz, Wartella, & Zelenak, 1991

that, among the variables studied, economic deprivation was the most important contributor to suicide risk.[19]

Aboriginal people were once self-reliant and effectively lived off the land. However, through the process of colonization, the opportunities to engage in traditional subsistence activities were taken away. The living conditions have now become similar to those found in some Third World countries. Statistics show that 84% of Aboriginal households live below the Canadian poverty line. For the on-reserve Aboriginal population, the average income was 56% below the Canadian average.[20] In 1996, it was estimated that approximately 52% of Aboriginal children (0-14) lived under the poverty line, compared to 23% of all Canadian children.[21]

Unemployment

Most studies done in the general population show that suicide attempts are strongly associated with unemployment (in both men and women). Rising unemployment is also related to increased suicide rates, more so for men. Rates of unemployment are significantly higher for Aboriginal Canadians when compared to the general population (19.4 % compared to 10%). Unemployment is especially widespread for Aboriginal people living on reserves. Approximately 42% of Aboriginal people living on reserve rely on social assistance, compared to 25% of Aboriginal individuals living off reserve.[22]

In trying to find work, Aboriginal people are often faced with numerous obstacles. Jobs in their own communities may be limited at times, due to a lack of natural resources upon which to base local economic development. When Aboriginal people move to urban centres, they can be confronted with discrimination in the labour market and can find that their education and skills may be insufficient to compete successfully in the job market. Although most young people may not be seeking employment, they witness the impact unemployment is having on their family members and other members of the community. Adolescents see little opportunity for work and may begin to feel helpless and hopeless about their future.

Housing conditions

The inadequate infrastructure of some Aboriginal communities contributes to physical, mental, emotional, and social dysfunction. Housing, water, sanitation, fire and emergency services, communication and transportation systems, as well as recreational, education and health facilities can be below standard or inaccessible to everyone in the community. Statistics show that 29% of Aboriginal people live in overcrowded housing, compared with 2% of the general Canadian population. Houses occupied by Aboriginal people are twice as likely to be in need of major repairs as those of other Canadians. In addition, 23% of on-reserve houses have neither piped or well water.[23]

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[19] Bachman, 1992 (cited in Kirmayer, 1994)

4. Risk factors at the cultural level

Summary of risk factors at the cultural level:

- *breakdown of cultural values and belief systems*
- *loss of control over land and living conditions*
- *negative attitude of the predominant non-Aboriginal culture*

Cultural disruption

Cultural disruption comes about when the complex interaction of relationships, knowledge, languages, social institutions, beliefs, values, and ethical rules that unite a people and give them a collective sense of belonging is forced to change. Over decades, significant pressure from governmental, educational, medical and religious institutions to assimilate Canada's Aboriginal peoples into the mainstream culture has resulted in tremendous cultural disruption. Residential schools, relocation and confinement to reserves, inappropriate foster placement and adoption policies, and political marginalization are all examples of the kinds of oppressive experiences that have been imposed on Aboriginal people by mainstream institutions. The legacy of these experiences has been the breakdown of cultural ways and a loss of identity.

There is some evidence of a relationship between cultural disruption and suicide. First, other indigenous populations around the world that have undergone similar stresses to their cultural foundations also tend to show higher rates of social disorder and suicide. Second, research has shown that a return to cultural roots and a strengthening of a community's self-determination has a tendency to lower the rate of suicide in that community.

Marginalization

The literature often uses the term "marginalization" when referring to individuals who do not acquire the skills, values, and tradition of either the mainstream or traditional culture. This situation is very relevant for many Aboriginal youth who are "caught between two cultures" and have difficulty relating to either of them. This failure to become integrated in either culture may represent a risk factor for today's Aboriginal youth.

5. Protective factors

Summary of protective factors:

- *support from family and friends*
- *perceived connectedness to family and friends*
- *strong cultural ties*
- *good physical and mental health*
- *strong spiritual ties, regular attendance at spiritual events*
- *good school performance*
- *positive attitude towards school*
- *skills in stress management, communication and problem solving*
- *fear of suicide and moral objections to suicide*
- *sense of belonging*
- *positive self-esteem*
- *early identification and appropriate treatment of psychiatric illness*

Cultural continuity

Achieving a high level of local community control (or cultural continuity) and identity seems to offer some protection from suicide in certain communities. A recent study found that the extent to which communities in British Columbia are actively engaged in a process of rebuilding or maintaining their cultural continuity is directly related to the rate of suicide of that community. As such, Aboriginal communities that have taken active steps to preserve and rehabilitate their own cultures are shown to be those in which youth suicide rates are lowest.[24] The concept of cultural continuity may protect youth against suicide by sustaining a sense of self and a will to live, especially when faced with adversities.

Social networks and connectedness

Generally, it has been convincingly demonstrated that social support and good social relations are important to one's mental health. A study focusing on American Indian/ Alaskan young people (male and female) found that a willingness to discuss problems with friends and family, emotional health, and connectedness to family were all protective factors that reduced the risk for suicide attempts. A recent large American study showed that a strong connection to family and school, and perceived caring and

[24] Chandler & Lalonde, 1998

connectedness to others, protected mainstream teenagers against a range of health risk behaviours, including suicidal thinking and behaviours, as well as harmful drug use. More specifically, the study identified the following protective factors: family support and parents who are involved in activities with their children and adolescents, are present in the home, and have high expectations for educational success.[25]

Spirituality

Spirituality, encompassing traditional spiritual knowledge and different religious affiliations, represents another important protective factor against suicide. Spirituality has always played an important part in the lives of Aboriginal people. Aboriginal spirituality is seen as a philosophy and a way of life and is based on the fundamental inter-connectedness of all natural things and all forms of life. Although the traditional lifestyle of Aboriginal people is no longer possible, there has been, in recent years, a revival of interest in many of the old traditions. For Aboriginal people, understanding these spiritual traditions is an important part of understanding one's self.

Although we are not aware of any research looking specifically at the association between strong traditional spirituality and its impact on Aboriginal suicide, we know that healthy and strong spiritual ties are generally linked to good mental well-being. There is, however, some indication that religion or regular attendance to religious ceremonies acts as a protective factor. One study of Inuit youth found that regular church attendance was associated with less likelihood of suicide attempts.[26] It may be that strong religious ties reduce the suicide rate by strengthening social ties and networks through participation in community activities.[27]

[25] Resnick, Harris, & Blum, 1993
[26] Malus, Kirmayer, & Boothroyd, 1994
[27] Kirmayer, 1994

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Appendix B

Glossary of terms

Aboriginal population: refers to people who are First Nation, Métis or Inuit.

At-risk individual: person who has been identified as having certain suicide risk factors (e.g. previous suicide attempt and/or has been exposed to certain risk conditions (e.g. recent suicide of a close peer).

Caregiver: Someone who offers care, support, and direction to an individual who is having problems.

Cluster: Term used to describe two or more suicides or suicide attempts that take place close to one another in time and space and may involve imitation.

Contagion: A process by which one suicide may facilitate others

Community gatekeepers: Members of the community who have significant contact with young people as part of their regular professional duties or volunteer responsibilities.

Contributing factors: factors which act to exacerbate an existing risk for suicide (e.g. substance abuse).

Coping skills: attitudes and skills that an individual can use to handle a stressful situation.

Early intervention: interventions targeting groups of young people who are exhibiting signs of early risk (precursors of risk) to suicide and suicidal behaviour, but where a specific risk for suicide has not yet been identified; may also include efforts to develop supportive environments and improve the response capacity of various systems.

Gatekeeper: refers to an individual who typically comes into contact with the target population (i.e. youth) as part of their daily routine.

Goal: A goal is a broad statement that describes what a program or activities should achieve.

Lethal means: typically refers to those methods of suicide that are most likely to result in immediate death (e.g. firearms, poisons, bridges/high places).

Long-term indicators: Long-term indicators are signs that may take many months or years to show progress.

Mental health promotion: universal interventions targeting the general population, designed to improve personal well-being through strategies aimed at increasing personal strengths and competencies and/or system-focused interventions aimed at increasing social support and belonging.

Objective: An objective states exactly what a program should do. Objectives are identifiable and measurable actions to be completed by a specific time.

Postvention: describes the activities that help to reduce the aftereffects of loss by suicide.

Protective factors: factors describing those conditions which act to lessen the risk for suicide (e.g. availability of at least one significant adult who can provide warmth, care, and understanding).

Risk condition: refers to an event or social context (e.g. social alienation) which potentially elevates the risk for suicide and suicidal behaviour.

Risk factor: refers to an individual trait (e.g. hypersensitivity) or demographic factor which potentially elevates the risk for suicide and suicidal behaviour.

Short-term indicators: Short-term indicators are signs that appear within a few weeks or months after programs or activities start and that show progress toward meeting objectives.

Stage-setting factors: factors which set the stage for a vulnerability to suicide (e.g. family history of suicide).

Suicide: death caused by self-inflicted, intentional injury.

Suicide attempt: potentially self-injuring behaviour motivated by an intent to die with a non-fatal outcome.

Suicidal behaviours: a broad spectrum of behaviours which include suicidal gestures, threats, and attempts (sometimes also referred to as non-fatal suicidal behaviours).

Suicide ideation: thoughts about suicide.

Suicide rates: the total number of deaths by suicide divided by the total population and converted to a rate per 100,000.

Trigger factors: factors which act as a trigger for persons predisposed to suicide (e.g. sudden loss or failure).

Youth: used in this document to refer to children and adolescents.