Preventing Youth Suicide: A Guide for Practitioners

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Preventing Youth Suicide

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

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

Intended Audience

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

Information for youth and for parents can be found through links on the Corporate Government website: www.gov.bc.ca/childteensuicideprevention

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

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

Contact Information

Child and Youth Mental Health Policy Branch
Ministry of Children and Family Development
PO BOX 9731 STN PROV GOVT
VICTORIA, BC
V8W 9S1

Telephone: 250 387-9749
Fax: 250 356-0580
Email: MCF.ChildYouthMentalHealth@gov.bc.ca

Crisis Response Services

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

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

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

For a user-friendly, comprehensive summary of additional ways to get help go to http://mindyourmind.ca/help

Crisis Support for Aboriginal Peoples

Native Youth Crisis Hotline at 1-877-209-1266

British Columbia Aboriginal People Crisis Line at 1-800-588-8717

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

Support for GLTBQ youth

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

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

A list of provincial and national LGBTQ friendly crisis lines is available on the Stigma and Resilience Among Vulnerable Youth Centre website

Additional information on community resources, events and support services for GLTBQ youth and their families and friends is available at Pflag Canada

Background

Glossary of Terms

A great deal of time and energy has been devoted to bringing more precision to the terms used for describing a broad range of suicidal behaviours.[1] In the absence of a common understanding across research and practice contexts about the meaning of some basic terms, the potential for misunderstanding and confusion remains high. While multiple perspectives continue to be debated in the field, and different countries use different terms,[2] the following definitions can bring some much needed clarity.

Suicide – intentional, self-inflicted death

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

Suicide ideation – thoughts of harming or killing oneself

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

Non-suicidal self-injury (NSSI) - behaviours which involve the deliberate destruction of body tissue, which are not socially sanctioned, and which take place in the absence of an intention to die[3]

Self-harm – a broad concept, commonly used in the UK and Europe, includes NSSI, suicide attempts, and self-harm, regardless of intent[4]

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

Suicide Statistics

Canada

Rates of suicide among Canadian youth, aged 15 to 19, tripled between the 1950s and the 1980s. Much of this jump was accounted for by an increase in suicides among young males. Since the 1980s rates of suicide among Canadian youth have started to plateau, with a slight decline observed in the last two decades.[5] See Table 1 below.

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

Year	Rate per 100,000
1950	3.3
1960	3.3
1970	7.0
1980	11.4
1990	11.6
2000	10.9
2010	8.9

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

First Nations, Inuit and Métis

Rates of suicide among Aboriginal youth (First Nations, Inuit and Métis) aged 10-29 in Canada are estimated to be 5 to 6 times higher than youth in the general population[6]. Unintentional (motor vehicle collisions) and intentional (suicide) injuries are the leading causes of death among Aboriginal youth.[7] Over a third of all deaths among Aboriginal youth are attributable to suicide.[8] At the same time, it is important to acknowledge that there is considerable variation in suicide rates across Indigenous communities. Many First Nations communities have very low or zero rates of suicide. [9]

The First Nations and Inuit Health Branch, Health Canada provides more information on this topic http://www.hc-sc.gc.ca/fniah-spnia/promotion/suicide/index-eng.php

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

Rates of suicide among GLBTQ youth are difficult to establish since sexual orientation is not always systematically documented by coroners at the time of death and many young people are not 'out' at the time of their suicide. At the same time a growing body of research confirms that many (though not all) sexual minority youth are at increased risk for depression and suicidal behaviours compared with their heterosexual peers.[10] Negative social responses, peer victimization, harassment and discrimination - which are all part of a broader socio-political pattern of societal homophobia[11] and heteronormativity - collectively contribute to elevated rates of suicidal behaviours among GLBTQ youth.[12] It is worth remembering there is great variation, fluidity and diversity among GLBTQ youth and a queer sexual orientation does not confer an inevitable risk for suicide.[13]

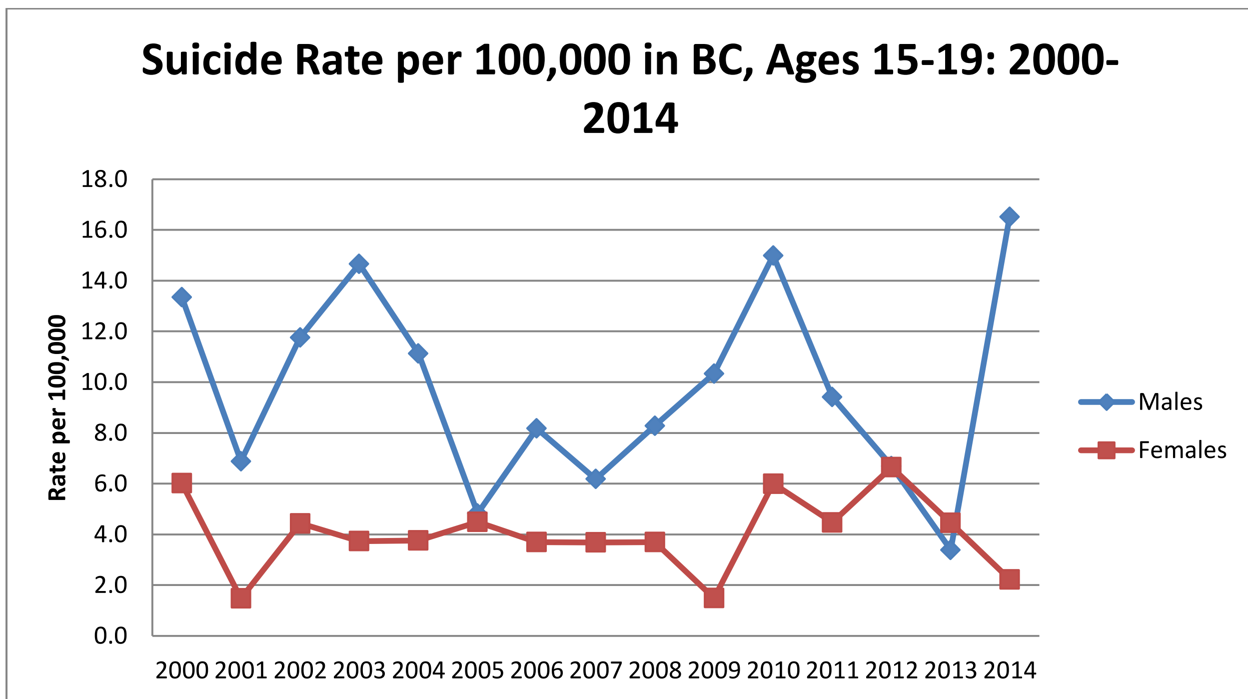
British Columbia

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

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

Figure 1 shows rates of suicide per 100,000 among BC males and females, aged 15 to 19, during the period of 2000 – 2014.

Figure 1



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

2011-14 data from BC Vital Statistics Agency; prepared by the Population Health Surveillance, Engagement and Operations branch, Population and Public Health, Ministry of Health, February 2016

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

The *BC Coroners Service* lists suicides by age, gender, method, month and municipality.

The *BC Vital Statistics Annual Report* includes a Detailed Cause of Death by Gender and Age. Suicides are listed under the following ICD-10 codes: X60-X84, Y870.

Suicide Among Aboriginal Peoples in BC

Rates of suicide among Aboriginal youth in BC vary dramatically across communities. Good evidence exists to suggest that those communities with high levels of "cultural continuity factors" (including: self-government, land claims, education, health care, cultural facilities, police and fire service and Indigenous language use) have lower rates of youth suicide compared with those communities with fewer of these factors.[14]

Suicidal thoughts and behaviours

Recent national surveys from the US examined the prevalence of suicide ideation, plans, and attempts among young people.[15] Among those aged 13-17, lifetime prevalence rates were 12.1% for ideation and 4.1% for attempts. Approximately one third of those who report suicide ideation go on to make a suicide plan and 60% of youth who have a suicide plan go on to make an attempt. Suicidal behaviours are more common among female adolescents.

According to the most recent McCreary Adolescent Health Survey, which surveys youth in British Columbia, three percent of males, grades seven to 12 made a suicide attempt in the previous year and eight percent reported suicide ideation [16] Compared with 2008, this represents a slight decrease in the number of males who reported suicide ideation (from 9% in 2008 to 8% in 2013). The number of suicide attempts in the previous year reported by adolescent males remained steady at three percent.

In 2013 approximately nine per cent of female youth, grades seven to 12, made a suicide attempt in the previous year and 17 per cent considered it. This represents an increase in the percent of adolescent girls who reported suicide ideation (14% of female youth reporting suicide ideation in 2008 compared with 17% in 2013). There was also a slight increase in the number of reported suicide attempts among female youth (from 7% in 2008 to 9% in 2013).

Non-suicidal self injuries (NSSI)

NSSI are behaviours that involve the intentional destruction of bodily tissues, using methods that are not socially sanctioned, which take place without conscious intent to die. Estimates of NSSI among youth range from 14 to 40 per cent in community populations.[17]

According to the 2014 McCreary Adolescent Health Survey 15% percent of students (8% of males vs.22% of females) reported cutting or injuring themselves on purpose without intending to kill themselves in the past year.[18]

To learn more about responding to and treating non-suicidal self-injurious behaviours among youth, go to Interdisciplinary National Self-Injury Network Canada

Risk and Protective Factors

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

Risk factors are those factors and social conditions that are associated with an elevated risk for suicide and suicidal behaviour. Recent reviews of the empirical literature confirm that there are a number of factors that have been linked to suicide and suicidal behaviours among youth.[19 20 21 22 23]

- Older adolescents and males are statistically more likely to die by suicide than females, children or younger adolescents.
- Research suggests that suicide and suicidal behaviours among youth are strongly associated with depression, anxiety, problematic substance use, disordered eating and disruptive behaviour disorders. Co-occurring conditions (e.g. depression and problematic substance use) are also very common among suicidal youth.[24 25]
- Previous suicidal behaviour, including prior suicide attempts, planning and/or rehearsal, are significant risk factors for further suicidal behaviour.[26]
- Hopelessness, aggression, recklessness, purposelessness, social withdrawal and impulsivity have been linked to suicidal behaviour.
- Family factors, including high levels of parent-child conflict, parental mental illness and a family history of suicidal behaviour can elevate the risk for suicide among youth.[27]
- Many youth who attempt suicide have a history of childhood emotional, physical and/or sexual abuse.[28]
- Stressful life events, which typically precipitate suicidal acts, further contribute to suicide risk among youth, especially in combination with existing vulnerabilities. These commonly include interpersonal conflict, rejection, failure, humiliation, and loss.
- Exposure to a peer suicide is also a potential risk factor among some youth with pre-existing vulnerabilities.[29]
- Sensationalized media reports about suicide and having access to the means for suicide are additional risk factors for youth suicide.[30]
- Among Aboriginal youth, a number of additional risk factors have been identified, many of which can be traced to the enduring negative legacy of colonization, residential schools and policies of assimilation, including cultural dislocation, loss of land and language, racism, and multi-generational trauma [31 32]
- Homophobia, peer victimization and discrimination contribute to elevated risks for suicide and self-harm among sexual minority (GLBT) youth[33 34]

Table 2 summarizes the risk and protective factors for suicide among youth (* of particular relevance to Aboriginal youth)

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

Important Considerations Regarding Risk Factors:

1. Knowledge about suicide risk factors is often distilled from "psychological autopsy" studies. Such studies rely on retrospective analyses to identify those factors most strongly associated with a suicidal outcome.
2. Research into suicide risk is valuable for the way that it sheds light on common factors associated with elevated risk among some young people.[35]
3. Risk factor research has also been criticized for converting complex and dynamic human experiences and social conditions into de-contextualized, individual-level, static, and unitary variables.[36 37 38]
4. Traditional approaches to studying and documenting suicide risk factors typically focus on individual-level risks which can potentially mask the role of social, structural and institutional factors in perpetuating social inequities and injustice which influence mental health and suicide. [39 40 41]
5. Risk factors are cumulative and they interact in complex ways making it impossible to describe a singular profile of a "typical" suicidal youth.
6. Risk factors for suicide are dynamic, often fluctuating, and they vary in their severity which means that certain combinations of risk factors may elevate risk in some individuals but not in others.
7. Risk factors exist at multiple levels and are very often deeply embedded in social, historical, cultural, political and institutional practices that exist "outside the person"[42 43]
8. It is important to consider multiple, less well-documented forms of risk, including the effects of oppressive social practices and historical relations of power on certain groups and populations in western society. These include for example, the negative historical effects of colonization on Indigenous youth[44] or the damaging effects of homophobia and heterosexist biases on sexual minority youth.[45 46]

Protective Factors

Protective factors refer to those individual and social factors and experiences that appear to reduce the likelihood of suicide despite exposure to risk.[47] Protective factors are important focal points in any youth suicide prevention strategy and include "reasons for living," spiritual practices, and other hope-activating circumstances that support resilience, promote community healing, and strengthen practices of solidarity that sustain individual and community well-being.[48 49 50]

While protective factors are less well-established through research, preliminary evidence suggests that the following factors may serve to protect youth against a range of social problems[51 52 53]: coping and problem solving skills, experience with success and feelings of effectiveness, strong sense of belonging and connection, social support, interpersonal competence, family warmth, support and acceptance, success at school, supportive school climate, school-based anti-harassment policies and practices, strong cultural identity, community self-determination and a commitment to social justice. Specific cultural factors have been associated with resilient outcomes among Indigenous youth, including: traditional activities, traditional languages, spirituality and traditional healing.[54]

Social Determinants of Health

Recent research on the social determinants of health, including for example income distribution, education, employment, early childhood development, and housing, has convincingly established the connection between poor health and inequitable social arrangements and adverse living conditions.[55] [56] Meanwhile, the concept of *intersectionality* highlights the way that identity markers such as age, race, gender, sexual orientation and (dis)ability dynamically interact to shape individual lives and realities, creating benefits for some groups while limiting access to opportunities and resources for others.[57] In other words, we live in a world characterized by social inequities, many of which are maintained through institutional arrangements and structural forces that differentially influence individual and group opportunities for education, employment, housing and access to services.[58] For that reason, experiences of despair, suffering and suicidal behaviours among youth cannot be completely understood, nor adequately responded to, by focusing exclusively on person-centred variables such as psychological vulnerabilities or mental health status. A social justice orientation is an important lens to bring to any effort designed to improve individual mental health and social well-being,[59] even though it has largely been underexplored in much of the suicidology research.

Important Considerations Regarding Protective Factors

1. Assessing protective factors or “reasons for living” provides an important balance to the focus on risks, vulnerabilities and threats to well-being.
2. In clinical practice, an active and deliberate focus on eliciting youth strengths, capacities and resources is an essential component of any comprehensive assessment practice.
3. Young people, families, communities, and local cultural traditions all provide important resources for healing.
4. Focusing on strengths and opportunities serves to remind youth, families and communities of their own assets which have often been neglected, forgotten or denied.
5. The presence of protective factors does not serve to “cancel out” risk factors, especially when multiple imminent risk factors are present (frequent, intense ideation and strongly expressed intent to die).[60]
6. When conceptualizing community-wide prevention strategies, protective factors at the societal level include the social determinants of health such as early childcare and development, income, job security, housing, access to education, community self-determination, and policies of social justice and inclusion.[61]

Age-Related Considerations

Suicide rates tend to increase with age. This is due in part to the fact that many of the well-known risk factors for suicide, including for example major depression, increase during adolescence.[62] The co-occurrence of problems, especially depression, anxiety and substance use, is common among adolescents who die by suicide.[63] Certain social stressors exacerbate suicide risk (e.g. break-up of romantic relationships, educational challenges and parental pressure) and these experiences tend to be more common during adolescence.[64]

Prevention strategies that attend to the multiple contexts of adolescents' lives (families, peers, school), and which reflect culturally diverse pathways to growth and resilience, are strongly supported.[65] Recognizing the importance of peer belonging and acceptance, supporting increasing independence within the context of loving relationships, and promoting active problem solving approaches among this age group are key strategies to keep in mind.[66]

In many Aboriginal communities, creating opportunities for Elders and youth to come together, supporting the **transmission of cultural values**, and preserving Indigenous language(s) have also been linked to reduced suicide rates in among First Nations youth in BC.[67] [68]

Though statistically rare, suicide does occur among pre-pubertal children.[69] It is important not to underestimate children's understandings of the meaning of suicide, nor to discount the possibility that children do engage in suicidal behaviour.[70] Other issues to consider when thinking about suicide risk among children include[71] [72]:

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

When assessing suicide risk in pre-pubertal children, keep questions concrete, use a combination of questions and empathic reflections, and match language to the child's level of understanding.[73] For an example of questions that could be used to assess suicide risk in children, go to "Sample Questions to Ask Young Children About Suicide".

See also the Toolkit on Children and Suicide prepared by the Centre for Suicide Prevention

Approach

Principles and Values

- Many youth suicides are preventable.
- Reducing emotional distress and suffering, addressing injustice and advancing hope among youth, their families, and communities are key aims.
- A transactional-ecological approach which recognizes the role of broad level social determinants in the emergence of suicide risk stands in contrast to an individualizing or pathologizing approach.[74 75 76]
- There is no single answer or simple solution to preventing youth suicide.
- Strategies for preventing suicide should be informed by the research evidence where available.
- Some aspects of suicide and its prevention are not easily captured by traditional research methods and so our knowledge about “what works best” is always imperfect, evolving and subject to change.
- Multiple forms and sources of knowledge are important to mobilize for youth suicide prevention. This includes: young people’s knowledge, skills and experiences; clinical judgment of practitioners; knowledge generated through research and scholarship; local knowledge of communities; and the knowledge of those with lived experience of suicide and suicide attempts.
- Problem oriented approaches which locate problems within young people, narrowly focus on disorders and deficits, and fail to capitalize on individual, family and community strengths and assets in the generation of solutions are not only ineffective, but risk perpetuating further harm
- Young people have a valuable contribution to make and their voices, ideas and wisdom should always be actively elicited and supported.
- Parents and family members are important allies in the prevention of youth suicide.
- Efforts to promote youth and family well-being and reduce risks for suicide should be informed by the concepts of cultural safety and social justice which are predicated on multiple forms of engagement and relational values of respect, trust, justice, relational accountability and safety[77]
- Elevated rates of suicide, substance misuse, violence and trauma witnessed among Aboriginal communities can be understood as a direct consequence of the history of colonization[78]
- De-colonizing practices, which orient attention to the systems and structures that perpetuate oppression and inequity, particularly among Indigenous youth, families and communities, invite practitioners to understand the social and historical embeddedness of problems like depression, despair, and suicide and highlight the need for individual, organizational, and social action
- Praxis – a form of ethically informed, wise action that integrates theory and practice – offers a helpful touchstone for guiding action at the community level.[79]

A Comprehensive Approach

Comprehensive, multi-strategy, ecological-transactional approaches, which are implemented across an array of settings and contexts and developed by/with local communities, are recommended.[80] [81] These community strategies and practices should be informed by current research evidence and should also honour and build on local community knowledge, values and traditions.

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

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

Comprehensive Approaches in Aboriginal Communities

Comprehensive approaches which reflect holistic views of children, youth, families and communities; recognize the significance of land and place; and draw on the distinct strengths and cultural practices of Indigenous communities hold the most promise.

The BC First Nations Health Authority recently produced a user -friendly toolkit for preventing and responding to suicide in First Nations communities. Hope, Help and Healing is grounded in an Indigenous perspective on wellness. The toolkit includes a number of planning templates and practical tools to help guide communities in the development of a comprehensive approach to suicide prevention.

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

Adolescent Suicide Prevention Program Manual is a useful guide that outlines a public health approach to addressing suicide in Native American communities.

Acting on What We Know: Preventing Youth Suicide in First Nations is a useful report that summarizes the literature and highlights the importance of community driven approaches.

A Comprehensive Planning Framework

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

Table 3 “Mapping a community wide approach to Youth Suicide” provides one example of how this work might be conceptualized at a community level. It highlights specific topic areas including some of the most promising youth suicide prevention strategies identified in the professional and empirical literature.[82] [83] [84] [85] [86] The horizontal axis represents a continuum of prevention interventions from population-focused mental health promotion efforts to clinical interventions with individuals-at-known risk. A list of key target groups and settings is described along the vertical axis.

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

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

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

Developed by Jennifer White (2012)

Well-Being and Resilience Promotion

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

Research on resilience lends justification to those practices that promote change at both the individual and social environmental levels. The concept of resilience reflects three overlapping domains that collectively emphasize the importance of processes, context, relationships, and resource provision: [87]

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

For more information on the evidence base supporting resilience promotion in children, youth and families check out the resources available through the Children's Health Policy Centre at Simon Fraser University.

Aboriginal Youth Well-Being and Community Resilience

The undeniable resilience of Indigenous children, youth, and families who have maintained health and well-being despite facing a number of cultural assaults and historical adversities, must not be overlooked. Researchers have begun to identify those social practices and relational processes that can strengthen social relations and promote resilience at the community level. Many resilience-promoting mechanisms exist outside the individual, lending support to a multi-strategy approach, which engages with individuals, social relationships, resources and contexts.[88] These processes include:[89]

- strengthening social capital, networks and support
- revitalizing language
- enhancing cultural identity and spirituality
- supporting families and parents to insure healthy child development
- enhancing local control and collective efficacy
- building infrastructure (material, human and information)
- respecting human diversity

For many Indigenous communities, storytelling is a key mechanism for teaching and mobilizing culturally informed values and practices. Living in harmony and maintaining respectful co-existence with all living things are important cultural teachings that can be conveyed through both traditional and contemporary stories. Such stories link individuals, families, and communities, through the past, present and future, and can provide an important resource for resilience.[90]

Positive Youth Development Programs

Positive youth development programs are informed by the empirical research in prevention which recognizes that the same set of individual, family, school and community factors can predict both positive outcomes (e.g. success in school) and negative outcomes (e.g. school dropout) among children and youth.[91] Positive youth development is a broad category that encompasses a wide range of programs, including many primary prevention programs that have their origins in the substance abuse prevention field. According to a recent review of the evidence,

> *Positive youth development includes ecological, asset or strength-based approaches that promote healthy growth through supportive community environments and good relationships. The focus is on building relationships with caring adults that support engagement in challenging activities in which the youth are active participants, rather than solely the recipients of services or support.*[92]

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

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

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

Many positive youth development programs are guided by the “Five C’s”[93 94]:

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

“Sixth C:” Contribution - Engaging in contributions to one’s community[95]

While proponents of the positive youth development approach have made an important contribution to the prevention field by focusing on youth strengths instead of deficits, many youth researchers and practitioners argue that positive youth development does not go far enough to recognize the debilitating effects of social and structural oppression that many racialized and minority youth experience, including racism, poverty, unemployment, violence, and limited access to resources. A related criticism is that many positive youth development

approaches are based on dominant white, middle class values which do not adequately reflect the lived realities of all youth.[96] One way to address some of these limitations is to recognize the role of socio-political and institutional contexts in perpetuating inequities and taking specific actions to reduce oppression and social injustice when conceptualizing and responding to social problems among youth such as youth suicide.

Other more recently developed approaches to positive youth development highlight the importance of drawing on cultural strengths and traditions. Specifically, programs that are designed to promote the positive development of Indigenous youth ought to draw on culturally meaningful frameworks and incorporate traditional healing practices as a way to strengthen Indigenous youths' sense of cultural and spiritual identity, connectedness, and sense of belonging.[97] [98]

Implementation Ideas and Tools

Lions Quest Canada is a leader in Positive Youth Development and they offer tools and resources for promoting youth well-being and strengthening community capacity

The Resilience Research Centre provides a range of valuable tools, research reports and training opportunities dedicated to promoting a multidimensional notion of resilience.

The McCreary Centre Society has developed a toolkit *From the Inside Out* which is designed to promote and support resiliency in adolescents aged 11 to 14,

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

The Stigma and Resilience Among Vulnerable Youth Centre offers a number of research reports and resources for strengthening social environments and fostering resilience among vulnerable youth.

Additional Resources on Positive Youth Development

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

Kenyon, D & Hanson, J. (2012). Incorporating traditional culture into positive youth development programs with American Indian/Alaska Native youth. *Child Development Perspectives, 6*(3), 272-279.

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

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

Wexler, L., Gubrium, A., Griffin, M. & DiFulvio, G. (2013). Promoting positive youth development and highlighting reasons for living in Northwest Alaska through digital storytelling. *Health Promotion Practice, 14*, 617-623.

Youth Skill Building

The promotion of youth competencies and the development of specific life skills are relevant for the prevention of youth suicide and suicidal behaviours. Youth skill building is one important component in an overall youth suicide prevention strategy. Research suggests that youth who respond to stress and crisis with self-harming behaviours may be limited in their coping and problem solving abilities, lending support to programs, which seek to enhance these skills[99] [100]. Social skills training approaches have been successful in addressing other high-risk youth behaviours such as depression, aggression and substance use.

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

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

Values-Based Teachings For Aboriginal Youth

Other approaches which explicitly reflect Aboriginal teachings and values have also been summarized in the literature. The "Seven Sacred Values or Teachings" provides one example of a "wise practice" approach to promoting mental health and reducing violence among Indigenous peoples.[101]

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

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

The First Nations Mental Wellness Continuum is a comprehensive framework that reflects key cultural values and teachings to promote First Nations mental wellness.

Other strengths-based, culturally relevant approaches to promoting skills among Aboriginal youth include such strategies as school-based youth engagement strategies, peer mentoring programs, providing support for school-based transitions, storytelling, and cultural leadership development.[102] [103]

Skill-building Programs for Elementary School Aged Children

A universal prevention program, called the Good Behavior Game (GBG) is designed to reduce aggression and disruptive behaviour and promote pro-social behaviours among children in the first and second grades. It shows promise in preventing or delaying suicide ideation and attempts in adolescence.[104] Using a game-like structure to promote children's pro-social skills through the use of rewards and incentives and by encouraging teammates to regulate peers based on the pursuit of mutual self-interests, the GBG is designed to assist first and second grade classroom teachers set acceptable standards for behaviour and create an integrated approach to behaviour management where all children are supported to learn in a context that is free from aggression and disruption.

Implementation Ideas and Tools

The Children's Mental Health Research Quarterly includes a summary of the research on promoting positive behaviour in children

Zippy's Friends- Partnership for Children is a universal, mental health promotion program designed to strengthen the coping abilities of children aged five to seven

PAX Good Behaviour Game is an evidence-based children's mental health promotion program that improves self-management, collaboration and positive peer relationships. It has also been shown to prevent later mental health problems, including suicidal thoughts and behaviours.

FRIENDS for Life is an example of a school based early intervention and prevention program that is focused on preventing anxiety and depression and promoting resilience among children and youth through a number of specific skill building efforts. In BC, the Ministry of Children and Family Development (MCFD) partners with the Ministry of Education, participating school districts and independent schools to provide the FRIENDS program

The FRIENDS for Life Parent Program is an on-line resource that complements the FRIENDS program offered in BC schools and provides parents and families an opportunity to be involved and learn ways to reinforce the FRIENDS skills at home through videos, parent-friendly activities and much more

Strategies for Healthy Youth Relationships provides a number of curriculum resources, materials for parents, and guidelines for youth service providers for reducing violence and risk-taking behaviour within schools and communities
.

The *Search Institute* also provides a number of downloadable resources for asset building in young people

The American Indian Zuni Life Skills Development program is a school-based, culturally responsive, skill-building curriculum that may be suitable for other Indigenous populations with appropriate modifications

Additional Resources on Youth Skill Building

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

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

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

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

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

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

Youth Participation and Engagement

Youth participation has been defined as "a constellation of activities that empower adolescents to take part in and influence decision making that affects their lives and to take action on issues they care about." [105] An 'engaged youth' is someone who thinks the organization or activity is an important one, is well-informed about the organization/activity, and sees an important sense of purpose in the organization/activity.[106] There are a range of ways in which young people can be meaningfully engaged, from adult-initiated, shared decision making to youth-initiated and youth directed activities.[107] Youth participation in decision-making and youth engagement in extracurricular activities have been identified as important protective factors that can mitigate risks for suicidal behaviour. [108] [109]

Youth have knowledge, ideas and lived experiences that are relevant for the promotion of well-being and social justice. By actively involving youth in the design and implementation of programs and giving them meaningful opportunities to participate in responding to issues that affect them, local programs and policies are made more relevant, organizations are strengthened, and the health of the community is enhanced.

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

Such social justice oriented youth participation efforts recognize youth as active "agents" of social change which is in contrast to thinking of youth as passive service recipients or "assets".[110] Through careful mentorship, coaching and support, youth build on their existing strengths and learn important skills such as critical engagement, sociopolitical analysis, democratic participation, social and community problem solving, and mobilizing for systemic change.

Implementation Ideas and Tools

The BC Ministry of Family Development has created a user-friendly Youth Engagement Toolkit that offers resources and guidelines for strengthening youth engagement practices

The Centre for Excellence for Youth Engagement includes a number of articles and resources

The Free Child Project website offers numerous resources and examples of youth-led activism

Engaging and empowering Aboriginal youth is a toolkit designed for service providers

The Ontario Public Health Association has developed a *Youth Engagement Toolkit* to support public health professionals to use youth engagement as a strategy for promoting health and well-being

McCreary Centre Society includes a number of resources on youth engagement

Additional Resources on Youth Participation and Engagement

Armstrong, L. & Manion, I. (2015). Meaningful youth engagement as a protective factor for youth suicidal ideation. *Journal of Research on Adolescence, 25*(1). 20-27.

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

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

Ramey, H. et al (2010). Youth engagement and suicide risk: Testing a mediated model in a Canadian community sample. *Journal of Youth & Adolescence, 39,* 243-258.

Wang, C. (2006). Youth participation in photvoice as a strategy for community change. *Journal of Community Practice, 14*(1), 147-161.

Parent/Family Support Programs

Research points to the protective functions of close parental bonding, healthy parent-child communication, and effective family functioning in reducing risks for a range of child and youth mental health problems.[111] Several studies have demonstrated the important role of parental involvement, warmth, connection, listening and support in reducing risks for adolescent suicidal behaviour.[112] Such findings also suggest that parent education and family support programs, which are designed to improve parents' overall problem solving, communication and conflict resolution skills, and improve family relationships and strengthen bonds, can make an important contribution in the overall youth suicide prevention effort. Social support for parents, may in itself, be an important factor in promoting parental effectiveness.

Several family-level protective factors have been found to positively influence adolescent health and well-being including: positive parent-child relationships, positive discipline methods, close supervision, and communication of prosocial values and expectations. [113]

Core principles of effective family-focused preventive interventions have been distilled from the existing research and they are summarized below:[114]

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

Strengthening the Well-Being of Indigenous Families and Communities

In First Nations communities, the well-being of youth is inextricably tied to the healthy functioning of parents, extended family members and the community as a whole. A review of the literature[115] on promoting mental health among First Nations children and youth found that the most promising approaches had the following elements in common:

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

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

Canadian research suggests that programs designed to support young Indigenous children's development are more likely to be successful when programs are well-coordinated and guided by the following principles: [116]

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

Implementation Ideas and Tools

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

Strengthening Families for the Future is a Canadian program modeled after the Strengthening Families Program

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

Two BC resources offer a number of tools and programs for supporting parents and families: BC Council for Families and Parent Support Services of BC

Resources for strengthening Indigenous families are available through the First Nations Child and Family Caring Society of Canada and are detailed in Hook and Hub: Coordinating Programs to Support Indigenous Children's Early Learning and Development

Canadian Association of Family Resource Programs

Additional Resources on Parent and Family Support Programs

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

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

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

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

School-Based Mental Health Promotion

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

School climate reform initiatives are based on the growing evidence that confirms that pro-social norms, goals, and expectations can be cultivated through sustained attention to some of the broader social practices, patterns of relationships, and overall organizational structure of a school. By creating spaces of safety, respect and belonging, where all students can grow and learn, and where parents and families are actively engaged, many of the goals of school-based mental health promotion can be accomplished.[117]

The establishment of policies to support an overall positive school climate are an important component of any school-based mental health promotion effort. For example, anti-homophobic bullying policies in conjunction with the establishment of Gay-Straight Alliances (GSA) in schools, have been shown to have a potentially positive effect on students' mental health, including reducing risks for suicide ideation and attempts.[118]

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

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

Schools are a natural site for students to learn important social, emotional and relational skills. Eight core skills that enable students to live healthy, productive and meaningful lives have been identified by the Collaborative to Advance Social and Emotional Learning (CASEL)[119]:

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

Research suggests that these social and emotional skills can be taught to students through systematic approaches that include the following elements[120]:

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

In order for school-based mental health promotion initiatives to be effective, teachers and other school-based professionals need to be provided with sufficient opportunities for ongoing training and skill development in the area of child and adolescent mental health literacy. Efforts need to be collaboratively developed and designed, reflecting local needs, values and interests. This requires going beyond the implementation of evidence-based practice towards a more "community science approach" which emphasizes diverse participation, knowledge utilization, and capacity building at the local level.[121]

Implementation Ideas and Tools

The Mental Health Commission of Canada recently produced a report on School-based Mental Health Promotion, which includes a summary of the research, recommendations for practice and links to relevant resources.

The Pan-Canadian Joint Consortium for School Health has produced a Positive Mental Health Toolkit. It includes a number of useful resources and sample planning tools for promoting positive school health practices.

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

Oregon Resiliency Program, Strong Teens Curriculum is a curriculum developed to promote emotional resiliency with adolescents in grades nine to 12. The *Strong Teens* curriculum is aimed specifically at concerns and content relevant to adolescents or high school aged students. The *Strong Teens* lessons are designed to be easy to implement in school settings. There are 12 brief lessons that are designed to be taught once a week for 12 consecutive weeks. The lessons are designed to take 45 to 50 minutes each. These lessons are carefully designed and scripted for ease of implementation. The curricula were developed using evidence based concepts, instructional strategies and activities.

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

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

Advances in School Based Mental Health Journal includes a number of articles on mental health promotion in schools

McCreary Centre Society Report on Promoting Positive Mental Health Among BC Youth

Additional Resources on School Based Mental Health Promotion

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

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

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

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

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

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

Changing Social Norms

There is some evidence to suggest that population level interventions which target a whole community can make an important contribution to the overall suicide prevention effort. Specifically, a community wide, multi-layered intervention that focused on reducing modifiable risk factors and enhancing protective factors was implemented by the US Air Force over the period 1990 – 2002.[122] Strategies included reducing the stigma around help-seeking, improving understanding of mental health issues and changing policies and social norms. Results indicate that in following the multi-layered intervention, which targeted the whole community, there was a sustained decline in rates of suicide and other adverse outcomes, including accidental death, homicide and family violence.

Locally coordinated approaches to youth suicide prevention which are informed by a community wide, ecological perspective have also shown promise.[123] [124] Through a combination of gatekeeper training, discipline specific education for particular professional groups and protocol development, it has been shown that the capacity and competency of all community members to detect suicidality among youth can be strengthened.

Another more recent development aimed at changing social norms is the inclusion of those individuals with lived experience (i.e. prior suicide attempts) in the planning and development of suicide prevention programs. Such efforts are predicated on the idea that those who have lived through the experience of suicidality have something unique and valuable to offer to the overall project of youth suicide prevention. By including these first person narratives, the stigma surrounding mental health and suicidal behaviours is lessened and constructive opportunities for maximum participation in the development of solutions is increased.[125]

Recent suicide prevention initiatives that are dedicated to sharing the wisdom and insights from those with lived experience include:

Collateral Damage is a Canadian project that uses images and stories of those who have survived a loss due to suicide to promote more open dialogue and reduce the stigma surrounding suicide.

Live Through This is a collection of portraits and stories of suicide attempt survivors, as told by those survivors

What Happens Now: Life After Suicidal Thinking is a project of the American Association of Suicidology

National Action Alliance for Suicide Prevention: Suicide Attempt Survivors Task Force. (2014). The Way Forward: Pathways to hope, recovery, and wellness with insights from lived experience. Washington, DC

Additional Resources on Changing Social Norms

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

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

Community Self Determination and Control for First Nations

Issues of community self-determination and cultural relevance are of particular importance when planning and implementing youth suicide prevention programs in an Aboriginal community. In a series of studies conducted in British Columbia comparing community level characteristics of First Nations communities, researchers have identified variables that appear capable of differentiating communities with high rates of suicide from those communities with a suicide rate closer to zero.[126] These variables include self-government, land claims, control over education, health, police/fire and child protection and cultural facilities. Communities with low rates of youth suicide possess valuable and legitimate knowledge that can be shared with other communities.

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

Recognizing the value of Indigenous knowledge(s) is a pre-requisite in any de-colonizing effort aimed at supporting Aboriginal health, well-being and self-determination. A recent Canadian study showed that participating in culture camps designed to promote young peoples' involvement in cultural activities and strengthening their bonds with local Elders, had a positive impact on youth wellbeing. These cultural and community-building activities can be an important part of an overall youth suicide prevention strategy.[127] Unique characteristics of Indigenous knowledge systems include:[128]

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

The *Aboriginal Healing Foundation* has published a number of high quality research reports on suicide prevention, community healing and therapeutic approaches.

Implementation Ideas and Tools

Truth and Reconciliation Commission of Canada: Calls to Action provides 94 recommendations for redressing the legacy of residential schools in Canada and advancing the agenda of reconciliation

Aboriginal Affairs and Northern Development Canada describe a number of First Nations, Inuit and Métis "success stories" from across the country

What is Working What is Hopeful: Supporting Suicide Prevention Strategies Within Indigenous Communities tells the stories of Aboriginal communities and how they have healed from suicide.

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

Aboriginal Youth: A Manual of Promising Youth Suicide Prevention Strategies describes a comprehensive approach to preventing risks for suicide and suicidal behaviour among Aboriginal youth. Strategies are aimed at building on existing community strengths and resources. Several practical examples are offered.

The BC First Nations Health Authority recently produced a comprehensive document called *Hope, Help and Healing.* This is an excellent user-friendly planning toolkit for preventing and responding to suicide in First Nations communities

Additional Resources on Community Self-Determination for First Nations

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

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

Greenwood, M., de Leeuw, S., Lindsay, N. M., & Reading, C. (2015). *Determinants of Indigenous peoples' health in Canada: Beyond the Social.* Toronto, ON: Canadian Scholars' Press.

Harder H., Holyk, T. Russell, V. & Klassen-Ross, T. (2015). Nges Siy (I love you): A community –based youth suicide intervention in northern British Columbia. Interna*tional Journal of Indigenous Health(10),* 2, 21-32.

Harder, H., Rash, J. , Holyk, T., Jovel, E. & Harder, K. (2012). Indigenous youth suicide: A review of the literature. *Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health 10*(1), 125-142.

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

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

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

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

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

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

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

Education and Early Detection

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

- A number of effective and promising youth suicide prevention programs are summarized in the Children's Mental Health Research Quarterly
- The Substance Use and Mental Health Service Administration (SAMHSA) provide a database of interventions for the prevention and treatment of mental health and substance use problems through their National Registry of Evidence-based Programs & Practices [NREPP]

Parent Education About Suicide

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

Recent research suggests that actively involving family members in suicide prevention activities can have beneficial effects, including helping parents to recognize potential warning signs of suicide, providing parents and family members with concrete strategies for communicating their concerns, and reminding them of the important role that they play in offering care, hope, advocacy and support.[129]

Implementation Ideas and Tools

It's Time to Talk About it: A Family Guide for Youth Suicide Prevention offers families a number of valuable tips and suggestions for how to recognize risk and take action if they are worried about a family member

The Yellow Ribbon program includes helpful content on the topic of youth suicide prevention that is specifically aimed at parents

Additional Resources on Parent Education

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

Gryglewicz, K., Elzy, M., Brown, R. et al. (2014). It's time to talk about it: Utilizing a community-based research approach to develop a family guide for youth suicide prevention. *International Journal of Child, Youth & Family Studies, 5*(1), 47-69.

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

Youth Education About Mental Health & Suicide

Increasing awareness about the need to promote mental health literacy and awareness among students, teachers and administrators is growing. A national mental health literacy curriculum guide has recently been produced in Canada.[130]

Mental health literacy in the junior high and high school setting can be defined as having four unique but integrated components:

1. understanding how to foster and maintain good mental health
2. understanding mental disorders and their treatments
3. decreasing stigma
4. seeking help effectively[131]

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

Proponents of curriculum-based approaches to youth suicide prevention typically draw on the following, empirical grounds:[132]

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

Evaluations of school based suicide prevention programs typically assess students' knowledge and attitudes following a school based suicide prevention curriculum. Results indicate that the programs can be effective in increasing knowledge and influencing attitudes in the desired direction with no undesirable effects of the programs (e.g. increased levels of hopelessness).[133]

As one example of a promising multi-dimensional youth suicide prevention program, "Surviving the Teens" focuses on providing students with factual information about depression and suicide, promoting coping skills and self-efficacy, and enhancing help-seeking abilities.[134] A preliminary investigation suggests that the program can have a favourable impact on suicidal outcomes, although it is important to note that no control group was used in the evaluation design, which limits the findings.[135]

Only three programs have been associated with reductions in suicidal behaviours. Specifically, the Signs of Suicide (SOS) program, which includes a screening and educational component, was linked to a reduction in self-reported suicide attempts among participating high school students.[136] Also, the Good Behaviour Game (GBG) which targets early aggressive and disruptive behaviours among elementary school students was associated with fewer attempts and lower levels of suicide ideation among participants.[137] While both programs appear promising, the findings need to be interpreted with caution as the GBG was only evaluated once and the mechanism responsible for the observed reduction in suicide attempts in the SOS program is unclear. More recently, the Saving and Empowering Young Lives in Europe (SEYLE) multi-site study found that a universal, interactive, school-based workshop (approximately five hours in length) designed to raise awareness about depression and suicide, and enhance skills for managing distress, was effective at preventing suicide attempts and serious suicide ideation and planning.[138]

Recent qualitative studies have pointed to the importance of moving beyond information transmission activities when engaging young people in conversations about how to prevent youth suicide. Specifically, strategies that recognize young people as active, knowledgeable, and capable and which draw on their own knowledge, skills and experiences may be preferable to those that treat them as passive recipients of others' expert knowledge.[139]

Implementation Ideas and Tools

Best practices in school-based suicide prevention: A comprehensive approach was developed by Healthy Child Manitoba

Research informed, curriculum-based approaches to youth suicide prevention are detailed in the Youth Suicide Prevention School-Based Guide developed by the Louis de la Parte Florida Mental Health Institute at the University of South Florida.

The UCLA Center for Mental Health in Schools has prepared a comprehensive set of tools and tips to guide those implementing a school-based suicide prevention awareness program.

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

The American Association of Suicidology has compiled a list of recommended educational videos on the topic of youth suicide that might be suitable for inclusion in a classroom based context.

Here in British Columbia, a school-based suicide awareness program called "Reaching Out" has been developed by the Crisis Intervention and Suicide Prevention Centre of BC.

Additional Resources on Suicide Prevention Education for Youth

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

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

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

Katz, C., Bolton, S., Katz, L., Isaak, C., Tilston-Jones, T., & Sareen, J. (2013). A systematic review of school-based suicide prevention programs. *Depression and Anxiety, 00*, 1-16. doi: 10.1002/da.22114

King, K., Strunk, C. & Sorter, M. (2011). Preliminary effectiveness of surviving the teens suicide prevention and depression awareness program on adolescents' suicidality and self-efficacy in performing help-seeking behaviors. *Journal of School Health, 81,* 583-590.

Klimes-Dougan, B., Klingbeil, D. & Meller, S. (2013). The impact of universal suicide-prevention programs on the help-seeking attitudes and behaviors of youth. *Crisis, 34*(2), 82-97.

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

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

Wasserman, D. et al. (2015). School-based suicide prevention programmes: The SEYLE cluster-randomised, controlled trial. *The Lancet, 385,*1536-44.

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

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

School-Based Screening

School-based screening is a strategy that is designed to increase detection and promote help seeking among potentially suicidal youth. Given that the majority of young people spend a great deal of time at school, classroom or school wide approaches for identifying potentially suicidal adolescents have been increasingly recommended as important youth suicide prevention strategies.[140] [141] Most suicide screening strategies are brief, self-report tools that can be administered easily and efficiently. Those students who score in the high risk range are subsequently interviewed to get a more complete understanding of their level of risk.

A recent study found that two-thirds of students who were referred for follow up care after the implementation of a school-based screening program did access services at the one year follow up, lending support to the idea that school-based screening programs can be effective in identifying vulnerable youth and facilitating important linkages to mental health and other help giving services.[142]

It is also important to be aware of potential concerns and cautions regarding the use of screening programs, including the lack of clear evidence demonstrating a favourable effect,[143] potential for false positives, the concern about increased workload among school-based personnel,[144] the fluctuating nature of suicide risk and the lack of research on the use of these tools with racialized minority students.[145]

Additional Resources on School-Based Screening

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

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

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

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

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

School and Community Gatekeeper Training

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

Content of gatekeeper training programs usually include:

- Exploration of beliefs and values about suicide
- Dispelling myths about suicide
- Warning signs
- Engaging with a person at risk for suicide
- Risk assessment
- Safety planning
- Resource and referrals

Skills addressed in gatekeeper training programs usually include:

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

Gatekeeper training can lead to enhanced suicide-specific intervention skills for the majority of participants. Learning and retention of skills may be strengthened even further through the use of role plays, supportive feedback and other active learning strategies.[146]

In Aboriginal communities, there is some concern that standardized gatekeeper training models may not always be effective or culturally appropriate. More specifically, a recent controlled trial undertaken in a Canadian Indigenous context concluded that the gatekeeper training had no significant impact on intervention skills, confidence about intervening, or readiness to engage with a suicidal person.[147] Some have suggested that making cultural adaptations to standard gatekeeper training, including the promotion of storytelling as a tool for learning and joint action, may be a promising approach.[148]

Implementation Ideas and Tools

For detailed information on available community gatekeeper training opportunities, visit LivingWorks or QPR.

The *Ontario Centre of Excellence for Child and Youth Mental Health* has developed a number of resources for promoting mental health literacy, many of which could augment gatekeeper training efforts.

Additional Resources on School and Community Gatekeeper Training

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

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

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

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

Sareen, J., Isaak, C., Bolton, S. L., Enns, M. W., Elias, B., Deane, F., Katz, L. Y. (2013). Gatekeeper training for suicide prevention in First Nations community members: a randomized controlled trial. *Depression and Anxiety, 30,* 1021–1029.

Wexler, L., White, J. & Trainor, B. (2015). Why an alternative to suicide prevention gatekeeper training is needed for rural Indigenous communities: presenting an empowering community storytelling approach. *Critical Public Health, 25*(2), 205-217.

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

Physician/Hospital Staff Education

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

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

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

Physician Education

Many young people visit their primary care providers when they are in emotional distress. With ongoing education and skill development, primary care providers (PCPs) can make an important contribution to the overall youth suicide prevention effort through early identification, treatment of common mental health disorders, and through the provision of information, counselling, care coordination and referrals. [149] Evidence suggests that PCP's can increase their knowledge and improve their practices in the recognition and treatment of depression which can have an effect on overall suicide rates, although the specific effects on youth depression and suicide have not yet been established.[150] [151] Training efforts need to be repeated on a regular basis.

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

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

When faced with answers in the affirmative, PCPs were prompted to ask an additional set of follow up questions and probes regarding planning, preparation and attempts.[152]

Recommendations for enhancing physician education include:[153]

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

Training for Emergency Department Personnel

- Many suicidal youth show up at hospital emergency departments and further risks for suicidal behaviour can be reduced if parents/caregivers of these youth receive education on means restriction from trained hospital emergency department staff
- Careful training, support and supervision of ED staff can increase the likelihood that suicidal youth who attend ED will receive competent care, and be treated with compassion and non-judgmental support[154]

Implementation Ideas and Tools

The British Columbia Ministry of Health in partnership with the Centre for Applied Research in Mental Health and Addictions (CARMA) recently produced a series of resources to support suicide prevention activities, including *Working With the Suicidal Patient: A Guide for Health Care Professionals*

Suicide Prevention Toolkit for Rural Primary Care Providers

Primary Care Toolkit- Patient Management Tools

Additional Resources on Physician Education/Hospital Staff Education

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

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

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

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

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

Risk Assessment & Treatment

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

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

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

Recommended books

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

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

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

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

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

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

As part of a series of tools to support the ongoing work of youth suicide prevention in BC the Ministry of Children & Family Development recently produced *Practice Guidelines for Working With Children and Youth at Risk for Suicide in Community Mental Health Settings*

A podcast with Shawn Shea, M.D., author of “The Practical Art of Suicide Assessment”, hosted on the Social Work Podcast blog, discusses his *Chronological Assessment of Suicide Events (CASE)* approach. During the podcast, he explains why it is important to assess for suicidal content at different time points and emphasizes the difficult and sensitive nature of eliciting information on suicidal ideation and intent.

A summary of helpful suicide interventions for mental health professionals has been compiled by John Somers-Flanagan.

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

Therapeutic Alliance

Building a strong therapeutic alliance with the young person is one of *the* most important components of therapeutic work with suicidal clients. It is also an explicit expectation outlined in the Child and Youth Mental Health policy on suicide prevention, intervention and postvention. It is a stance or attitude that is characterized by warmth, trust, empathy and care and serves to instil hope in the client. For youth, who often drop out of treatment prematurely or do not follow through with formal treatment recommendations, developing a strong therapeutic alliance from the outset is critical.[155 156]

Developing an empathic connection by explicitly recognizing the level of pain and desperation the suicidal youth is experiencing is key to developing a strong alliance.[157]

Other key issues to address that can serve to strengthen the therapeutic alliance include[158]:

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

Personal and professional characteristics that can enhance the therapeutic relationship include flexibility, warmth, appropriate self-disclosure, empathy, sense of humour and maintenance of professional authority.[159]

Other specific strategies for enhancing the therapeutic alliance when working with youth include:[160 161]

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

For more information on cultivating a therapeutic alliance and “joining the patient” check out the Guidelines for Clinicians at the Aeschi Group

Recommended readings

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

Risk Assessment & Documentation

Suicide risk assessment represents the cornerstone of effective therapeutic work with suicidal youth. Several suicide risk assessment instruments, checklists and scales are available.[162] [163] It is important to note that some standardized scales can generate a high number of "false positives" and should never be used alone or as a substitute for a thorough clinical assessment. Many suicide risk assessment tools and processes have been developed for use with adult populations and may not always be appropriate for youth populations.

The best strategy is to develop a comprehensive, systematic, culturally informed, age appropriate, and collaborative approach to assessing suicide risk that considers empirically validated risk factors, incorporates clinical knowledge and judgment, and humanizes the whole process through warmth, empathy, connection, and other relational strategies.[164]

In order to work in a culturally responsive way, the young person's expectations regarding communication style should be actively elicited. Furthermore, assessing their comfort in disclosing personal information, uncovering beliefs about suicide and its causation, and understanding decision-making preferences are specific practices that can contribute to a stronger therapeutic relationship and reduce misunderstandings or cultural offense.[165]

Each young person carries multiple, intersecting and fluid cultural identities. At the same time, there are some unique challenges that some racialized and other non-dominant groups face as a result of their minority status, which are linked to suicide risks. Four cultural categories of suicide risk are important to consider when working with cultural and sexual minority groups: (1) cultural sanctions (i.e. acceptability of suicide), (2) idioms of distress (culturally meaningful ways of expressing distress), (3) minority stress (i.e. challenges associated with minority status), and (4) social discord (i.e. interpersonal conflict).[166]

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

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

Examples of quality suicide risk assessment approaches can be found at Practical Tools.

The purpose of a comprehensive suicide risk assessment is to estimate the risk for suicidal behaviour based on a careful weighing of the clinically relevant risk and protective factors. In recent years, there has been an increased emphasis placed on distinguishing between pervasive and enduring risk factors ("chronic") and more episodic and variable ("acute") risk factors in order to recognize the "fluid quality" of suicide risk and to be sensitized to issues of short-term vs. long-term risk.[167]

- Chronic risk factors tend to be static and enduring and create an overall vulnerability and susceptibility to suicide and suicidal behaviour (e.g. multiple suicide attempts, persistent maladaptive coping and cognitive styles)[168]
- Acute risk factors tend to be more episodic and variable and include triggering events, precipitants, suicide ideation and intent, and symptoms (e.g. depression, anxiety)[169]

Warning Signs

It is also important to consider the clinical and practical significance of specific warning signs for suicide. Warning signs tend to be concrete, observable and subjective (e.g. talking about suicide or noticeable changes in behaviour). Warning signs point to the potential for a heightened risk for suicide in the near term (i.e, within minutes, hours, or days). This is in contrast to acute or chronic risk factors which tend to be associated with suicide risk in the medium or longer term (i.e. days to weeks to years). [170]

Experts in the US have recently released an updated consensus statement regarding the warning signs for suicide among youth. They include:

- Talking about or making plans for suicide.
- Expressing hopelessness about the future.
- Displaying severe/overwhelming emotional pain or distress.
- Showing worrisome behavioral cues or marked changes in behavior, particularly in the presence of the warning signs above. Specifically, this includes significant:
  - Withdrawal from or changing in social connections/situation
  - Changes in sleep (increased or decreased)
  - Anger or hostility that seems out of character or out of context
  - Recent increased agitation or irritability

In general, as suicide intent and symptom severity escalates, the more elevated the risk for potential suicide and suicidal behaviour.[171] Youth who have a number of risk factors (e.g. depression and problematic substance use) and who have a previous history of suicidal behaviour and report having current and specific thoughts of suicide should be considered at high risk.

Most approaches to suicide risk assessment underscore the importance of systematically eliciting information across a number of key domains.[172 173 174]

- predisposing vulnerabilities (e.g. depression, substance use, previous history of suicidal behaviour)
- precipitating factors (e.g. conflict, breakup of relationship, health crisis)
- mental status, including affective, cognitive and behavioural states
- current level of suicidal thinking and planning (e.g. capability, desire, intention)[175]
- protective factors (or contraindications), (e.g. coping skills, hopeful attitude towards the future, strong social support)

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

One way to approach a comprehensive suicide risk assessment and to meet expected standards of care in this area is to use a series of anchoring questions as prompts, which taken together, can guide the systematic inquiry. At the same time, it is important to maintain an empathic, relational connection and avoid peppering young people with a barrage of questions or adopting a mechanistic, disengaged style. This way of organizing the assessment can also be adapted to provide the structure for clinical record-keeping. For example:

1. Is the young person a member of a group known to be at statistically elevated risk for suicide? (e.g. male, older adolescent, Aboriginal youth, person living with a mental illness, GLBTQ youth)
2. What are the relevant historical or predisposing factors that need to be taken into account? (e.g. previous history of suicidal behaviour, history of psychiatric diagnoses, family history of suicide, history of childhood maltreatment, cultural stress, historical trauma, structural violence)
3. What are some of the precipitating factors? (e.g. stressful life events, including violence, bullying, relationship breakup, conflict with a family member, failure, disciplinary crisis)
4. What are some of the warning signs of potential imminent risk? (e.g. thoughts of suicide, noticeable change in behaviour, anxiety/agitation, anger, social withdrawal, mood change, hopelessness)
5. What is the level of current suicidal thinking and planning? (e.g. duration, specificity and intensity of ideation, level of planning, access to means, behavioural rehearsal, suicidal desire, capability, intent)[176]
6. What are some specific protective factors (e.g. resilience, positive coping and problem solving skills, supportive family, relational connections and social support, plans for the future, willingness to ask for help, community networks of belonging and social connectedness)[177] [178]

Risk Assessment with Young Children

When assessing risk for suicide in *pre-pubertal children*, consider the following[179]:

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

Sample Questions to Ask Young Children about Suicide[180]:

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

Estimating Risk Levels

After a careful weighing of risk and protective factors, clinicians need to estimate the current level of suicide risk. The following categories are often used to conceptualize different risk zones: none, low, moderate, high or imminent.[181] The estimation of risk is both science and art and experienced clinicians recognize the importance of attending to the whole person, understanding suicide risk within a dynamic context and being thorough and persistent in eliciting specific information.

Six key cautions are worth noting[182]:

1. Just because a young person denies suicide ideation, the suicide risk assessment process should not come to an end.
2. When a young person has multiple, enduring risk factors that place them at high risk on an ongoing basis, it is important to carefully attend to the presence of specific warning signs which may signal imminent risk
3. The absence of a history of suicide attempts does not mean that the individual is not at risk.
4. The presence of only a few risk factors does not mean suicide can be ruled out.
5. Clinicians cannot dismiss high suicide risk when client reports no ideation.
6. The presence of protective factors does not serve to “cancel out” risk factors, especially when multiple imminent risk factors are present (frequent, intense ideation and strongly expressed intent to die).[183]

Treatment Plan

The treatment plan developed by the clinician needs to correspond to the estimated level of risk. At a minimum, a treatment plan needs to address the following, all of which should be documented in the clinical record:[184]

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

Documentation

Maintaining a clear record that documents the risk assessment, estimation of risk, approach to safety planning, treatment goals and clinical consultations is an important aspect of good clinical care. Documentation is important for the following reasons[185]:

1. To convey relevant information to other professionals
2. To serve as a quality assurance checklist
3. To provide protection against malpractice
4. Good clinical documentation rests on good clinical care
5. Even if good clinical care has been provided, if the documentation is poor, the risk for litigation rises

Despite the additional time involved in adequately documenting a suicide risk assessment, outpatient clinicians are strongly encouraged to document their suicide risk assessment and treatment plans as soon as possible following clinical evaluation of the child or youth.[186] Overly simplistic "yes/no" tickable boxes (i.e. Is the person suicidal?) and subjective rating scales (from 1 to 5) are generally poor substitutes for a thorough risk assessment and a step-by-step account of subsequent clinical judgment and planning.

In outpatient settings, documentation of suicide risk should be undertaken as follows[187]:

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

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

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

Screening Questions for Suicidal Thinking in Youth provides some helpful prompts for asking adolescents about potential suicidal thinking, developed by Dr. Tyler Black, a BC-based Child and Adolescent Psychiatrist.

The Behavioral Research and Therapy Clinics at the University of Washington provide a number of assessment tools and links to the scholarly literature on the assessment of suicide risk

The Collaborative Assessment and Management of Suicidality (CAMS) is a therapeutic framework for conceptualizing and managing suicide risk which places strong emphasis on actively engaging the suicidal person in the whole assessment process

Additional Resources on Risk Assessment

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

Chu, J., Floyd, R., Diep, H., Pardo, S., Goldblum, P. & Bongar, B. (2013). A tool for the culturally competent assessment of suicide: The cultural assessment of risk for suicide (CARS) measure. *Psychological Assessment, 25*(2), 424-434.

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

Linehan, M., Comtois, K. & Ward-Ciesielski, E. (2012). Assessing and managing risk with suicidal individuals. *Cognitive and Behavioral Practice, 19*, 218-232.

Ranahan, P. (2016). Protocols or principles? Re-imagining suicide risk assessment as an embedded, principle-based ongoing conversation in youth work practice. *Child & Youth Services, 0*(0), 1-19. doi: 10.1080/0145935X.2016.1158095

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

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

Rogers, J. & Russell, E. (2013). A framework for bridging cultural barriers in suicide risk assessment: The role of compatibility heuristics. *The Counselling Psychologist,* DOI: 10.1177/0011000012471823.

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

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

Crisis Response & Safety Planning

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

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

A helpful way of conceptualizing suicide and organizing initial responses to a person in a suicidal crisis[188] has been developed to support those who work with individuals in crisis. In this model, four characteristics of suicide are identified which, taken together, provide the practitioner with the mechanisms for building rapport, understanding the nature of the suicidal crisis and structuring the risk assessment process. Four characteristics of suicide are listed below.[189]

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

A seven stage model for effectively working through a crisis includes the following[190]:

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

While crisis intervention skills are foundational competencies for all child and youth mental health practitioners to possess, it is equally important to pay attention to the unique context of each individual young person when responding to suicidal crises. In other words, standardized, “one-size-fits-all” approaches can sometimes be experienced as de-humanizing and distancing by persons in distress. By focusing on the unique meaning of the crisis while at the same time upholding the standard of care for treating suicidal persons, clinicians are more likely to cultivate the trust that is required for ongoing therapeutic rapport.[191]

Safety planning is another important clinical tool.[192] Safety plans should be incorporated into the overall treatment plan based on the risk assessment process. A safety plan is different from a "no-suicide contract" because it offers a vehicle for negotiating the action to be taken by the suicidal person depending on his or her level of subjective distress and suicidality. Even though "no-suicide contracts" are often used in clinical practice, there is no evidence to support their efficacy as a deterrent to suicidal behaviour.

Some of the specific limitations of no-suicide contracts are summarized below[193] [194]:

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

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

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

Here is one example of a safety plan[195]:

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

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

Coping with Suicidal Thoughts is designed to assist individuals experiencing suicidal ideation and while it is written for adults, it offers a sample safety plan outline that could be adapted for youth.

Another resource *'Coping Statements for Suicidal Thoughts'* offers a list of helpful and hopeful alternatives to suicide from the Speaking of Suicide website.

Responding to Suicidal Risk provides guidelines, advice, and pitfalls to avoid when assessing and responding to suicide risk.

Treatment

Promising Psychosocial Treatments[1]

A review of the outcome-based psychotherapy research literature suggests that the therapeutic relationship is *the* most important ingredient in any therapeutic change effort. More specifically:[196]

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

Meanwhile, recent, systematic reviews of the literature on the treatment of youth suicidal behaviour suggest that due to methodological limitations, no one treatment approach can be said to be "well established".[197 198 199] Given the tremendous variation that exists among distressed adolescents, young people exhibit different responses to different treatment interventions. No one approach could ever be considered useful for all young people, across all cultures and contexts.[200] At the same time, a number of treatment approaches for addressing suicidality in youth have been identified as promising based on the existing evidence. These include dialectical behaviour therapy (DBT-A), collaborative assessment and treatment (CAMS), cognitive behaviour therapy (CBT), and other problem-solving approaches.[201 202 203]

Other promising treatment approaches with active skill-building and problem-solving components that include family-level interventions, have also been recommended.[204] These include interpersonal therapy (IPT), multi systemic family therapy (MST), and attachment based family therapy.[205 206 207] One example of an integrated model that combines elements of CBT, DBT and family therapy has been proposed for working with depressed and suicidal adolescents. It includes the following components:[208]

- Chain analysis of the index suicide attempt and the associated events
- Development of a safety plan and "hope kit"
- Collaborative agenda setting
- Exploration of therapy-interfering behaviours
- Skill building
- Relapse prevention
- Encourage family support, improve family problem-solving skills and communication

Additional Resources on Promising Psychosocial Treatments

Aeschi Group Movement for Improving the Therapeutic Approach to the Suicidal Person

Asarnow, J., Berk, M., Hughes, J. & Anderson, N. (2015). The SAFETY Program: A Treatment-Development Trial of a Cognitive-Behavioral Family Treatment for Adolescent Suicide Attempters, J*ournal of Clinical Child & Adolescent Psychology, 44*(1), 194-203.

[1] The material in this section is adapted from *Practice Guidelines for Working With Children and Youth at Risk for Suicide in Community Mental Health Settings*

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

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

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

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

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

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

Ougrin, D., Tranah, T., Stahl, D., Moran, P. & Asarnow, J. (2015). Therapeutic interventions for suicide attempts and self-harm in adolescents: Systematic review and meta-analysis. *Journal of the American Academy of Child & Adolescent Psychiatry, 54*(2), 97-107.

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

Muehlenkamp, J, Ertelt, T. & Azure, J. (2008). Treating outpatient suicidal adolescents: Guidelines from the empirical literature. *Journal of Mental Health Counseling, 30*(2), 105-120.

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

Indigenous Healing Practices

Many questions remain about whether western forms of therapy can be usefully adapted for particular cultural groups. [209] Given the nature of historical trauma faced by Indigenous peoples, therapeutic strategies that fail to engage with the broad social determinants of mental health and which obscure the sociopolitical and historical contexts of suffering, are bound to be limited. Further, child and youth mental health clinicians always need to be alert to the potential for their preferred therapeutic practices to be experienced as culturally unsafe for some groups.

No randomized controlled studies have been conducted to evaluate treatments for suicidal Aboriginal youth.[210] Therapeutic approaches to working with Aboriginal youth often represent an integrated blend of western approaches and Indigenous healing practices.[211] Several writers emphasize the importance of understanding Aboriginal worldviews and historical experiences when engaging in any healing practices with Indigenous peoples[212]. Such approaches go beyond therapeutic "techniques" and do not easily fit into models or frameworks that emphasize "evidence-based practices." When working with Indigenous peoples, a number of issues take on particular salience. These include: balance, connectedness, spirituality, connection with nature, ceremony and tradition.[213] Some Indigenous scholars have referred to this as 'culture-as – treatment.' [214] Participation in cultural healing practices has spiritual, political and pragmatic dimensions and can be conceptualized as a rejection of colonial relations of power and a re-valuing of Indigenous ways of life.

The First Nations Mental Wellness Continuum Framework is a national framework that identifies strategies for enhancing service provision and delivering culturally safe and effective services for First Nations in Canada

The National Aboriginal Health Organization's (NAHO) First Nations Centre has published a number of reports which describe the role of traditional knowledge in facilitating healing for First Nations people

The Thunderbird Partnership Foundation has a number of excellent resources for supporting strengths-based, culturally safe and comprehensive approaches to promoting Indigenous well-being across a broad continuum of care

Recommended Readings on Indigenous Healing Practices

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

Gone, J. (2013). Redressing First Nations historical trauma: Theorizing mechanisms for Indigenous culture as mental health treatment. *Transcultural Psychiatry,50*(5), 683-706.

Harder H., Holyk, T. Russell, V. & Klassen-Ross, T. (2015). Nges Siy (I love you): A community –based youth suicide intervention in northern British Columbia. Interna*tional Journal of Indigenous Health(10),* 2, 21-32.

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

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

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

Vukic, A., Gregory, D. Martin-Misener,R. & Etowa, J. (2011). Aboriginal and western conceptions of mental health and illness. *Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health* 9(1), 65-86.

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

Wexler, L. & Gone, J. (2012). Culturally responsive suicide prevention in Indigenous communities: Unexamined assumptions and new possibilities. *American Journal of Public Health, 102*(5), 800-806.

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

Parent/Family/Caregiver Involvement in Treatment

Several studies have demonstrated the important role of parental involvement, warmth, connection, listening and support in reducing risks for adolescent suicidal behaviour.[215] The success of any treatment with suicidal adolescents is heightened when parents/caregivers and other family members are actively enlisted to support the treatment goals. Acknowledging parents/caregivers as collaborative partners in the delivery of mental health care is an important guiding principle when working with youth at risk for suicide. [216] Parents/caregivers have a high need for particular kinds of support when dealing with a son or daughter who is thinking about suicide or engaging in self-harm.[217] Specifically, parents express a need for emotional support for themselves and their families, parenting information, especially parent-child communication, and general knowledge about managing self-harm.

Attachment based family therapy (ABFT) is a therapeutic intervention that is designed to strengthen adolescent-parent relationships and has been shown to be effective at reducing risks for depression and suicide. A strong emphasis is placed on building skills, awareness and insights among parents and adolescents.[218]

Other specific strategies for maximizing parent involvement include[219] [220]:

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

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

Recommended Reading

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

Byrne, S., Morgan, S., Fitzpatrick, C. et al. (2008). Deliberate self-harm in children and adolescents: A qualitative study exploring the needs of parents and carers. *Clinical Child Psychology and Psychiatry, 13*(4), 493-504.

Ewing, E. S., Diamond, G. & Levy, S. (2015). Attachment based family therapy for depressed and suicidal adolescents: Theory, clinical model and empirical support. *Attachment & Human Development, 17*(2),136-156.

Hooven, C. (2013). Parents-CARE: A suicide prevention program for parents of at-risk youth. *Journal of Child and Adolescent Psychiatric Nursing, 26,* 85-95.

The F.O.R.C.E Society for Kids Mental Health also has a number of useful guides and resources for parents.

Family and School Interventions for Youth at Risk

In recent years, there has been heightened attention paid to the unique needs of children of parents living with a mental illness.[221 222] Children of parents with depression are at heightened risk for depression and other mental health problems. Depression is a risk factor for suicide and suicidal behaviour. **Family focused** group interventions that target the offspring of parents with depression are designed to reduce risk factors, promote competencies and increase awareness of depression in family members. While the effect of these types of intervention on the specific outcome of suicide-related behaviour among youth is not entirely clear, they have been shown to be effective at reducing depressive symptoms among adolescents of parents with depression, which makes it a promising youth suicide prevention strategy to pursue.[223]

- Engaging with parents with depression, providing psycho-educational materials, teaching strategies for enhancing resilience in children, linking information to families' particular illness experience and providing long term support and follow up, represent a promising and comprehensive approach to reducing risks for depression among children and youth.[224]

Meanwhile, **school-based, indicated prevention programs** that target youth-at-risk have become more common. These approaches are based on enhancing social support and building skills. Rigorous program evaluations, several of which are based on strong experimental designs, have been conducted to assess the effectiveness of school based, indicated prevention programs for potential high school dropouts. Results indicate that brief, skill-based, social support enhancement interventions can be effective in reducing risks for suicide both immediately after the program, 10 weeks later and at nine month follow up.[225 226 227]

Implementation Ideas and Resources

The BC Ministries of Children and Family Development and of Health have produced a comprehensive manual that can guide the development and delivery of a community workshop on the topic of *Supporting Families with Parental Mental Illness*.

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

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

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

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

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

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

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

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

Pitman, E. & Matthey, S. (2004). The SMILES program: A group program for children with mentally ill parents or siblings. *American Journal of Orthopsychiatry, 74*(3), 383-388.

Continuity of Care

Engaging youth who are at risk for suicide can be particularly challenging for several reasons[228] [229]:

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

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

One promising strategy that has been shown to improve treatment linkages to community mental health services for suicidal youth who present at Emergency Departments is the Family Intervention for Suicide Prevention (FISP).[230] FISP consists of a brief youth and family crisis therapy session in the Emergency Department. The intervention involves several components including: helping youth to conceptualize their suicidality as a problem that requires action; educating families about the importance of community-based mental health services; keeping the home safe by restricting access to potential means (e.g. guns, pills); strengthening family support; developing a safety plan for managing future crises; and promoting a strengths-based approach that focuses on fostering safe coping skills and bolstering reasons for living.

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

- The Suicide Prevention Resource Center (SPRC) has produced a useful set of recommendations for enhancing continuity of care with a specific focus on the pivotal role of hospital emergency departments

- An Australian Educational Resource Booklet provides guidelines for effective responses to suicidal behaviours in an emergency setting

Means Restriction

Recent reviews of the evidence confirm that the presence of firearms in the home represents an independent risk factor for suicide among young people. Specifically, studies undertaken in the United States which compared youth suicide victims with community controls found that guns were four to five times more likely to be found in the homes of those who died by suicide, even after adjusting for confounding variables like psychopathology.[231] While in Canada, the relative risk of youth suicide as a result of firearms being kept in the home is less than the United States, it is still important to consider and strengthen opportunities to modify the environments of potentially high risk youth wherever possible.

- Findings from other countries also suggest that means restrictions efforts can have an important impact on reducing suicidal behaviour and suicide rates.[232] [233]
- These measures include reducing access to domestic gas, gun possession control efforts, reducing carbon monoxide emissions from vehicles, reducing the size of analgesics packages, installing bridge barriers and safer prescribing practices.

At a more practical level, teaching parents and adult caregivers of at risk, vulnerable youth about the importance of keeping their homes safe and limiting access to potential means of suicide is another specific strategy that holds promise. In one study, researchers were able to follow adult caretakers, whose children and youth (aged six to 19) had attended the Emergency Department (ED) in the previous two months for a mental health assessment, to determine if receiving means restriction education at the time of their ED visit made a difference in their future actions regarding limiting access to lethal means. Findings revealed that training in means restriction was significantly associated with new action to limit access to firearms, prescriptions and over-the-counter medications, but not alcohol.[234]

The Harvard School of Public Health has a useful website dedicated to the topic of means restriction

Postvention and Bereavement

In the field of suicide prevention, the term "postvention" has been coined to refer to those activities and processes that are undertaken *after* a suicide has taken place. When a young person dies by suicide, it has been suggested that at least three friends are significantly affected. [235]A coordinated and thoughtfully informed postvention response that is guided by the professional and empirical literature is designed to identify youth at potential risk, reduce risks for imitative suicidal behaviour and subsequent mental health problems, and facilitate healthy expressions of grief.

Current Knowledge about Postvention[236][237]

- Postvention strategies are directed at peer survivors of a youth suicide as they can be at heightened risk for psychological distress and imitative suicidal behaviours
- Current evidence regarding the effectiveness of postvention strategies is scarce
- A coordinated community response is an important part of an effective postvention response
- Tentative support exists for the effectiveness of post-suicide screening efforts in facilitating detection of those at potential risk
- Proximity to the person who died by suicide might not be the only factor to consider in determining potential risk for imitative suicidal behaviour, other factors include perceived similarities to the deceased – including age, gender and ethnicity[238]
- It is possible to identify and respond to youth at risk following an outbreak of suicides and suicidal behaviours through a standardized and systematic approach to detecting risk and by facilitating referrals for immediate crisis response

Implementation Ideas and Tools

headspace is an initiative of the Australian Government's, Youth Mental Health Initiative and they have produced the document *Suicide Postvention Toolkit: A Guide for Secondary Schools.*

The Connect Program provides a number of helpful resources for responding to those who have experienced a loss due to suicide.

Queensland Government of Australia has produced the document*, Principles for Providing Postvention Responses to Individuals, Families and Communities Following a Suicide Death*

Additional Resources on Postvention

Cox, G. et al. (2012). Suicide clusters in young people: Evidence for the effectiveness of postvention strategies. *Crisis, 33*(4), 208-214.

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

Understanding and Reducing Contagion

Contagion refers to the observed phenomenon of one person's suicide leading to other suicides, often referred to as imitative or "copy-cat suicides"[239 240]. In such cases, the initial suicide appears to have a triggering effect on some specific individuals, especially those who have pre-existing vulnerabilities, including for example, a history of suicidal behaviour, depression and those who have perceived similarities to the person who died.

Strategies for Minimizing Contagion

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

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

Reducing Risks for Contagion Through Social Media

In recent years there have been increased concerns about the potential for social networking sites like Facebook to contribute to suicide contagion. For example, after the death of a young person by suicide, social networking sites often become emotionally charged gathering sites for young people to express their thoughts, ideas and questions, raising concerns about the potential for these sites to inadvertently glamorize the person who died. There is also a concern that repeated and detailed online discussions about suicide can act as "natural advertisements" for suicide as a way of coping with emotional distress, especially among those youth who may already be vulnerable. Video sharing (e.g. Youtube) has also increased in popularity particularly among young people and there is a concern that repeated and explicit exposure to others' self-harming behaviours could normalize these behaviours and/or have a disinhibitory effort on some viewers, who may already be vulnerable. [241]

At the same time, there are also a number of ways that social networking sites can engage young people in very positive and life-affirming ways. A recent review of the literature on social media and suicide prevention suggests that social media can offer a number of specific, life-affirming benefits, including:[242]

- Reaches large numbers of otherwise hard-to-reach people
- Explicit expressions of suicidal ideation can enable others to intervene and hopefully prevent, a suicide
- Provides an anonymous, accessible and nonjudgmental forum for sharing experiences and for giving and receiving support

The National Suicide Prevention Lifeline has developed a comprehensive manual that provides specific guidelines for online postvention It includes suggestions for how to direct people who may be accessing the deceased's profile to helpful and trustworthy resources.

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

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

Additional Resources on Reducing Risks for Contagion Through Social Media

The International Association for Suicide Prevention has assembled a list of resources on the topic of suicide prevention and social media

Clinical Advisory Services Aeotearoa (CASA) New Zealand has also produced a helpful guide on *Social Media and Suicide Postvention*

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

Supporting Youth Survivors

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

Talking to Children About Suicide by Margo Requarth is a useful place to begin.

The SAVE 'What to tell Children' webpage can offer additional guidance on explaining suicide to young children or talking to children after a suicide death in the family.

The Centre for Addiction and Mental Health (CAMH) has produced some helpful tips for talking with children who have lost a parent to suicide.

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

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

Supporting Family Survivors

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

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

A booklet, entitled *Hope and Healing* which was published by the BC Ministry of Health in partnership with the Centre for Applied Research in Mental Health and Addictions (CARMA), offers practical suggestions to survivors and those who care about them.

.Lists of Canadian Survivor Support Groups are located at http://www.suicideprevention.ca/ or contact your local Mental Health Centre.

On-Line Bereavement Support and Additional Resources

The *Canadian Association for Suicide Prevention* (CASP) offers compassionate advice and resources to those who are grieving a loss due to suicide

The Alliance of Hope offers help and healing for those who have lost a loved one to suicide

Other helpful online resources for suicide survivors are provided through *Your Live Counts* and *Survivors of Suicide* and *Collateral Damage*

An online DVD documents the experiences of loss among those who have lost a loved one to suicide

The American Association of Suicidology has also published a Handbook for Survivors of Suicide

School and Community Protocols

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

- The BC Council for Families recently produced a helpful planning document that outlines a step-by-step guide for developing a postvention response plan entitled *Suicide Postvention is Prevention:A Proactive Planning Workbook for Communities Affected by Youth Suicide*

- Some School Districts have collaborated with Child and Youth Mental Health Services to develop specific protocols that will guide their actions in the aftermath of a youth suicide. Such protocols typically spell out the respective roles and responsibilities of schools and mental health centres when responding to the needs of students at risk for suicide and they include contact information for local resources. These protocols are best prepared in advance of any crisis.

The BC Ministry of Education has developed a document to guide responses in the aftermath of a sudden or unexpected death

Helpful guidelines for responding to crises in the schools have been developed by the UCLA School Mental Health Project

Media Education

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

- The Canadian Psychiatric Association recently produced *Media Guidelines for Reporting Suicide*
- The International Association of Suicide Prevention Task Force produced guidelines on *Suicide and the Media*
- Other media guidelines, based on the research literature have been compiled

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

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

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

See also the CDC Guidelines on suicide contagion and recommendations for reporting on suicide

Organizational & System-Level Interventions

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

Professional Development Training

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

Elements of competent and ethical care in the treatment of suicidal individuals include[243]:

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

- Recognizing and Responding to Suicide Risk (RRSR) is an advanced-level skill development workshop for mental health clinicians that is based on established core competencies for working with individuals at risk for suicide

- The SPSM Chat is a Twitter community of suicide prevention experts, persons with lived experience, and other communications professionals, who generate, curate and share information on suicide prevention using the hashtag #SPSM

- LivingWorks has developed a one day training session for clinical practitioners who will be working with suicidal clients on a longer term basis called suicide to Hope

- The Suicide Prevention Resource Center offers a range of online training opportunities

- A series of online webinars on the topic of suicide prevention are available from the Centre for Suicide Prevention

- An on-line course to become a "Suicide Intervention Specialist" is now available from QPR

- River of Life is an on-line suicide prevention curriculum aimed at preventing youth suicide among Aboriginal youth

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

Planning and Service Coordination

Some of the most promising prevention and treatment strategies for reducing risks for suicide among youth have been outlined in other sections. Simply having knowledge about "what works", no matter how strong or compelling the research evidence is, is not enough to lead to significant changes in suicide prevention and intervention practices.[244] Practice is influenced by much more than the possession of knowledge and thus strategies designed to support practitioners to practice in a more "evidence-based way" need to go beyond simplistic "knowledge transfer" efforts.[245] Active strategies that are designed to foster engagement, promote dialogue, encourage reflection, facilitate shared leadership and enable critique are recommended.[246]

Another important consideration for community planners is the understanding that youth suicide prevention cannot be seen as an exclusively "professional endeavour". To enable communities to "own" the issue of youth suicide prevention, opportunities also need to be created for youth, parents and concerned community citizens to get involved. Community participants need to be given the opportunity to actively engage with the youth suicide prevention agenda.[247] This means they must be provided with meaningful opportunities to participate in the emerging plans, which may include challenging and/or questioning the relevance and appropriateness of the suicide prevention program's goals and objectives.

The way that the problem of suicide is framed is also an important consideration. For example, an exclusive focus on individuals can often conceal from view some of the social, historical and political factors that contribute to elevated suicide risk. This is particularly significant when addressing suicide in Indigenous communities. As others have pointed out:[248]

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

Together to Live offers a number of excellent tools and resources to support a whole community approach to youth suicide prevention

The Action Alliance for Suicide Prevention also has a number of useful reports, links to resources, and program examples.

Mobilizing Local Knowledge and Coalition Building

Creating opportunities for input from a number of diverse perspectives is identified as an important strategy for building broad commitment to the issue of youth suicide prevention.[249] Some youth suicide prevention practices (e.g. media education, gatekeeper training, means restriction, etc.) are best addressed by a broad range of professionals and community members working together. Other youth suicide prevention efforts, like clinical assessment and treatment programs for example, are therapeutic services that are delivered by professional practitioners who have specialized knowledge, skills and interests. Not every component of the local youth suicide prevention effort requires the direct involvement of every individual or group with a vested interest.

In order to advance a *comprehensive* approach that recognizes that clinical services and treatment approaches are but one aspect of the overall youth suicide prevention effort, we need to find ways to creatively engage the broader community.[250] The view being promoted here is that community driven youth prevention plans will be more effective than "ready-made solutions" imported from outside if they:

- evolve out of a consideration of multiple knowledges and realities[251]
- reflect the interests of a range of professionals and community members who have respectfully engaged with one another through fair and equitable dialogue[252]
- recognize that young people have valuable insights, knowledge and wisdom

For ideas about how to initiate and sustain community wide prevention efforts in your community, check out the *Communities That Care* program material

The Canadian Mental Health Association has produced a useful *Toolkit on Community Mental Health Promotion*

Proactive Policies and Protocols

It is important to develop a locally coordinated, systematic service delivery response network that will ensure that youth at risk for suicide receive timely assessments, effective care, efficient follow up and careful monitoring.[253] Many communities have opted to develop proactive protocols and policies that spell out the respective functions and responsibilities of each service delivery agency. Partners that are most commonly included are hospital emergency departments, community-based mental health centres, schools, police, crisis response programs and child protection offices.

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

For example see these guidelines on developing organizational policies and protocols for responding to suicidal behaviour

The JED Foundation which is dedicated to reducing suicide on college campuses has also developed several resources and institutional protocols

Research and Evaluation

Communities are advised to monitor the effects of their local prevention program efforts by setting clear and realistic goals, identifying indicators of progress[254], and carefully monitoring processes (e.g. referral rates, help-seeking, level of youth participation) and outcomes (suicide attempts and deaths).[255] Quantitative measures (e.g. percent of trained gatekeepers who correctly identify the level of suicide risk in a simulated interview) and qualitative measures (e.g. young people's description of their experience receiving professional mental health services) are both important to monitor.

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

The Suicide Prevention Resource Center has a number of excellent materials including, toolkits, practical advice and educational resources for evaluating community-based suicide prevention programs.

An interactive guide for thinking about how to use and understand evidence to prevent community violence has been developed by the CDC. It is highly relevant for community based suicide prevention planning and evaluation activities.

Indigenous Research Approaches

Several excellent resources have been produced which draw on Indigenous ways of knowing when conceptualizing and conducting research and evaluation. A key question to ask is:

- How does your program work to decolonize the lives and lived spaces of Indigenous children, youth, families and communities?

Other recommended books include:

Tuhiwai Smith, L. (2012). *Decolonizing methodology: Research and Indigenous peoples* (2nd Ed.). New York: Zed Books.

Wilson, S. (2008). Res*earch is ceremony: Indigenous research methods*. Halifax: Fernwood Publishing.

Sociopolitical Interventions

Policy and practice interventions that are aimed at recognizing and transforming the macro-level social conditions that contribute to inequities and oppression are key to any prevention effort. Anti-racism, critical consciousness, de-colonization, youth activism and social change movements are interrelated efforts that together, speak to the growing recognition across a number of sectors that there can be no mental health without social justice. [256] [257]

"levels of mental distress among communities need to be understood less in terms of individual pathology and more as a response to relative deprivation and social injustice… both health-damaging behaviours and violence, for example, may be survival strategies in the face of multiple problems, anger and despair related to occupational insecurity, poverty, debt, poor housing, exclusion and other indicators of low status"[258]

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

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

Several high-level priorities for promoting social justice and mental health have been identified and include:[259]

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

Additional Resources on Social Justice, Advocacy and De-Colonizing Practices

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

Battiste, M. (2013), *Decolonizing education: Nourishing the learning spirit.* Saskatoon, SK: Purich Publishing Ltd.

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

Morisillo, J. & Prilleltensky, I. (2006). Social actions with youth: Interventions, evaluation and psychopolitical validity. *Journal of Community Psychology, 35*(6), 725-740.

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

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

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

Cultural pathways to decolonization by Bill Mussell

WHO Report on Mental health, resilience and social inequities

Unique Challenges

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

Rural and Remote Practice

Providing clinical services in rural settings can be both challenging and rewarding.[260] [261] On one hand, isolated practitioners have very few, if any, local referral agencies and alternative professionals for providing client care. Rural practitioners often wear many hats. Other specific challenges include:

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

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

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

Cultural Safety and Diversity Competency

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

Providing therapeutic care that is "culturally safe" is an additional component for effective practice.[262] [263] Where the cultural safety approach departs from the traditional cultural competency model is in its analysis of existing institutional power relations that serve to perpetuate inequities.[264] In this way, it resembles a decolonizing approach to practice. By inviting practitioners to reflect on the ways in which their *own* cultural identities, worldviews and assumptions impact on the therapeutic relationship, the traditional emphasis on understanding the unique cultural characteristics of the "exotic other" gives way to a more critically conscious, self-reflective stance that includes a consideration of structure, individual agency and power.

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

Summary of Cultural Safety

- Involves actions that recognize, respect and nurture clients' unique cultural identities and safely meets their needs, expectations and rights[265]
- Enables safe service to be defined by those receiving the service[266]
- Moves beyond cultural awareness and sensitivity to address structural factors that perpetuate inequities and disadvantage
- Requires high levels of clinician self-awareness and critical self-reflection

Recommended Readings on Cultural Safety and Diversity Competency

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

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

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

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

Ethical and Legal Considerations

Confidentiality

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

Other exceptions to confidentiality include[267]:

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

Ontario's and British Columbia's information and privacy commissioners recently produced a *Practice Tool For Exercising Discretion: Emergency Disclosure of Personal Information by Universities, Colleges and Other Educational Institutions* to support decision making in situations where individuals may be at risk of suicide. A quote from this document makes our ethical and legal responsibility unambiguously clear, "… life trumps privacy, and our laws reflect that reality".

The Canadian Mental Health Association- BC Division has recently released *Information Sharing in the Context of Child and Youth Mental Health and Substance Use in BC*, a resource on best practice approaches when sharing information in child and youth mental health and/or substance use contexts.

Informed Consent

Thoroughly informing children and youth and their parents/caregivers about the treatment process is an ethical and legal requirement. Taking time "up-front" to explicitly outline the treatment process, including limits to confidentiality, the rationale for treatment including any risks or benefits, as well as treatment alternatives, is an essential element of providing competent clinical care.[268]

A recent article revisits the topic of informed consent with suicidal children and youth and includes a number of helpful recommendations, including[269]:

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

When working with younger children, we have an ethical obligation to treat children with dignity and respect which means providing them with as much information as they are deemed capable of absorbing. This has been referred to elsewhere as "assent" to treatment (instead of consent).[270]

Elements of Informed Consent[271]

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

Protection from Harm

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

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

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

See the *Mental Health Act in BC* or the *Guide to the Mental Health Act* for more information

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

When a Client Dies by Suicide

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

Common Reactions to Losing a Client to Suicide

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

The Clinician Survivor Task Force of the American Association of Suicidology (AAS) has a useful section of their website dedicated to supporting therapists who have lost a client to suicide.

See also *Guidelines to Assist Clinical Staff After the Suicide of a Patient*

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

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

Practical Tools

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

1. recognizing suicide risk
2. assessing suicide risk
3. responding to suicide risk and deaths
4. developing a comprehensive approach to suicide prevention

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

Tools to Support Recognition of Suicide Risk

The warning signs of youth suicide have recently been updated to reflect the empirical literature

Responding to People at Risk For Suicide: How Can You and Your Organization Help? is a practical guide to promote awareness of the warning signs of suicide and how to help produced by the Queensland Government (Australia).

Tools to Support Assessment of Suicide Risk

Assessment of Suicide and Risk Inventory is a comprehensive tool designed to document suicide risk developed by Dr. Tyler Black

Tool for the Assessment of Suicide Risk in Adolescents (TASR-Am) is a tool developed by Dr. Stan Kutcher to assist clinicians in their assessment and documentation of the most common risk factors associated with youth suicide .

Suicide Risk Assessment: A Resource for Health Care Organizations is a comprehensive guide that is designed to help Canadian health care organizations with understanding and standardizing the practice of high-quality suicide risk assessment

The *Suicide Assessment Five-step Evaluation and Triage (SAFE-T)* is a helpful pocket card that guides clinicians through the process of suicide risk assessment through the use of five key steps.

The Suicide Risk Assessment and Management Protocol: Emergency Department was developed in Australia in recognition of the important role played by hospital emergency departments in the management and treatment of suicidal individuals.

Working With the Suicidal Patient: A Guide for Health Care Professionals is a useful step-by-step guide for assessing and managing suicidal behaviour in adults. It was designed for health care providers, including those that may be working in an acute care/emergency setting. While it was developed for use with adults, it provides relevant guidelines for youth and emphasizes family involvement in safety plan and intervention.

University of Washington Risk Assessment Protocol (UWRAP) is a comprehensive approach for assessing and managing suicide risk. It offers a step-by-step approach for evaluating suicidality and provides guidance to assessors on how to respond to suicide risk

Linehan Risk Assessment and Management Protocol (LRAMP) is a treatment form for clinicians to complete. It was designed for adult clients but could be adapted for youth populations.

Tools to Support Organizational Responses to Suicidal Behaviours

Principles for Developing Organizational Policies and Protocols for Responding to Clients at Risk of Suicide and Self Harm is a practical tool developed by the Queensland Government (Australia) to support the development of proactive organizational policies for responding to clients at risk for self-harm.

Practice Tool for Exercising Discretion: Emergency Disclosure of Personal Information was recently produced by the Office of the Information and Privacy Commissioner of BC to support decision making when working with individuals at risk for suicide.

Tools to Support Responses After a Suicide

The Hope and Healing Booklet is a practical guide for supporting survivors of a loved one's suicide in BC

The Lifeline Online Postvention Manual provides guidelines for reducing contagion and constructively responding to a suicide death through social networking sites

After a Suicide: A Toolkit for Schools was developed to provide direction and guidance to schools and communities following the suicide death of a community member

Suicide Postvention Toolkit: A Guide for Secondary Schools is an Australian resource. It offers guidance to secondary schools who have experienced a suicide death, with an emphasis on addressing immediate needs and building capacity in the longer term

Clinical Advisory Services Aeotearoa (CASA) New Zealand has produced a helpful guide called *Social Media and Suicide Postvention* which includes several specific online strategies for reducing risks for contagion and promoting healthy recovery following a suicide death

Principles for Providing Postvention Responses to Individuals, Families and Communities Following a Suicide Death was produced by the Queensland Government of Australia and offers short and long term strategies for responding to a suicide death.

Tools to Support the Development of a Comprehensive Approach to Suicide Prevention

The BC First Nations Health Authority recently produced a user -friendly toolkit for preventing and responding to suicide in First Nations communities. Hope, Help and Healing is grounded in an Indigenous perspective on wellness.

Oregon Health Authority produced a Youth Suicide Prevention and Intervention Plan: 2016-2020.

Best Practices in School-based Youth Suicide Prevention: A Comprehensive Approach was developed by Healthy Child Manitoba to support school administrators develop a comprehensive approach to suicide prevention in the schools.

Coming Together to Care: A Suicide Prevention and Postvention Toolkit for Texas Communities provides a number of planning tips and resources that could be adapted for other communities

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

References

[1] Silverman, M., Berman, A., Sanddal, N., O'Carroll, P. & Joiner, T. (2007). Re-building the tower of babel: A revised nomenclature for the study of suicide and suicidal behaviors. *Suicide and Life Threatening Behavior, 37*(3), 248-263.

[2] DeLeo, D., Burgis, S., Bertolote, J., Kerkhof, A., & Bille-Brahe, U. (2006). Definitions of suicidal behavior: Lessons learned from the WHO/EURO Multicentre Study, *Crisis, 27*(1), 4-15.

[3] Klonsky, E. & Muehlenkamp, J. (2007). Self-injury: A research review for the practitioner. *Journal of Clinical Psychology, 63*(11), 1045-1056.

[4] Ougrin, D., Tranah, T., Stahl, D., Moran, P. & Asarnow, J. (2015). Therapeutic interventions for suicide attempts and self-harm in adolescents: Systematic review and meta-analysis*. Journal of the American Academy of Child and Adolescent Psychiatry, 54(*2), 97-102.

[5] Kutcher, S. &Szumilas, J. (2008). Youth suicide. *Canadian Medical Association Journal, 178*(3), 282-284.

[6]Kirmayer, L., Brass, G., Holton, T., Paul, K. Simpson, C. & Tait, C. (2007). *Suicide among Aboriginal people in Canada.* Ottawa, ON: Aboriginal Healing Foundation.

[7] First Nations, Inuit and Métis Health Committee, Canadian Paediatric Society (2011). Preventing unintentional injuries in Indigenous children and youth in Canada. *Canadian Pediatric Society*.

[8] Kirmayer, L. , Brass, G., Holton, T., Paul, K. Simposon, C. & Tait, C. (2007). Suicide among Aboriginal people in Canada. Ottawa, ON: Aboriginal Healing Foundation.

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

[10] Marshal, M. et al. (2011). Suicidality and depression disparities between sexual minority and heterosexual youth: A meta-analytic review. *Journal of Adolescent Health, 49*, 115-123.

[11] Hong, J., Espelage, D. & Kral, M. (2011). Understanding suicide among sexual minority youth in America: An ecological systems analysis. *Journal of Adolescence, 34*(5), 885-894.

[12] Russell, S. (2005). Beyond risk: Resilience in the lives of sexual minority youth. *Journal of Gay & Lesbian Issues in Education, 2*(3), 5-18.

[13] Cover, R. (2012). *Queer youth suicide, culture and identity: Unliveable lives?* Surrey, UK: Ashgate.

[14] Hallett, D., Chandler, M. & Lalonde, C. (2007). Aboriginal language knowledge and youth suicide. *Cognitive Development, 22*, 392-399.

[15] Nock, M., Green, J., Hwang, I., McLaughlin, K., Sampson, N., Zaslavsky, A. & Kessler, R. (2013). Prevalence, correlates and treatment of lifetime suicidal behavior among adolescents: Results from the national comorbidity survey replication adolescent supplement. *JAMA Psychiatry,* E1-E11, Advance online publication. doi:10.1001/2013.jamapsychiatry.55

[16] Smith, A., Stewart, D., Poon, C., Peled, M., Saewyc, E., & McCreary Centre Society (2014). *From Hastings Street to Haida Gwaii: Provincial results of the 2013 BC Adolescent Health Survey*. Vancouver, BC: McCreary Centre Society.

[17] Cloutier, P., Martin, J., Kennedy, A., Nixon, M & Muehlenkamp. J. (2010). Characteristics and co-occurrences of adolescent non-suicidal self-injury and suicidal behaviours in pediatric emergency crisis services. *Journal of Youth and Adolescence, 39*, 259-269.

[18] Smith, A., Stewart, D., Poon, C., Peled, M., Saewyc, E., & McCreary Centre Society (2014).

[19] Evans, Hawton & Rodham, (2004). Factors associated with suicidal phenomena in adolescents: A systematic review of population based studies. *Clinical Psychology Review, 24*, 957-979.

[20] King, C. & Merchant, C. (2008). Social and interpersonal factors relating to adolescent suicidality: A review of the literature. *Archives of Suicide Research, 12*, 181-196.
[21] Bridge, J., Goldstein, T. & Brent, D. (2006). Adolescent suicide and suicidal behavior. *Journal of Child Psychology and Psychiatry, 47(*3), 372-394.
[22] Steele, M. & Doey, T., (2007a). Suicidal behaviour in children and adolescents. Part 1: Etiology and risk factors. Canadian Journal of Psychiatry, 52, 21S-33S.
[23] Spirito, A. & Esposito-Smythers, C. (2006). Attempted and completed suicide in adolescence. *Annual Review of Clinical Psychology, 2*, 237-266.
[24] Esposito-Smythers, C., Walsh, A., Spirito, A., Rizzo, C., Goldston, D., & Kaminer, Y. (2012). Working with the suicidal client who also abuses substances. *Cognitive and Behavioral Practice, 19*, 245-255.

[25] Nock, M. et al (2013).
[26] Nock, M. et al. (2013)
[27] Hawton, K., Saunders, K. & O'Connor, R. (2012). Self-harm and suicide in adolescents. *Lancet, 379,* 2373-2382.
[28] Dube, S., Anda, R.,Felitti, V. et al. (2001). Childhood abuse, household dysfunction, and the risk of attempted suicide throughout the lifespan. *Journal of the American Medical Association, 286*(24), 3089-3096.
[29] Swanson, S. & Colman, I. (2013). Association between exposure to suicide and suicidality outcomes in youth. *Canadian Medical Association Journal, 185*(10), 870-877. doi: 10.1503 /cmaj.121377

[30] Gould, M., Jamieson, P. & Romer, D. (2003). Media contagion and suicide among the young. American Behavioral Scientist, 46, 1269-1284.
[31] Royal Commission on Aboriginal Peoples (RCAP). (1995). *Choosing life: Special report on suicide among Aboriginal people*. Ottawa: Canadian Government Publishing.
[32] Isaak,, C. et al. (2010). Community-based suicide prevention research in remote on-reserve first nations communities. *International Journal of Mental Health and Addictions, 8*, 258-270.
[33] Myer, I. (2003). Prejudice, social stress and mental health in lesbian, gay and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin, 129*(5), 674-697.
[34] Marshal, M. et al. (2011). Suidality and depression disparities between sexual minority and heterosexual youth: A meta-analytic review. *Journal of Adolescent Health, 49*, , 115-123.
[35] Russell (2005)
[36] Haines, K. & Case, S. (2008). The rhetoric and reality of the 'risk factor prevention paradigm' approach to preventing and reducing young offending. *Youth Justice, 8*, 5-20.
[37] France, A., Freiburg, K. & Homel, R. (2010). Beyond risk factors: Towards a holistic prevention paradigm for children and young people. *British Journal of Social Work, 40*, 1192-1210.
[38] Russell, S. (2005).
[39] McPherson, C. & McGibbon, E. (2010). Addressing the determinants of child mental health: Intersectionality as a guide to primary health renewal. *Canadian Journal of Nursing Research, 42*(3), 50-64.
[40] Hong, et al. (2011)
[41] Weaver, J. & Munro, D. (2013). Austerity, neo-liberal economics, and youth suicide: The case of New Zealand, 1980-2000. *Journal of Social History, 46*(3),757-783.
[42] Alcantara, C. & Gone, J. (2007). Reviewing suicide in Native American communities: Situating risk and protective factors within a transactional-ecological framework. *Death Studies, 31*, 457-477.

[43] Hjelmeland, H., Dieserud, G., Dyregrov, K., Knizek, B. L., & Leenaars, A. A. (2012). Psychological autopsy studies as diagnostic tools: Are they methodologically flawed? *Death Studies, 36*, 605-626.

[44] MacNeil, M., (2008). An epidemiologic study of Aboriginal adolescent risk in Canada: The meaning of suicide. *Journal of Child and Adolescent Psychiatric Nursing, 21*(1), 3-12.
[45] Scourfield, J., Roen & McDermott, (2008). Lesbian, gay, bisexual and transgender young people's experiences of distress: Resilience, ambivalence ad self-destructive behaviour. *Health and Social Care in the Community, 16*(3), 329-336.
[46] Poon, C. & Saewyc, G., (2009). Out yonder: Sexual minority adolescents in rural communities in BC. *American Journal of Public Health, 99*(1), 118-124.
[47] Hawkins, D., Shapiro, V. & Fagan, A. (2010). Disseminating effective community prevention practices: Opportunities for social work education. *Research on Social Work Practice, 20*(5), 518-527.
[48] Gutierrez, P., (2006). Integratively assessing risk and protective factors for adolescent suicide. *Suicide and Life Threatening Behavior, 36*(2) 129-135.
[49] Fiske, H. (2008). *Hope in action: Solution focused conversations about suicide*. New York: Routledge.
[50] Reynolds, V. (2011). Hate kills. Suicide prevention as justice doing. Keynote address at the Canadian Association for Suicide Prevention (CASP) Conference. Vancouver: BC.
[51] Alcantara & Gone (2008)
[52] Russell, S. (2005).
[53] Prilleltensky, I. & Prilleltensky, O. (2006). *Promoting well-being: Linking personal, organizational and community change*. Hoboken, NJ: John Wiley & Sons, Inc.
[54] Fleming, J. & Ledogar, R. (2008). Resilience, an evolving concept: A review of literature relevant to Aboriginal research. *PImatisawin: A Journal of Aboriginal and Indigenous Community Health,6(*2) 7-23.
[55] Raphael, D. (2009). *Social determinants of health.* Toronto: Canadian Scholars Press.
[56] Raphael, D. (2014). Social determinants of children's health in Canada: Analysis and implications. *International Journal of Child, Youth & Family Studies, 5*(2), 220-239.

[57] McPherson & McGibbon (2010)
[58] Farmer, P. (2005). *Pathologies of power: Health, human rights, and the new war on the poor.* Berkeley, CA: University of California.
[59] Prilleltensky, I. & Prilleltensky, O. (2006).
[60] Joiner, T., Kalafat, J., Draper, J., Stokes, H., Knudson, M., Berman, A. & McKeon, R. (2007). Establishing standards for the assessment of suicide risk among callers to the national suicide prevention lifeline. *Suicide and Life Threatening Behavior, 37*(3), 353-365.
[61] Raphael (2009)
[62] Rutter, M., (2007). Psychopathological development across adolescence. *Journal of Youth and Adolescence, 36*-101-110.
[63] Steele & Doey, (2007a)
[64] Rutter (2007)
[65] Alacantra & Gone (2008)
[66] Daniel, S. & Goldston, D., (2009). Interventions for suicidal youth: A review of the literature and developmental considerations. *Suicide and Life Threatening Behavior, 39*(3), 252-268.
[67] Hallett, D., Chandler, M. & Lalonde, C. (2007) . Aboriginal language knowledge and youth suicide. *Cognitive Development, 22,* 392-399.
[68] Kirmayer, L. , Brass, G., Holton, T., Paul, K. Simposon, C. & Tait, C. (2007). Suicide among Aboriginal people in Canada. Ottawa, ON: Aboriginal Healing Foundation.
[69] Rutter, (2007)
[70] Barrio, C., (2007). Assessing suicide risk in children: Guidelines for developmentally appropriate interviewing. *Journal of Mental Health Counseling, 29*(1), 50-66.

---

[71] Mishara, B., (1999). Conceptions of death and suicide in children 6-12 and their implications for suicide prevention. *Suicide and Life-Threatening Behavior, 29*, 105-118.
[72] Steele & Doey, (2007a)
[73] Barrio, C., (2007). Assessing suicide risk in children: Guidelines for developmentally appropriate interviewing. *Journal of Mental Health Counseling, 29*(1), 50-66.
[74] Mignone & O'Neil (2005)
[75] Alacantra & Gone, (2008)
[76] Marsh, I. (2010). *Suicide: Foucault, history and truth.* Cambridge: Cambridge University Press.
[77] Smye, V. & Browne, A., (2002). Cultural safety and the analysis of health policy affecting Aboriginal people. *Nurse Researcher, 9*(3), 42-56.
[78] Kirmayer, L. MacDonald & Brass, G. (2001)
[79] White, J., (2007). Knowing, doing and being: A praxis-oriented approach to child and youth care. *Child and Youth Care Forum, 36*(5/6), 225-244.
[80] Alacantra & Gone, (2008)
[81] Baber, K. & Bean, G., (2009). Frameworks: A community based approach to preventing youth suicide. *Journal of Community Psychology, 37*(6), 684-696.
[82] Berman, A., Jobes, D. & Silverman, M., (2006). *Adolescent suicide: Assessment and intervention* (2nd ed.). Washington, DC: American Psychological Association.
[83] White, J., (2005). *Preventing youth suicide: Taking action with imperfect knowledge.* Vancouver, BC. Mental Health Evaluation and Community Consultation Unit.
[84] Macgowan, M., (2004). Psychosocial treatment of youth suicide: A systematic review of the research. *Research on Social Work Practice, 14*(3), 147-162.
[85] Steele, M. & Doey, T., (2007b). Suicidal behaviour in children and adolescents. Part 2: Treatment and prevention. *Canadian Journal of Psychiatry, 52*,35S-45S.
[86] Gould, M., Greenberg, T., Velting, D. & Shaffer, D., (2003). Youth suicide risk and preventive interventions: A review of the past 10 years. *Journal of the American Academy of Child and Adolescent Psychiatry, 42,* 386-405.
[87] Ungar, M., (2008). Putting resilience theory into action: Five principles for intervention. In L. Liebenberg & M. Ungar (Eds.), *Resilience in action* (pp. 17-35). Toronto, ON: University of Toronto Press.
[88] Fleming, J. & Ledogar, R. (2008). Resilience, an evolving concept: A review of literature relevant to Aboriginal research. *PImatisawin: A Journal of Aboriginal and Indigenous Community Health,6(*2) 7-23.
[89] Kirmayer, L. et al. (2009). Community resilience: Models, metaphors and measures. *Journal of Aboriginal Health,* 62-117.
[90] Kirmayer, L. et al. (2012). Toward an ecology of stories: Indigenous perspectives. In M. Ungar (Ed.). The social ecology of resilience: A handbook of theory and practice (pp.399- 414). New York: Springer.
[91] Catalano, R., Berglund, M., Ryan, J., Lonczak, H. & Hawkins, D., (2002). Positive youth development in the United States: Research studies on evaluations of positive youth development programs. *Prevention & Treatment* (5), 15.
[92] Sancassiani, F. et al. (2015). Enhancing the emotional and social skills of the youth to promote their well-being and positive development: A systematic review of universal school-based randomized controlled trials. *Clinical Practice and Epidemiology in Mental Health, 11*, 21-40.
[93] Lerner, R. & Thompson, L., (2002). Promoting healthy adolescent behavior and development: Issues in the design and evaluation of effective youth programs. *Journal of Pediatric Nursing, 17*(5), 338-344.
[94] Vo, D. & Park, J., (2009). Helping young men thrive: Positive youth development and men's health. *American Journal of Men's Health, 3(*4), 352-359.

[95] Lerner, J. V., Phelps, E., Forman, Y. & Bowers, E. P., (2009). Positive youth development. In R. M. Lerner & L. Steinberg (Eds.), *Handbook of adolescent psychology* (3rd ed., Vol. 1,pp. 524-557). Hoboken, NJ: Wiley.
[96] Ginwright, S. & Cammatota (2002). New terrain for youth development: The promise of a social justice approach. *Social Justice, 29*(4), 82-95.
[97] Kenyon, D & Hanson, J. (2012). Incorporating traditional culture into positive youth development programs with American Indian/Alaska Native youth. *Child Development Perspectives, 6*(3), 272-279.
[98] Howard, C. (2010). Suicide and Aboriginal youth: Cultural considerations in understanding positive youth development. *Native Social Work, 7,* 163-180.
[99] Sadowski, C. & Kelley, M., (1993). Social problem solving in suicidal adolescents. *Journal of Consulting and Clinical Psychology, 61,* 121-127.
[100] Fitzpatrick, K., Witte, T. & Schmidt, N., (2005). Randomized controlled trial of a brief problem-orientation for suicidal ideation. *Behaviour Therapy, 36*(4), 323-333.
[101] Wesley-Esquimaux, C. & Snowball, A. (2010.). Viewing violence, mental health and addictions through a wise practice lens. *International Journal of Mental Health and Addiction, 8,* 390-407.
[102] Crooks, C., Chiodo, D., Thomas, D., & Hughes, R. (2010).Strengths-based programming for First Nations youth in schools: Building engagement through healthy relationships and leadership skills. *International Journal of Mental Health and Addictions, 8,* 160-173.
[103] Wexler, L., Gubrium, A., Griffin, M. & DiFulvio, G. (2013). Promoting positive youth development and highlighting reasons for living in Northwest Alaska through digital storytelling. *Health Promotion Practice, 14*, 617-623.
[104] Wilcox, H., Kellam, S., Brown, H., Poduska, J., Wang, W., & Anthony, J., (2008). The impact of two universal randomized first- and second-grade classroom interventions on young adult suicide ideation and attempts. *Drug and Alcohol Dependence, 95* (Suppl 1), S60-S73.
[105] O'Donoghue, J., Kirshner, B. & McLaughlin, M. (2002). Introduction: Moving youth participation forward. *New Directions for Youth Development, 96,* 15-24.
[106] Centres of Excellence for Children's Well-Being. What is youth engagement? Retrieved from http://www.engagementcentre.ca/files/Whatis_WEB_e.pdf

[107] Gurstein, P., Lovato, C., Ross, S. (2003). Youth participation in planning: Strategies for social action. Canadian *Journal of Urban Research, 12*(2), 249-274.
[108] Armstrong, L. & Manion, I. (2015). Meaningful youth engagement as a protective factor for youth suicidal ideation. *Journal of Research on Adolescence, 25*(1). 20-27.
[109] Ramey, H. et al (2010). Youth engagement and suicide risk: Testing a mediated model in a Canadian community sample. *Journal of Youth & Adolescence, 39,* 243-258.
[110] Ginwright , S. & James, T. (2002). From assets to agents of change: Social justice, organizing and youth development. *New Directions for Youth Development, 96*, 27-46.
[111] Toumbourou, J. & Gregg, E., (2002). Impact of empowerment-based parent education program on the reduction of youth suicide risk factors. *Journal of Adolescent Health, 31*, 277-285.
[112] Hooven, C. (2013). Parents-CARE: A suicide prevention program for parents of at-risk youth. *Journal of Child and Adolescent Psychiatric Nursing, 26,* 85-95.

[113] Kumpfer K. & Aldarondo, R. (2003). Family-strengthening approaches for the prevention of youth problem behaviors. *American Psychologist, 58*(6), 457-465.
[114] Kumpfer & Aldarondo (2003).
[115] Mussell, B., Cardiff, K. & White, J., (2004). *The mental health and well-being of Aboriginal children and youth: Guidance for new approaches and services.* Chiliwack, BC: Sal 'i' shan Institute.
[116] Ball, J. (2005). Hook and hub: Coordinating programs to support Indigenous children's early learning and development. Paper presented at the World Indigenous Peoples Conference

on Education, Aotearoa/NewZealand. Retrieved from http://www.ecdip.org/docs/pdf/WIPCE%20Hook%20and%20Hub.pdf

[117] Thapa, A., et al. (2013). A review of school climate research. *Review of Educational Research, 83*(3), 357-385.

[118] Saewyc, E., et al. (2014). School-based strategies to reduce suicidal ideation, suicide attempts, and discrimination among sexual minority and heterosexual adolescents in Western Canada. *International Journal of Child, Youth & Family Studies, 5(*1), 89-112.

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

[120] Elias & Weissberg, (2000)

[121] Weist, M. (2005). Fulfilling the promise of school-based mental health: Moving toward a public mental health promotion approach. *Journal of Abnormal Child Psychology, 33*(6), 735-741.

[122] Knox, K. Litts, D., Talcott, G., Catalano, J. & Caine, E., (2003). Risk of suicide and related adverse outcomes after exposure to a suicide prevention programme in the US air force: Cohort study. *British Medical Journal, 327*, 1376-1378.

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

[124] Alacantra & Gone, (2008)

[125] Sucide Prevention Australia (2009). *Position statement on supporting suicide attempt survivors.* Retrieved from http://suicidepreventionaust.org/wp-content/uploads/2012/01/SPA-SuicideAttemptSurvivors-PositionStatement.pdf

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

[127] Harder H., Holyk, T. Russell, V. & Klassen-Ross, T. (2015). Nges Siy (I love you): A community –based youth suicide intervention in northern British Columbia. Interna*tional Journal of Indigenous Health(10),* 2, 21-32.

[128] Battiste, M. (2010). *Aboriginal resilience, resistance and renaissance in forging a transsytemic reform of knowledge and learning.* Landsdowne Lecture, University of Victoria.

[129] Gryglewicz, K., Elzy, M., Brown, R. et al. (2014). It's time to talk about it: Utilizing a community-based research approach to develop a family guide for youth suicide prevention. *International Journal of Child, Youth & Family Studies, 5*(1), 47-69.

[130] Kutcher, S. (2013). Mental health and high school curriculum guide: *Understanding mental health and mental illness.* Retrieved from http://teenmentalhealth.org/curriculum/home-1/

[131] Kutcher, S. & Wei, Y. (2014). School mental health literacy: A national curriculum guide shows promising results. *Education Canada, 54*(3), Retrieved from http://www.cea-ace.ca/education-canada/article/school-mental-health-literacy

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

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

[134] King, K., Strunk, C. & Sorter, M. (2011). Preliminary effectiveness of surviving the teens suicide prevention and depression awareness program on adolescents' suicidality and self-efficacy in performing help-seeking behaviors. *Journal of School Health, 81,* 583-590.

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

[136] Aseltine, R. and DiMartino, R. (2004). An outcome evaluation of the SOS suicide prevention program. *American Journal of Public Health,* 94, 446-451.

[137] Wilcox, H., Kellam, S., Brown, H., Poduska, J., Wang, W., & Anthony, J., (2008). The impact

of two universal randomized first- and second-grade classroom interventions on young adult suicide ideation and attempts. *Drug and Alcohol Dependence, 95* (Suppl 1), S60-S73.

[138] Wasserman, D. et al. (2015). School-based suicide prevention programmes: The SEYLE cluster-randomised, controlled trial. *The Lancet, 385,*1536-44.
[139] White, J. & Morris, J. (2010). Precarious spaces: Risk, responsibility and uncertainty in youth suicide prevention education. *Social Science & Medicine,* 71, 2187-2194.
[140] Shaffer, Q, Scott, M., Wilcox, H., Maslow, C. , Hicks, R., Lucas, C. P, Garfinkel, R. & Greenwald, S., (2004).The Columbia Suicide Screen: Validity and reliability of a screen for youth suicide and depression. *Journal of the American Academy of Child & Adolescent Psychiatry, 43,* 71-79.
[141] Joe, S. & Bryant, H., (2007). Evidence-based suicide prevention screening in schools. *Children & Schools, 29(*4), 219-227.
[142] Gould, M., Marrocco, F., Hoagwood, K., Kleinman, M., Amakawa, L. & Altschuler E., (2009). Service use by at-risk youths after school-based suicide screening. *Journal of the American Academy of Child and Adolescent Psychiatry, 48*(12), 1193-1201.
[143] Wasserman, D. et al. (2015). School-based suicide prevention programmes: The SEYLE cluster-randomised, controlled trial. *The Lancet, 385,*1536-44.
[144] Hallfors, D., et al. (2006). Feasibility of screening adolescents for suicide risk in “real-world” high school settings. *American Journal of Public Health, 96(*2), 282-287.
[145] Joe & Bryant, (2007)
[146] Cross, W., Matthieu, M., Lezine, D. & Knox, K. (2010). Does a brief suicide prevention gatekeeper training program enhance observed skills? *Crisis, 31*(3), 149-159.
[147] Sareen, J., Isaak, C., Bolton, S. L., Enns, M. W., Elias, B., Deane, F., Katz, L. Y. (2013). Gatekeeper training for suicide prevention in first nations community members: a randomized controlled trial. *Depression and Anxiety, 30,* 1021–1029.
[148] Wexler, L. & White, J. (2014). Promoting support and Indigenous suicide prevention through storytelling**.** *Critical Public Health.* doi: http://dx.doi.org/10.1080/09581596.2014.904039

[149] Taliaferro, L. & Borowky, I. (2011). Physician education: A promising strategy to prevent adolescent suicide. *Academic Medicine, 86*, 342-347.
[150] Appleby, L., Amos, T., Doyle, U., Tomenson, B., & Woodman, M., (1996). General practitioners and young suicides: A preventive role for primary care. *British Journal of Psychiatry, 168,* 330-333.
[151] Pfaff, J, Acres, J. & McKelvey, R., (2001). Training general practitioners to recognize and respond to psychological distress and suicide ideation in young people. *Medical Journal of Australia, 174*, 222-226.
[152] Wintersteen M. (2010). Standardized screening for suicidal adolescents in primary care. Pediatrics.125, 938–944.
[153] Taliaferro, L. & Borowky, I. (2011).
[154] Larkin, G. & Beautrais, A. (2010). Emergency departments are underutilized sites for suicide prevention [Editorial]. *Crisis,31*(1), 1-6.
[155] Rudd, D., (2006). The assessment and treatment of suicidality. Sarasota, FL: Professional Resource Press.
[156] Daniel & Goldston, (2009)
[157] Berman, Jobes & Silverman, (2006)
[158] Rudd, M.D., Joiner, T. & Rajab, M., (2001). *Treating suicidal behavior: An effective time limited approach.* New York: Guilford Press.
[159] Berman, Jobes & Silverman, (2006)
[160] Berman, Jobes & Silverman., (2006)
[161] Karver, M. & Caporino, N. (2010). The use of empirically supported strategies for building a therapeutic relationship with an adolescent with oppositional defiant disorder. *Cognitive and Behavioral Practice, 17,* 222-232.

[162] Goldston, D., (2000). *Assessment of suicidal behaviors and risk among children and Adolescents* (Technical report submitted to National Institute of Mental Health) Bethesda, MD:NIMH.
[163] Range, L. M., (2005). The family of instruments that assess suicide risk. *Journal of Psychopathology and Behavioral Assessment, 27*, 133-140.
[164] Jobes, D., Rudd, D., Overholser, J. & Joiner, T., (2008). Ethical and competent care of suicidal patients: Contemporary challenges, new developments and considerations for clinical practice. *Professional Psychology, Research and Practice, 39(*4), 405-413.
[165] Rogers, J. & Russell, E.(2013). A framework for bridging cultural barriers in suicide risk assessment: The role of compatibility heuristics. *The Counselling Psychologist,* DOI: 10.1177/0011000012471823.

[166] Chu, J., Floyd, R., Diep, H., Pardo, S., Goldblum, P. & Bongar, B. (2013). A tool for the culturally competent assessment of suicide: The cultural assessment of risk for suicide (CARS) measure. *Psychological Assessment, 25*(2), 424-434.

[167] Rudd, D., (2006).
[168] Rudd, D., (2006).
[169] Rudd, D., (2006).
[170] Rudd, D. (2008). Suicide warning signs in clinical practice. *Current Psychiatry Reports, 10*, 87-90.
[171] Rudd, D., (2006).
[172] Berman, A. Jobes, D. & Silverman, M., (2006).
[173] Shea, S., (2002).
[174] Rudd, D. (2006)
[175] Joiner, et al. (2007)
[176] Joiner, et al. (2007)
[177] Rudd, D. (2007)
[178] Mignone & O'Neil (2005)
[179] Jacobsen, L., et al. (1994). Interviewing prepubertal children about suicidal ideation and behavior. *Journal of the American Academy of Child and Adolescent Psychiatry, 33*(4), 439-452.
[180] Jacobsen, et al. (1994)
[181] Rudd, M.D., Joiner, T., & Rajab, M., (2001). *Treating suicidal behavior: An effective time limited approach.* New York: Guilford Press.
[182] Kleepsies, P. & Dettmer, E., (2000). An evidence-based approach to evaluating and managing suicidal emergencies. *Journal of Clinical Psychology, 56*(9), 1109-1130.
[183] Joiner, et al. (2007)
[184] Berman, Jobes & Silverman, (2006)
[185] Shea, (2002)
[186] Shea, (2002)
[187] American Psychiatric Association, (2003). Practice guidelines for the assessment and treatment of patients with suicidal behaviours. *American Journal of Psychiatry, 160*(11), 1-60.
[188] Kalafat, J. & Underwood, M., (2005). Crisis intervention in the context of outpatient treatment of suicidal patients. In R. Yufit & D. Lester (Eds.), *Assessment, treatment and prevention of suicidal behavior*. New York: Wiley.
[189] Kalafat & Underwood, (2005)
[190] Roberts, A., (1991). *Contemporary perspectives on crisis intervention and prevention.* Englewood Cliffs, NJ: Prentice-Hall.

[191] Rogers, J. & Soyka, K.(2004). "One size fits all": An existential constructivist perspective on the crisis intervention approach with suicidal individuals. *Journal of Contemporary Psychotherapy, 34*(1), 7-21.
[192] Rudd, Joiner & Rajab, (2001)
[193] Farrow, T. & O'Brien, A., (2003). 'No-suicide contracts' and informed consent: An analysis of ethical issues. *Nursing Ethics, 10*(2), 200-207.
[194] Weiss, A., (2001). The no-suicide contract: Possibilities and pitfalls. American Journal of Psychotherapy, 55(2), 414-419.
[195] Rudd, Joiner & Rajab, (2001)
[196] Wampold, B. (2007). Psychotherapy: The humanistic (and effective) treatment. *American Psychologist,* 857-873.
[197] Macgowan, M., (2004). Psychosocial treatment of youth suicide: A systematic review of the research. *Research on Social Work Practice, 14*(3), 147-162.
[198] Steele & Doey, (2007b).
[199] Daniel, S. & Goldston, D. (2009). Interventions for suicidal youth: A review of the literature and developmental consideration. *Suicide and Life Threatening Behavior,39*(3), 252-268.
[200] Daniel & Goldston, (2009).

[201] Jobes, D. (2009). The CAMS approach to suicide risk: Philosophy and clinical procedures. *Suicidologi, 14*(1), 3-7.

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

[203] Miller, A., Rathus, J., & Linehan, M. (2007). *Dialectical behavior therapy with suicidal adolescents.* New York: Guilford Press.

[204] Muehlenkamp, J, Ertelt, T. & Azure, J. (2008). Treating outpatient suicidal adolescents: Guidelines from the empirical literature. *Journal of Mental Health Counseling, 30*(2), 105-120.

[205] Diamond, et al. (2012). Attachment-based family therapy for suicidal lesbian, gay, and bisexual adolescents: A treatment development study and open trial with preliminary findings. *Psychotherapy, 49*(1), 62-71.

[206] Robinson, J., Hetrick, S. & Martin, C. (2011). Preventing suicide in young people: Systematic review. *Australian and New Zealand Journal of Psychiatry, 45*, 3-26.
[207] Tang, T., Jou, S., Co, C., Huang, S. & Yen, C. (2009). Randomized study of school-based intensive interpersonal psychotherapy for depressed adolescents with suicidal risk and parasuicidal behaviours. *Psychiatry and Clinical Neurosciences, 63,* 463-470.

[208] Klomek & Stanley (2007)
[209] Nelson, J. Ryan, K., Rotumah, D. et al. (2014). Aboriginal practitioners offer culturally safe and responsive CBT: Response to commentaries. *Australian Psychologist, 49,* 22-27.

[210] Katz, Elias, O'Neil, J, et al (2006). Aboriginal suicidal behaviour research: From risk factors to culturally sensitive interventions. *Canadian Academy of Child and Adolescent Psychiatry, 15*(4), 159-167.
[211] Duran, E. (2006). *Healing the soul wound: Counselling with American Indians and other native peoples.* New York: Teachers College Press.
[212] Mussell, Cardiff & White (2004).
[213] McCormick, R. (2009). Aboriginal approaches to counseling. In L. Kirmayer & G. Valaskakis (Eds.), *Healing traditions: The mental health of Aboriginal peoples in Canada (*pp. 337-354). Vancouver: UBC Press.

[214] Gone, J. (2013). Redressing First Nations historical trauma: Theorizing mechanisms for Indigenous culture as mental health treatment. *Transcultural Psychiatry,50*(5), 683-706.

[215] Hooven, C. (2013). Parents-CARE: A suicide prevention program for parents of at-risk youth. *Journal of Child and Adolescent Psychiatric Nursing, 26,* 85-95.

[216] Slovak, K. & Singer, J. (2012).

[217] Byrne, S., Morgan, S., Fitzpatrick, C. et al. (2008). Deliberate self-harm in children and adolescents: A qualitative study exploring the needs of parents and carers. *Clinical Child Psychology and Psychiatry, 13*(4), 493-504.

[218] Ewing, E. S., Diamond, G. & Levy, S. (2015). Attachment based family therapy for depressed and suicidal adolescents: Theory, clinical model and empirical support. *Attachment & Human Development, 17*(2),136-156.

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

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

[221] Marsh, D. (2011). Children of parents with mental illness. *Family Connections.* http://www.bccf.ca/all/resources/children-parents-mental-illness

[222] Pitman, E. & Matthey, S. (2004). The SMILES program: A group program for children with mentally ill parents or siblings. *American Journal of Orthopsychiatry, 74*(3), 383-388.

[223] Clarke, et al. (2001). A randomized trial of a group cognitive intervention for preventing depression in adolescent offspring of depressed parents. *Archives of General Psychiatry, 58*, 1127-1134.

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

[225] Eggert, L., Thompson, E., Herting, J. & Nicholas, L., (1995). Reducing suicide potential among high-risk youth: Tests of a school-based prevention program. *Suicide and Life-Threatening Behavior, 25*(2), 276-296.

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

[227] Thompson, E., Eggert, L., Randell, B. & Pike, K., (2001). Evaluation of indicated suicide risk prevention approaches for potential high school dropouts. *American Journal of Public Health, 91*(5), 742-752.

[228] Gould, M., Greenberg, T., Velting, D. & Shaffer, D., (2003). Youth suicide risk and preventive interventions: A review of the past 10 years. *Journal of the American Academy of Child and Adolescent Psychiatry, 42,* 386-405.

[229] Daniel & Goldston, (2009)

[230] Asarnow, J. et al. (2011). An emergency department intervention for linking pediatric suicidal patients to follow-up mental health treatment.P*sychiatric Services, 62,* 1303-1309.

[231] Brent, D. & Bridge, J., (2003). Firearms availability and suicide. *American Behavioral Scientist, 46(*9), 1192-1210.

[232] Daigle M.S., (2005). Suicide prevention through means restriction: Assessing the risk of substitution. A critical review and synthesis. *Accid Anal Prev., 37*(4), 625-32.

[233] Hawton, K., (2002). United Kingdom legislation on pack sizes of analgesics: Background, rationale, and effects on suicide and deliberate self-harm. *Suicide and Life Threatening Behavior, 3*2(3), 223-229.

[234] Kruesi M., Grossman, J., Pennington, J., Woodward, P., Duda, D. & Hirsch, J., (1999). Suicide and violence prevention: Parent education in the emergency department. *Journal of the American Academy of Child & Adolescent Psychiatry.38*(3),250-5.
[235] Cox, G. et al. (2012). Suicide clusters in young people: Evidence for the effectiveness of postvention strategies. *Crisis, 33*(4), 208-214.
[236] White, J., (2005). Preventing suicide in youth: Taking action with imperfect knowledge. Vancouver, BC: Mental Health Evaluation and Community Consultation Unit (Mheccu), Department of Psychiatry, UBC.
[237] Hacker, K., Collins, J., Gross-Young, L., Almeida, S. & Burke, N., (2008). Coping with youth suicide and overdose. One community's efforts to investigate, intervene and prevent suicide contagion. *Crisis, 29*(2), 86-95.
[238] Diego, D. & Travis, H., (2008). *Social modeling in the transmission of suicidality. Crisis, 29*(1), 11-19.
[239] Velting, D.M. & Gould, M.S., (1997). Suicide contagion. In R.W. Maris, S. Canetto & M.M. Silverman (Eds.), *Review of suicidology* (pp. 96–137). New York: Guilford.
[240] Zenere, F., (2009). Suicide clusters and contagion. *Principal Leadership, 10*(2), 12-16.
[241] Luxton, D. June, J. Fairall, J. (2012). Social media and suicide: A public health perspective. *American Journal of Public Health, 102*, S195-S200.
[242] Robinson, J. et al. (2016). Social media and suicide prevention: A systematic review. *Early Intervention in Psychiatry, 10,* 103-121.
[243] Jobes, et al. (2008)
[244] Barwick, M., Boydell, K., Stasiulis, E. et al. (2005). *Knowledge transfer and implementation of evidence-based practice in children's mental health.* Toronto, ON: Children's Mental Health Ontario.
[245] Broner, N., Franczak, M., Dye, C. & McAllister, W., (2001). Knowledge transfer, policymaking and community empowerment: A consensus model approach for providing public mental health and substance abuse services. *Psychiatric Quarterly, 72*(1), 79-102.
[246] Prilleltensky, I. & Prilleltensky, O., (2006). Promoting well-being: Linking personal, organizational and community change. Hoboken, NJ: John Wiley & Sons, Inc.
[247] Stacey, K., et al. (2007). Promoting mental health and well-being in Aboriginal contexts: Successful elements of suicide prevention work. *Health Promotion Journal of Australia, 18*(3), 247-254.
[248] Kirmayer, et al. (2007)
[249] Hays, C., Hays, S., DeVille, J. & Mulhall, P. (2000). Capacity for effectiveness: The relationship between coalition structure and community impact. *Evaluation and Planning, 23*, 373-379.
[250] Miller, R. & Shinn, M., (2005). Learning from communities: Overcoming difficulties in dissemination of prevention and promotion efforts. *American Journal of Community Psychology, 35*(3/4), 143-157.
[251] Schorr, L., (2003). Determining "what works" in social programs and social policies: Toward a more inclusive knowledge base. Retrieved February 2, 2009 from http://www.brookings.edu/papers/2003/0226poverty_schorr.aspx
[252] Public Conversations Project, (2003). Constructive conversations about challenging times: A guide to community dialogue. Retrieved February 3, 2009 from http://www.publicconversations.org/pcp/pcp.html
[253] Joyce, A., et al. (2004). Continuity of care in mental health services: Toward clarifying the construct, *Canadian Journal of Psychiatry, 49*, 539-550.
[254] Prilleltensky & Prilleltensky (2006)
[255] Downey, L., Ireson, C., Slavovais, S. & McKee, G. (2008). Defining elements of success: A critical pathway of coalition development. *Health Promotion Practice, 9*(2), 130-139.
[256] Prilleltensky & Prilleltensky (2006)

[257] Friedli, L. (2009). *Mental health, resilience and inequalities.* Copenhagen: WHO. Available at http://www.euro.who.int/__data/assets/pdf_file/0012/100821/E92227.pdf
[258] Friedli (2009)
[259] Friedli (2009)
[260] McIlwraith, R. D., Dyck, K. G., Holms, V. L., Carlson, T. E., Prober, N. G., (2005). Manitoba's rural and northern community-based training program for psychology interns and residents. *Professional Psychology: Research and Practice, 36*(2),164-172.
[261] Stamm, B. H., (2003). Essays from the field. In B. H. Stamm, N. F. Piland, B. Crouse, J. Boulger, G. Davis, B. A. Ide, et al. (Eds.) *Rural behavioral health care: An interdisciplinary guide* (pp. 11-20).
[262] Ramsden, I., (1992). Teaching cultural safety. *New Zealand Nursing Journal. 85*(1), 21-23.
[263] Smye, V. & Browne, A., (2002). Cultural safety and the analysis of health policy affecting Aboriginal people. *Nurse Researcher, 9*(3), 42-56.
[264] Hart, A., Hall, V. & Henwood, F., (2003). Helping health and social care professionals to develop an 'inequalities imagination': A model for use in education and practice. *Journal of Advanced Nursing, 41*(5), 480-489.
[265] Wood, P. & Schwass, M., (1993). Cultural safety: A framework for changing attitudes. *Nursing Praxis, 8*, 4-5.
[266] Gibbs, K., (2005). Teaching student nurses to be culturally safe: Can it be done? *Journal of Transcultural Nursing, 16*(4), 356-360.
[267] Schultz, W., et al. (2006). *Counseling ethics: Issues and cases*. Ottawa, ON: Canadian Counseling Association.
[268] Jobes, D., Rudd, D., Overholser & Joiner, T., (2008). Ethical and competent care of suicidal patients: Contemporary challenges, new developments, and considerations for practice. *Professional Psychology, Research and Practice, 39(*4), 405-413.
[269] Rudd, D., Brown, G., Jobes, D., Joiner, T., Cukrowcz.K. & Silverman, M., (2009). Informed consent with suicidal patients: Rethinking risks in and out of treatment. *Psychotherapy Theory, Research, Practice and Training, 46*(4), 459-468.
[270] Henkelman, J. & Everall, R., (2001). Informed consent with children. *Canadian Journal of Counseling, 35*(2), 109-121.
[271] Rudd, Joiner, & Rajab, (2001)