A FRAMEWORK

FOR

SUICIDE PREVENTION PLANNING

IN MANITOBA

Manitoba

ACKNOWLEDGEMENTS

This document is the result of a collaborative effort by many people. Manitoba Health and Healthy Living recognizes the dedication from this working group and wishes to thank the members as well as all others involved for their commitment in the development of this document.

- Amanda Meawasige, First Nation Youth Suicide Prevention Initiative, Assembly of Manitoba Chiefs
- Beverly Pageau, Manitoba Health/Healthy Living, Mental Health & Addictions Branch
- Bev Trachuk, Mood Disorders Association of Manitoba
- Deborah Barron-McNabb and Jacquie McLeod, Manitoba Métis Federation
- Don Gamache, Nor-man Regional Health Authority
- Earnest Daniels, Elder, Selkirk Mental Health Centre
- Kathy Foley, Brandon Regional Health Authority
- Loretta Bayer, Manitoba Health and Healthy Living, Aboriginal Health Branch
- Marion Cooper, and Jackie Habing, Winnipeg Regional Health Authority
- Marlene Potash, Suicide Prevention Education Awareness Knowledge (S.P.E.A.K)
- Mary-Jo Bolton, Manitoba Network for Suicide Prevention
- Pat Olafson, Interlake Regional Health Authority/North Eastman Regional Health Authority
- Stan Franklin, Burntwood Regional Health Authority

And to the numerous people of Manitoba who contributed by:

- ❖ participating in focus groups that gave valuable direction to the committee and the final document;
- ❖ providing review of the documents draft versions and providing feedback for the completion of the framework document; and
- ❖ breathing life into the purpose behind the document by supporting the efforts & work of the committee.

This document is the beginning and there is much more work ahead.

Our vision is that this Framework will serve as a foundation to foster hope and as a tool to ultimately alleviate the impact of suicide for all the people living in Manitoba.

Development of the Framework

A provincial committee was struck to develop a framework to be used by Manitoba Health and Healthy Living, Regional Health Authorities and participating organizations to develop plans to address suicide. The committee, with representation from Regional Health Authorities, Self-Help groups, consumers, family members, First Nations and Métis communities met from July 2004 to December 2005.

The committee looked at data on suicide and self inflicted injury, reviewed best practice literature, inquest recommendations, and suicide prevention strategies from other jurisdictions. A summary of this research is presented in the document "A Background Report" available through the Mental Health and Addictions Branch, Manitoba Health and Healthy Living.

The main components and basic structure of the framework was influenced by the Canadian Association of Suicide Prevention Blueprint.

Background

Suicide is known to be associated with a complex interaction of biological, psychological, and social risk factors including mental illness and/or addictions and a history of trauma, multiple personal problems, ill health and loss. Protective factors include healthy individual coping strategies, family, social and community supports.

RISK FACTORS

Mental illness and substance abuse
There is strong research showing that up to 70% to 97% of suicide victims have a diagnosable mental illness, especially depression and substance use disorder. Recent data from Manitoba also shows "diagnosis of a mental illness within the last year" to be one of the key factors predicting suicide and suicide attempt.

Exposure to adversity and trauma
Numerous studies show clear linkages between childhood and adult adversity and suicidal behaviour. Recent data from New Brunswick (2005) shows that as well as mental illness, many individuals had a long trajectory of difficulties throughout their lives, including personal, social and family problems. The literature also points decisively to exposure to recent stresses as a precipitating factor in suicidal behaviour.

Genetic and biological predispositions
There is a body of research that has found genetic and biological predispositions to suicidal behaviour, aggressive and impulsive behaviour and the mental disorders with which suicide is associated.

Access to lethal means
Studies report that access to a range of lethal methods of suicide leads to increased rates of suicide by that method.

Risk factors for suicide differ with age. Factors such as childhood adversity and recent stress are more influential in younger people. Mood disorder plays a more significant role with increasing age.

PROTECTIVE FACTORS

A number of factors have been suggested as contributing to resilience to suicidal behaviour for young people including:

- Good coping skills and problem-solving behaviours
- Strong self-esteem
- Strong connections to family and school
- Secure cultural identity

A number of factors are also known to act as protective factors for adults including:

- Social support
- Good coping and adaptive skills
- Good physical and mental health
- Strong religious and spiritual values
- Early and sustained treatment of depression
- Restricted access to means of suicide

AT-RISK GROUPS

Any individual with risk factors in the absence of adequate protective factors could be at risk of suicide. However, data indicate that some groups do have a higher incidence of suicide than others. In Manitoba between 1992 and 1999, 79% of the suicides were male, although females are hospitalized for intentional injury almost twice as often as males. Youth and seniors more often die as a result of suicide than middle age adults. The group with the highest risk of all in the general population in Manitoba is senior males age 85 and over (34 per 100,000). The next most vulnerable group is males age 20-24 (25 per 100,000).

Suicide is almost twice as high in the Aboriginal population as the non-Aboriginal population. According to the 2001 Statistics Canada Census, Aboriginal individuals comprise approximately 13.6% of the total population of Manitoba. According to data collected by the Chief Medical Examiner of Manitoba from 1994 to 2001 Aboriginal individuals accounted for 25% of the completed suicides. Within certain age ranges, suicide can be higher. For example, according to data from Manitoba Health, First Nations youth suicides represent 56% of the total number of youth suicides.

Little data exists to distinguish suicide rates between First Nations on-reserve, First Nations off-reserve, Métis and Inuit groups. Aboriginal communities in general however have identified suicide as a pressing issue, particularly among youth.

The literature on Aboriginal suicide prevention emphasizes the history of colonization and resulting cultural breakdown in Aboriginal communities. Aboriginal communities today experience high rates of poverty, unemployment, health problems, injury and family breakdown. Researchers are increasingly looking to strategies emphasizing cultural revitalization, including traditional spiritual healing to increase protective factors for Aboriginal individuals, families and communities.

It has been reported that the incidence of suicide is of concern in the gay/lesbian communities, possibly because of increased stress in the lives of individuals who face discrimination and personal struggle.

SUICIDE PREVENTION

Suicide is a complex issue with complex contributing factors; therefore the prediction and prevention of suicide is difficult. However, we do know that by far the most significant predictor of suicide comes from mental health measures. In order to focus limited resources, therefore, and target efforts that will cause the most immediate gain suicide prevention efforts should be first directed at ensuring adequate and timely treatment for mental health and substance use disorders, and addressing the factors that lead to these disorders.

There is some evidence that targeting suicide prevention efforts at groups known to be at high risk offers some increased levels of success.

It is also widely accepted that suicide intervention and prevention requires an" inter-disciplinary" and "inter-jurisdictional" approach. "Inter-disciplinary" because at risk individuals come into contact with professionals from all disciplines (e.g. health, education, justice, recreation, etc). Responsibility for suicide prevention does not fall neatly into only one professional practice. "Inter-jurisdictional" because services and programs span the jurisdictions of municipal, provincial and federal authority. Responsibility for suicide prevention does not rest solely within the mandate of any one jurisdiction.

Inter-jurisdictional barriers to service provision, including health and social services, have been highlighted as posing special problems for Aboriginal communities especially on-reserve. The difficulties involved in supporting communities and providing specialized services in the north and other remote communities have also been cited as presenting further challenges to Aboriginal as well as non-Aboriginal communities in those areas.

How To Use the Framework

The Manitoba Suicide Prevention Framework is comprised of five components:

A. Assessment and Planning
B. Mental Health Promotion
C. Awareness and Understanding
D. Prevention, Intervention and Postvention
E. Data Surveillance, Research and Evaluation

For each component, goals and objectives have been identified. The document also provides examples of practical activities and resources from various jurisdictions that have been identified in prevention literature or shared by communities. The list of activities is not meant to be an exhaustive list, but rather a selection of examples to help in the development of a regional work plan.

Community Needs Assessment Process

When a group is developing a suicide prevention work plan it will first want to consider how to select the specific goals, objectives and activities best for their community. A community consultation process should occur and begin with a forum and/or other needs assessment process to identify specific community strengths, weaknesses, opportunities and threats.

Consideration of the following questions may be helpful in an assessment process:

1. What are the strengths in your community? Which activities will help you build on these strengths?
2. What are the priority risk factors identified in your community? Which activities would help you address these risk factors?
3. What are the gaps or needs in service delivery in your community? Which activities would help you address these gaps?
4. How strong is the evidence to support the activity?
5. What resources are available to accomplish the activities? Can the activity be accomplished with available resources and partnerships? Are there outside resources that can be accessed?
6. Are there opportunities to develop partnerships with other sectors?
7. In what time frame do you wish to show success? Can the activity demonstrate some success or progress within this identified time frame?
8. What is the potential impact of the activities and can it be measured?
9. Is there readiness/support for this work in the community?

Suicide Prevention Work Plan

From the needs assessment and analysis, a Suicide Prevention work plan can be developed. The needs assessment identifies the current status (where you are) and where you want to go (the community's vision and goals). The work plan then identifies what you do (target objectives and action plans) to achieve those goals.

The work plan needs to have clear, realistic goals and objectives with time-lines, a process for monitoring and specific persons responsible for activities.

This framework offers a selection of goals and activities that can be undertaken at the provincial, regional or local levels, depending on the mandate of the group.

A. Assessment and Planning

Develop an appropriately resourced structure to implement suicide prevention activities.

Goal 1: Develop or enhance partnerships to endorse a suicide prevention framework and ensure implementation and sustainability of the framework.

Objectives:

1. Develop a provincial inter-departmental, inter-jurisdictional Suicide Prevention Committee to develop, implement and evaluate Suicide Prevention activities at the provincial level...
2. Develop regional level and/or community level inter-agency, inter-jurisdictional Suicide Prevention Committees to develop, implement and evaluate regional and/or local suicide prevention work plans.
    - Ensure adequate representation from many sectors, e.g. Health, Justice, Family Services and Housing, Education, Aboriginal communities, and jurisdictions e.g. Municipality, Tribal Council, Province, Federal, etc. on suicide prevention committees.
    - Ensure representation from high risk groups on suicide prevention committees.

Examples of Activities:

1. Host a regional Suicide Prevention Forum to identify community strengths and gaps in service and regional goals and priorities. Proceed to develop and implement a suicide prevention work plan with an inter-agency committee. Two examples of this process are:
    - The Inuusiqatasiarniq Youth Suicide Prevention Strategy – National Inuit Youth Council at http://www.niyc.ca/ .
    - The Suicide Prevention Implementation Network (SPIN) in Brandon. Information about SPIN can be obtained by contacting Kathy Foley of the Brandon Regional Health Authority at foleyk@brandonrha.mb.ca or by calling (204) 571-8460.
2. Develop a clear, realistic annual work plan. Indicate time-lines, identify persons responsible for activities and ensure evaluation is built in. Make good use of resources; identify the greatest need and the largest impact for change.
3. Ensure representatives from high-risk groups participate on the Suicide Prevention Committee.
4. Consider a Suicide Prevention “Consensus Document”, similar to the Co-occurring Disorders Initiative consensus document to solicit commitment from partners and stakeholders. Information about the structure of this Initiative can be accessed through the AFM website at www.afm.mb.ca.
5. Develop a formal affiliation with the Canadian Association for Suicide Prevention (CASP). There is currently Manitoba representation on the board of CASP and

consideration should be given to the development of a provincial chapter of CASP. CASP can be accessed at:

CASP Office, c/o The Support Network
#301, 11456 Jasper Ave.
Edmonton, Alberta, T5K 0M1
Phone: 780 482-0198
www.thesupportnetwork.com/CASP/main.html

Examples from Aboriginal Communities

6. Review the "Community Planning Tool Kit" a resource for First Nations communities recently published by the National Aboriginal Health Organization (NAHO). The tool kit is designed to assist Aboriginal communities to plan suicide prevention initiatives. It is comprised of two phases - Phase I: Community Assessment and Phase II: Community Planning for Healing. NAHO can be contacted at:

   NAHO
   220 Laurier Avenue West, Suite 1200
   Ottawa, Ontario, K1P 5Z9
   Phone: 613- 237-9462
   Toll Free: 877-602-4445
   Fax: 613-237-1810
   E-mail: naho@naho.ca

7. Review the ASCIRT (Aboriginal Suicide & Critical Incident Response Team) Mobilization Manual for a model of establishing teams that mobilize and empower communities to address the factors that can lead to suicide. The Inter Tribal Health Authority in British Columbia hosts the ASCIRT initiative with the goal of providing intensive and comprehensive support to its 29 member nations on suicide.

   ASCIRT
   © Inter Tribal Health Authority
   534 Centre Street - Nanaimo
   Phone (250) 753-3990 – Fax (250) 753-5224

B. Mental Health Promotion

Build healthy and resilient individuals, families, communities and cultures.

Goal 1: Enhance primary prevention activities.

Objectives:

1. Increase the number of programs that promote resiliency and protective factors for individuals, families, communities and cultures.
2. Increase mental health literacy, and suicide awareness including messaging about the importance of seeking help, and decreasing stigma about suicide.
3. Increase connections and networking in health promotion, community health, addictions and injury prevention.
4. Increase collaboration of mental health promotion activities across sectors.

Examples of Activities:

General Information & Awareness

1. Approach the Canadian Mental Health Association (CMHA) to obtain "Hot Cards" which can be distributed locally. Hot Cards indicate the signs of someone experiencing emotional distress and explain where to get help. In Manitoba the CMHA can be contacted by calling (204) 953-2350, or accessed on the web at www.cmhamanitoba.mb.ca/go.aspx.

2. Develop media campaigns that promote mental health, reduce stigma and encourage recognition of mental health problems and mental illness. Strengthen health promotion messages about the link between mental and physical health.

Healthy Parenting

3. Develop and promote parenting programs. Several models exist, including:
    1. Healthy Baby Programs (29 programs throughout the province that are delivered in more than 90 communities). Healthy Baby Programs are funded through community agencies in some regions and in others, through the RHAs.
    2. Nobody's Perfect is an education and support program for parents of children from birth to age five, funded by Healthy Child Manitoba and delivered by Youville Clinic. www.gov.mb.ca/healthychild.
    3. Families First is a home visiting program to support high risk families funded by Health Child Manitoba and delivered by the public health system. Families First offers supports to families with children from pregnancy to school entry. www.gov.mb.ca/healthychild/familiesfirst
    4. How to Talk So Kids will Listen and Listen So Kids will Talk is training that can be obtained from various sources from professionals and para-professionals trained to deliver the training program.
    5. "Triple P Parenting" is designed as a training program to increase skills within the current service delivery system, including health, social services and education.

and is provided to staff of interested organizations and agencies across Manitoba. This gives parents the opportunity to access supports when they need them from trained professionals in their community. The Triple P training model assumes that the differing needs of parents will require differing levels of support. Triple P is based on a flexible system of 5 levels of increasing intensity from the universal support level (general information for all parents) to mid-range (tip sheets, parenting advice, and workshops) to the clinical level (for parents who experience significant problems with their children).

6. Develop and support family resource centres and/or family-oriented healing centres. Existing Family Resource Centres (some funded in whole or part by Healthy Child Manitoba) offer a variety of parenting supports, training and programs. www.gov.mb.ca/healthychild.

Healthy Schools

7. Approach local school division(s) to strengthen collaboration between counselling within schools and beyond schools (including referral protocols).
8. Develop a suicide awareness kit for use by schools that promote mental health, reduce stigma and encourage recognition of mental health issues and mental illness. Strengthen health promotion messages about the link between mental and physical health.
9. Include school counsellors and school clinicians in community mental health initiatives and committee meetings.

Healthy Workplaces

10. Establish a workplace wellness program – encourage physical fitness, healthy eating, good interpersonal relationships, smoking cessation, conflict resolution and problem solving.
11. Promote awareness of Employee Assistance Programs, self-help groups and other resources.
12. Incorporate wellness messages with paycheques.

Child and Youth Wellness

13. Contact Teen Talk for prevention services from a youth-friendly perspective for youth in school, youth at risk and service providers. Teen Talk youth educators provide realistic prevention education focusing on sexuality, reproductive health, body image, mental health, and anti-violence issues. Teen Talk can be accessed at http://www.klinic.mb.ca/teentalk.htm or by calling (204) 784-4090.
14. Develop a Peer Support program for youth.
15. Develop and promote teen drop-in centres
16. Develop and promote a booklet on depression and addictions targeted to youth.
17. Use mental health promotion resource packages for schools such as those available through the Healthy Schools Initiative, Manitoba Health. www.gov.mb.ca/health/healthyschools/
18. Place a section in school handbooks for students on emotional well-being and local resources for seeking help.
19. Involve students at risk in long-term mentoring programs.

20. Promote general practitioners/school guidance counsellors as youth friendly through the development of an “it’s confidential” program. This program would encourage young people to contact their doctor or counsellor and, if necessary, use the code words “it’s confidential” to ensure an urgent appointment with no questions asked.
21. Incorporate diversity awareness programs in schools, including gender, culture and sexual orientation.
22. Plan a youth wellness or family fun day.

Seniors

23. Develop and support “seniors-for-seniors” centres.
24. Establish a volunteer phone line to connect with shut-in seniors, such as “Take the ‘I’ Out of Isolation” at the Brandon Seniors for Seniors Co-op Inc. – phone 204-726-4691, fax 204-571-2050.

Gay/Lesbian

25. –Prepare a list of “gay-friendly” doctors and counsellors.
26. –Develop and advertise internet. support groups.
27. Develop and advertise accurate and supportive information on the Internet about the risk of suicide amongst homosexual people.
28. Provide sensitivity training for professionals. See Rainbow Resource Centre www.rainbowresourcecentre.org.
29. Provide training for students in acceptance of diversity.

New Canadians

30. Develop culturally appropriate prevention activities to assist immigrants and refugees with successful settlement and the attainment of social and emotional well-being.

Community Wellbeing

31. Link with a local Safe Communities Initiative. A list of Manitoba initiatives is available at www.gov.mb.ca/justice/safe/.
32. Develop a Homelessness Steering Committee to address the need for available, appropriate, affordable shelter.
33. Establish a community kitchen.
34. Increase media promotion of healthy lifestyles.
35. Incorporate mental health messages with utility bills.
36. Prepare displays on mental illness and mental health for Mental Illness Week, Mental Health Week, Suicide Awareness Week and Addiction Awareness Week.
37. Develop and deliver presentations to community groups on stress management, team building, conflict resolution, and communication skills.

Aboriginal Communities

38. Neah-Kee-Papa is a Manitoba Métis Federation program to increase the involvement of youth fathers in their children’s lives, and to support the healthy

development of children (funded through Healthy Child Manitoba and delivered by MMF).

39. Promote Aboriginal cultural identity and land-based teachings – an example is the Turtle Lodge Survival Camp for Youth at Sagkeeng First Nation.
40. Promote the Aboriginal Youth Network http://ayn.ca, a web resource with information on health topics, education, and employment etc. for Aboriginal youth.
41. Facilitate self-improvement courses. An example in the Aboriginal Community is the "Turtle Concepts: Options for People" (www.turtleconcepts.com). E-mail at info@turtleconcepts.com. The program offers community based 'confidence tours' celebrating youth and restoring confidence in Aboriginal people.
42. Host community discussions:

    to identify the values and beliefs the community members want to follow;
    to discuss colonization and its effects on individuals, families and communities; and
    to discuss community control in relation to decolonization and resiliency.

43. Support traditions, e.g. the use of the community's first language in daily activities, the use of traditional ceremonies and pow-wows in the community.
44. Foster activities that promote youth leadership.

C. Awareness and Understanding

Promote public understanding that suicide is an important community health issue and that it can often be prevented.

Goal 1: Encourage awareness across Manitoba that suicide is a significant community concern and that it is everyone's responsibility to help an individual at risk.

Objectives:

1. Increase activities to make community members more aware of suicide risk, suicide prevention and each individual's responsibility to help.
2. Increase awareness and support for persons suffering from mental illnesses and addictions, trauma, illness, grief, isolation and poverty.
3. Increase knowledge of mental health, addictions and crisis intervention resources.
4. Increase the number of community groups, professional groups and government sectors that integrate suicide prevention into their activities.

Examples of Activities:

1. Host a community educational session on suicide and su8icide prevention within high risk groups, e.g. Aboriginal communities, seniors, gay/lesbian communities.
2. Develop a suicide awareness and prevention website that will provide:
   - Lists of resources for people at risk and care providers.
   - A list of speakers (speakers' bureau), workshops, and event listings.
   - Links to key suicide prevention and intervention sites.
3. Make people aware of the Centre for Suicide Prevention **www.suicideinfo.ca.** The Centre for Suicide Prevention is a program of the Canadian Mental Health Association, Alberta Division. The home page links to:
   - Crisis centres in each province.
   - Confidential online crisis counselling centres such as Befrienders International (www.befrienders.org) and Kids Help Phone (www.kidshelp.sympatico.ca).
   - The Suicide Information and Education Collection (SIEC) – the world's largest collection of English-language materials on suicide and suicidal behaviour. (Includes archived past issues of the SIEC, feature of the month highlight issues such as suicide and the media, and spirituality and suicide).
4. Distribute public awareness materials and resource information (e.g., posters/ pamphlets/ business size cards listing local resources/ links to suicide prevention websites) to hospitals, schools, public health, community centres, sport centres, funeral homes, churches, synagogues, etc.
5. Review and modify school, university and college curricula to ensure mental health, mental illness and substance abuse are appropriately addressed.

Goal 2: Reduce stigma associated with suicide prevention, intervention and bereavement activities.

Objectives:

1. Improve public understanding and acceptance of individuals living with mental health and addictions.
2. Improve public understanding that treatment for mental illness and/or addictions is a fundamental component of health care in Manitoba.
3. Improve public understanding that suicide prevention is a fundamental component of health care in Manitoba.

Examples of Activities

1. Develop a public education campaign aimed at increasing the awareness of resources and the importance of decreasing stigma and seeking help for individuals with suicidal thoughts/behaviours, mental illness and/or addictions.
    - Targeted posters, such as those developed through the The Inuusiqatasiarniq Youth Suicide Prevention Strategy –on the web at http://www.niyc.ca/.
    - Create regional promotional materials which provide information on mental health, reducing the stigma surrounding mental illness, available resources, and links to further information.
2. Sponsor an event such as:
    - A provincial or regional conference on suicide and suicide prevention
    - A special-issue forum, e.g., youth and mental health during Mental Health Week.
3. Promote World Suicide Prevention Day on September 10.
4. Educate and encourage organizations and employers to consider ways to integrate suicide prevention activities into their ongoing work.

Goal 3: Improve media knowledge regarding suicide.

Objectives:

1. Increase appropriate reporting and portrayal of suicidal behaviour in all media.

Examples of Activities:

1. Invite local media to participate on your regional suicide prevention committee.
2. Develop a regional communication strategy; include the development and distribution of press information kits that provide a resource for reporting on suicide and contact information for local spokespersons.
3. Work with local media to promote good practice in the portraying and reporting of suicide, high risk groups and mental health/illness. Ensure all media has a copy of the CASP Media Guidelines: http://www.thesupportnetwork.com/CASP/mediaguidelines.html

4. Inform media of the code of ethics regarding suicide: “Reporting on Suicide: Recommendations for the Media” developed in collaboration with the World Health Organization. http://www.afsp.org/education/recommendations/
5. Implement a media monitoring process that keeps sponsors informed of appropriate coverage regarding suicide and provides constructive critique of misleading or hurtful depictions of suicide, mental illness or substance abuse.
6. Develop a process for nominating local media for excellence in reporting for the Canadian Association for Suicide Prevention, Media Award.

D. Prevention, Intervention and Postvention

Assist every community in the development of a full range of prevention, intervention and postvention services for individuals based on age, gender, culture and other specific risk factors.

Goal 1: Develop, implement and sustain community-based suicide prevention strategies specific to age, gender, cultural and ethnic needs.

Objectives:

1. Develop specific strategies for specific settings (e.g., mental health programs, correctional institutions, educational institutions, medical personnel)
2. Develop a specific strategy with associated activities for each high risk group.

Examples of Activities:

1. Develop resource kits for service organizations to develop setting specific suicide prevention strategies. Ensure all materials are translated into the languages of the community and at an appropriate reading level for the target audience.
2. Suicide rates are highest among the elderly, especially elderly men. The Centre for Suicide Prevention in Alberta published an alert in February 1998 (Alert #28) "Suicide Among the Aged" that identifies the issues and some solutions. Along with a complete bibliography of suicide and the aged, it can be accessed through the website at http://www.suicideinfo.ca/csp/assets/alert28.pdf.
3. Mobilize community to improve health status, such as in the Alkali Lake Program in Williams Lake British Columbia that experienced a dramatic turnaround in alcohol abuse. Starting with one sober person, the community eventually reached sobriety levels of ninety-five percent. The Alkali Lake story was made into a movie (and video) in 1992. The film, entitled "The Honour of All: The Story of Alkali Lake", has been described as inspirational to Aboriginal communities across North America. The film can be obtained by contacting by Phil Lucas Productions, Inc. (206) 392-9482. To contact the Alkali Lake Indian Band, Alkali Lake B.C – Box 4479 Williams Lake, BC V2G 2V5 Phone 250-440-5611, Fax 250-440-5721

   Other Aboriginal Resources include:

   - Inuusiqatasiarniq Youth Suicide Prevention Strategy – National Inuit Youth Council http://www.niyc.ca/
   - Aboriginal Youth: A Manual of Promising Suicide Prevention Strategies www.suicideinfo.ca/ca/csp/assets/promstrat_manual.pdf
   - White Stone: Training for Youth Educators - www.suicideinfo.ca
   - Acting of What we Know: Preventing Youth Suicide in First Nations - www.hc-sc.gc.ca
   - Information Centre on Aboriginal Health - www.icah.ca
   - Aboriginal Youth Network http://ayn.ca
   - Turtle Concepts: Options for People www.turtleconcepts.com
   - Saputiit Youth Association of Nunavik - www.saputiit.ca

Goal 2: Reduce the availability and lethality of suicide methods.

Objectives:

1. Educate the public to reduce access to lethal means e.g. educate the public about the specific risk of injury and/or death by suicide any time there is a firearm in the home or otherwise available.
2. Increase the number of professionals and family members routinely assessing risk in the home, including assessment for the presence of lethal means (firearms, drugs, poisons etc.) and educating about actions to reduce risk.
3. Support the development and use of tools to reduce the lethality of means (e.g., firearm locks, carbon monoxide shut-off controls, bridge barriers, medication containers, break-away bars).
4. Review relevant legislation and make recommendations toward any needed changes required to support these objectives.

Example of Activities:

1. Develop an emergency department screening tool to assess for the presence of lethal means in the home.
2. Incorporate education about reducing access to means into routine psychiatric care.
3. Advocate for incorporating education about reducing access to means into the programs of community agencies with a mandate to provide routine community safety education, e.g. police, fire department, Red Cross, local Safety Council, etc.
4. Incorporate information on suicide risk and prevention in Firearms Training Courses.
5. Develop a standardized practice for law enforcement to assess for lethal means and advocate for removal or safe storage.
6. Advocate for reliable ignition shut-off sensors that respond to potential lethal level of carbon monoxide.
7. Recommend closet rods that will hold a restricted amount of weight in facilities or homes housing high risk individuals.

Goal 3: Enhance the training of gatekeepers, volunteers and professionals for recognition of risk factors, warning signs and at-risk behaviours and for effective intervention.

Objectives:

1. Increase the numbers of gate keepers trained to identify suicide risk factors.
2. Increase the number of professional groups trained in the management of suicide risk and promotion of protective factors.
3. Increase the management of suicide risk and of identification and promotion of protective factors within key settings including:
    - workplaces;
    - schools, Colleges and Universities;
    - community service e.g., group homes;

- religious/spiritual institutions;
- correctional institutions;
- emergency response; and
- mental health, addictions and other health care settings.

Examples of Activities:

1. Promote the Applied Suicide Intervention Skills Training (ASIST) through Living Works (at the Suicide Education Information Centre, Alberta) for all health care professionals, corrections workers, addiction workers, teachers, youth workers, elderly workers, clergy, law enforcement officers etc. Contact www.livingworks.net.
2. Implement a program that promotes youth presenting on suicide prevention. Resources include 1) the five-day RCMP Sponsored White Stone program for Aboriginal youth educators and 2) the Suicide Program of the Youth Secretariat of the Assembly of Manitoba Chiefs.

   1) White Stone was developed in partnership between the RCMP Aboriginal Policing and Suicide Prevention Training Programs (SPTP). The Project has two components: teaching young adults and community caregivers about suicide prevention, and secondly, training them to present suicide prevention education sessions to youth in their home community. For contact information check http://www.suicideinfo.ca/csp/go.aspx?tabid=54.

   2) Through its Youth Secretariat, the Assembly of Manitoba Chiefs supports First Nations in the development of a community strategy to address youth suicide, and provides training to community members in the areas of suicide prevention, intervention, grief and loss, community capacity building and community planning. Contact (204) 987-9577/ www.manitobachiefs.com.

3. Provide recommendations to enhance curriculum at the Faculty of Medicine, Education, Nursing, Social Work, etc. regarding assessment of suicidal risk, crisis intervention and facilitating referrals.
4. Educate teachers to recognize and intervene when bullying occurs. Policies with clear consequences to address bullying are now legislated through the Public Schools Act amendment (safe schools charter).
5. Provide continuing education on intervention strategies for a suicidal person for doctors and emergency service personnel.

Goal 4: Promote effective professional practice to support clients, families and communities.

Objectives:

1. Develop policies and protocols and in-service training for assessment of suicidal behaviour among persons receiving care in primary health care settings, emergency departments, mental health settings and addictions treatment centres.
2. Increase the number of people who pursue mental health care after being treated for self-harming behaviours in hospital departments.

3. Design programming that is sensitive to specific experiences of individuals in high risk groups, e.g. with attention to losses experienced by seniors and Aboriginal individuals.
4. Develop policies and protocols for assessment of suicidal behaviour among persons in school systems.
5. Develop policies and protocols for assessment of suicidal behaviour among persons in the Child Welfare system.
6. Review and evaluate the option of using a standardized 'Suicide Risk Review' Tool.
7. Develop policies and protocols for assessment of suicidal behaviour across the age span (including children, youth, adults and the elderly).
8. Develop guidelines for providing education and support to family members and natural supports of persons receiving care for the treatment of mental health and addictions.
9. Increase support to those affected by suicidal behaviour, e.g., bereavement groups.

Examples of Activities:

Assessment

1. Ensure clinical protocols contain guidelines for assessment of patients following a suicide attempt and identify the need to follow-up and assess the risk of suicide 24-48 hours after discharge from hospital.
2. Develop standardized guidelines for assessing suicidal risk in individuals with an addiction.
3. Develop standardized guidelines for assessing suicidal risk for physicians.
4. Develop standardized guidelines Identify for jails and other correctional institutions.

Treatment and Follow-up/Referral

5. Develop a regional “pathway of care” or “map for referral service” for persons identified as being at risk of suicide.
6. Establish mental health and substance abuse treatment services in school settings.
7. Improve access to health professionals, elders and spiritual healers.
8. Consider implementing a plan for regional access to cognitive behavioural therapy with adults who have attempted suicide.
9. Develop and implement guidelines for discharge follow-up for individuals at risk. Anyone with a mental illness, especially depression or a history of self-harm within the previous three months and /or person with an addiction/co-occurring disorder should be included as at risk individuals.
10. Establish a process to facilitate transition of care from facility to community services for individuals at risk, to ensure the client has established a link with the appropriate resources.
11. Develop guidelines for schools on linkages with community agencies.
12. Incorporate spirituality and traditional healing into treatment services as appropriate.

Goal 5: Improve coordination between services and families for individuals at high risk.

Objectives:

1. Promote awareness of professionals about legal responsibilities regarding confidentiality (e.g. PHIA, Mental Health Act) and implications for managing suicide risk in the community.
2. Provide education to family members about legal responsibilities regarding confidentiality (e.g. PHIA, Mental Health Act) and implications for managing suicide risk in the community.
3. Develop policies and procedures for follow-up care after discharge or other transition of care for everyone deemed at high risk.
4. Develop policies, procedures and/or protocols and structures for community interagency cooperation and collaboration for individuals deemed at high risk.
5. Develop an integrated service plan that includes action to be taken if a person deemed to be at high risk does not attend follow-up or aftercare or is unable to follow the care plan.
6. Develop policies, procedures and/or protocols to actively seek input from families and friends.

Example of Activities:

1. Develop linkages with co-occurring disorders initiative committees to ensure services are coordinated.
2. Ensure family and natural supports are involved in service delivery.
3. Ensure family and consumer involvement at the planning level.
4. Develop materials on mental health issues and services for families.

Goal 6: Improve coordination between provincial and federal programs and services.

Objectives:

1. Identify gaps in service coordination between jurisdictions.
2. Develop policies, procedures and/or protocols and structures for inter-jurisdictional cooperation and collaboration for individuals deemed at high risk.

Goal 7: Prioritize service delivery for individuals at risk.

Objectives:

1. Improve the diagnosis and effective treatment of persons with mental illness, and/or addictions.
2. Develop and promote interventions and coordinated service delivery for persons with mental illness and/or addictions.

3. Develop and promote interventions and coordinated service delivery for all individuals at risk.

Example of Activities:

1. Review Emergency Room service delivery and improve triaging to expedite service for individuals at risk.
2. Develop a position for a psychiatric consultant specialist to decrease waiting times in Emergency Rooms.
3. Develop policies and /or protocols to ensure that after discharge or transition of care, that everyone deemed to be at high risk has follow-up within twenty-four hours and face-to-face contact within a maximum of seven days. Included as ”high risk” should be anyone with severe mental illness or history of self-harm within the previous three months.

Goal 8: Ensure availability of a comprehensive and coordinated crisis response system.

Objectives:

1. Ensure a minimum level of crisis intervention services exists within each region (i.e., crisis line, mobile crisis, crisis stabilization unit, psychiatric emergency services in hospitals).
2. Develop a provincial crisis line project to connect and coordinate existing crisis lines and to provide service where none exists.
3. Educate individuals in high-risk groups and the public about the availability and use of crisis intervention services.
4. Develop and implement support structures for families living with suicidal people.

Example of Activities:

1. Develop regional or provincial clinical consultation teams.
2. Review and streamline process for people in emotional distress to receive help in a timely fashion.
3. Promote awareness of local resources and supports – local public service announcements, posters, brochures.
4. Develop a support group or newsletter for families living with a suicidal person.

Goal 9: Improve services and support to those bereaved by suicide.

Objectives:

1. Increase the number of crisis support services to those impacted by a suicide.
2. Increase the number of longer-term support services to those impacted by a suicide (e.g., bereavement groups, rural retreats).
3. Develop and implement sensitivity training for First Responders.

Example of Activities:

1. Ensure a clear regional postvention plan is in place which includes components of the provincial Community Trauma Postvention Model.
2. Develop a postvention protocol for schools including guidelines to support families affected by both a suicide and a suicide attempt.
3. Develop a postvention toolkit targeted at specific audiences such as schools. This toolkit will include information on how to respond to a suicide, as well as warning signs of high suicide risk and who to contact if someone is displaying these signs.
4. Review local Emergency Medical Services protocols for suicide scene procedure and revise as needed. Helpful information is provided by the Suicide Prevention Resource Centre at http://www.sprc.org/featured_resources/customized/first_responders.asp. These resources include "How can emergency responders help grieving individuals?" and "How can emergency responders manage their own response to a traumatic event?"
5. Organize suicide survivors in your community to provide seminars on recognizing and managing the personal impact of suicide to first responders.
6. Establish a local Suicide Bereavement Support Group.
7. Hold regular healing circles with trained volunteers.
8. Host an annual memorial service for those bereaved by suicide.
9. Promote traditional Aboriginal healing through Smudging, Healing Circles, Sweat Lodge or Wiping of Tears Ceremony.
10. Develop a resource booklet to assist families bereaved by suicide, such as Hope and Healing, A Practical Guide for Survivors of Suicide, developed by Calgary Health Region. Contact Calgary Health Region, (403)-943-8131. The booklet can be downloaded or ordered at their website www.calgaryhealthregion.ca. (Mental Health Promotion and Illness Prevention). It can be viewed at http://www.lifelongmentalhealth.com/main_hopehealing.html

E. Data Surveillance, Research and Evaluation

Work toward the development of knowledge regarding suicide risk factors, protective factors and effective prevention.

Goal 1: Improve and expand surveillance systems.

Objectives:

1. Develop consistent Provincial standards and protocols for collecting information about suicide deaths and non-fatal attempts.
2. Develop standards for coroners to assist in accurately determining and reporting the cause of death.
3. Develop consistent Provincial standards and protocols for collecting information about suicide deaths and non-fatal attempts for Aboriginal people.

Example of Activities:

1. Advocate for the uniform collection of reliable data on suicidal behaviour.
2. Advocate for follow-back studies on completed suicides.
3. Encourage provincial agencies to produce an annual report on suicide.
4. Reinstate the practice of the Chief Medical Examiner‘s Office to collect information on “race”
5. Ensure better coordination of the Chief Medical Examiner‘s data with Vital Statistics data.

Goal 2: Promote and support the development of effective evaluation tools.

Objectives:

1. Increase the development and use of standardized assessment protocols for program evaluation.
2. Develop and enhance links between survivors, community resources and researchers to facilitate knowledge transfer.

Example of Activities:

1. Develop criteria by which suicide prevention activities can be evaluated.
2. Provide a provincial body with the resources and authority to oversee and report on evaluation results.
3. Develop short-term indicators, medium-term indicators and long-term quantitative or qualitative indicators to access effectiveness of suicide prevention activities.

Goal 3: Promote and develop suicide-related research.

Objectives:

1. Increase the study and reporting of risk factors, warning signs and protective factors for individuals, families, communities and society.

Example of Activities:

1. Recommend the hiring of a provincial Suicidologist to design, track, analyze and report on suicide statistics and research.

2. Adopt the recommendation from the Canadian Institutes of Health Research (February, 2003) on the national suicide research agenda, identifying six broad themes for ongoing investigation.

   The six themes adopted by CIHIR in 2003:

   - Data Systems: Improvement and Expansion
   - Evidence-based Practices
   - Mental Health Promotion
   - Multidimensional Models for Understanding Suicide-Related Behaviours
   - Spectrum of Suicide Behaviours, including Suicide Attempters
   - Suicide in Social and Cultural contexts

Goal 4: Improve reporting of research results.

Objectives:

1. Increase opportunities for dissemination of data and knowledge from surveillance, evaluation and research activities (e.g., through scientific journals, conferences, workshops and training).

Examples of Activities:

1. Participate provincially and nationally in suicide research.
2. Add surveillance systems to track suicidal ideation and self-injury that is non-fatal.
3. Establish evaluation protocols throughout any implementation process to build on the work of establishing evidence-based practices.
4. Establish a method of tracking data from all sources within the province. One suggestion would be the MHMIS (Currently under review)

GLOSSARY

Crisis
An unstable or crucial time or state of affairs in which a decisive change is impending; especially one with the distinct possibility of a highly undesirable outcome. The culminating point of a series of events causing a person's life to become unbalanced - a loss of 'equilibrium' or an inability to cope.

Culturally Relevant Programming
The delivery of programs and services so that they are consistent with the communication styles, meaning systems and social networks of clients, or program participants.

Emergency
An urgent need for assistance or relief. The need for imminent assistance. In medical terms, an emergency is considered an immediate threat to loss of limb, or life.

Gate-keeper
A gatekeeper is a key individual e.g. a friend, colleague, sports coach, teacher, doctor, etc. Gatekeepers will be in contact with individuals who are considering suicidal behaviour and they have the opportunity to intervene to help the individual.

Lethality
The extent to which an action or substance is capable of causing death.

Mental Health literacy
Like “language literacy” (ability to read and write), and “numeracy” (understanding of mathematical concepts) mental health literacy refers to knowledge and understanding of concepts related to mental health, mental illness and mental health supports.

Mental Health Promotion
Actions to maximize mental health and wellbeing in individuals, communities or populations. Mental health promotion includes a variety of strategies aimed at having a positive effect on mental health. These strategies work with the whole community to enhance mental wellness. They include the enhancement of self-esteem, resiliency and effective decision-making skills.

Natural supports
An individual (family member, friend, etc.) who plays a significant role in offering support to a consumer of mental health or addictions services. A natural support is not usually a part of the formal care system and is not remunerated for offering this support.

Para-suicide/ Attempted Suicide
Self-injuring behaviour motivated by an attempt to die with a non-fatal outcome.

Resiliency
A human ability to recover from disruptive change, illness, or misfortune.

Suicide/ Completed Suicide
Death caused by self-inflicted, intentional injury.

Suicidal Behaviour

All self-injurious behaviour motivated by an attempt to die, whether resulting in death or not.

Suicide Prevention

Activities directed toward the reduction of suicidal behaviour. Suicide prevention activities can be undertaken at four levels:

- Primary Prevention refers to activities that create healthy and supportive environments where risk factors are minimized and protective factors are increased e.g. building youth self-esteem, parenting programs.
- Secondary Prevention refers to activities that prevent the onset of suicidal crises with individuals who are identified as at risk e.g. gatekeeper training.
- Intervention refers to activities aimed at the immediate management of the suicidal crisis as well as longer term care and treatment of individuals at risk e.g. crisis lines, individual therapy, protocols for inter-agency collaboration for at risk individuals.
- Postvention refers to activities that deal with the aftermath of completed suicide e.g. interdisciplinary emergency debriefing teams or bereavement support groups.