## Methods to evaluate

| | Ask a Key Evaluation Question | Measure the Success |
|---|---|---|
| SHORT TERM* | Are youth satisfied with the information presented? | ➢ measure participants' feedback regarding the suicide awareness classes and their satisfaction with the materials presented |
| | Are youth more knowledgeable? | ➢ measure participants' knowledge (e.g. about warning signs and available community resources) before and after the lesson and compare results to determine whether the program has made a difference |
| | Are youth showing more favourable attitudes? | ➢ measure participants' attitudes (e.g. helping a friend in a non-judgmental manner, willingness to get help/break a confidence) |
| | Are youth demonstrating appropriate helping skills? | ➢ measure participants' skills (e.g. asking directly about suicide, telling an adult) |
| MEDIUM TERM** | Are youth retaining the knowledge and skills gained? | ➢ measure retention of knowledge and skills over a period of time |
| | Are youth correctly identifying and referring peers at-risk for suicide? | ➢ track the number of youths referred by their peers or self-referred to professionals/ organizations<br>➢ measure the appropriateness of these referrals |
| LONG TERM*** | Are suicide and suicidal behaviours among youth decreasing? | ➢ measure the number of deaths by suicide and attempted suicides in the community and compare to previous statistics |

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


## Suicide Prevention: Let's Talk About It

**Location:** Kativik School Board
2055 Oxford
Montreal, Quebec
H4A 2X6
Telephone: (514) 482-8220
Fax: (514) 482-8278

**Program description:** In the early 1990's, alarmed by the number of suicides and suicide attempts as well as the misconceptions people had about suicide, the Kativik School Board staff recognized the need to develop a suicide prevention program for implementation in the school system. The School Board decided to offer a suicide awareness education curriculum for the students as well as organize training sessions in suicide prevention for school staff.

After reviewing a number of suicide awareness education programs, Kativik School Board staff decided to adapt a program originally developed in Laval (Quebec). The Laval program was revised to reflect the reality of the Nunavik Regions and re-named "Suicide Prevention: Let's Talk About It". At the time the program was launched, several professionals and other individuals from 14 communities were trained in program implementation as well as basic intervention skills. The curriculum is currently being taught in community schools as well as other community settings. In the schools, the curriculum is usually taught by school counsellors as part of the Personal and Social Development curriculum.

The overall goal of the program is for students to develop an understanding about the issue of suicide. The specific goals of the program are as follows:

- develop a better understanding of the magnitude of the problem of suicide
- express knowledge, ideas, reactions, and beliefs about suicide
- distinguish between the myths and the realities surrounding suicide
- learn to recognize the risk factors
- learn to recognize the warning signs
- understand the stages of the suicidal process
- become familiar with the intervention steps in the prevention of suicide
- identify available resources and the importance of using them

The curriculum materials are presented over the course of 5 sessions. Methods of instruction include: lectures, group discussion, brainstorming, role playing, and reading on the topic. Schools implementing the curriculum are provided with a Presenter's guide, booklets on suicide awareness (for distribution to the students), and pamphlets (for

distribution to the parents). The Presenter's guide is intended for school staff members (or community members) who will be leading the sessions. The Presenter's guide provides all the necessary information to carry out the implementation.

The Presenter's guide warns that the curriculum should not be used for 3-6 months following a suicide in the school or community. As well, it is recommended that the program be discontinued immediately if a suicide occurs during the course of program implementation.

**Target groups:** The program is intended to be used with adolescents (from about 15 years of age) and adults.

**Partners involved:** Kativik School Board.

**Years in operation:** The curriculum was developed in 1993 and has been used in the schools since 1994.

**Source of funding and costs per year:** Funding for the development of the suicide awareness program was provided by the following organizations:

- Kativik School Board
- Kativik Regional Government
- Nunavik Regional Board of Health and Social Services
- Ungava Tulattavik Health Centre

There is no direct cost to the schools as all the materials are provided by the Kativik School Board.

**Resources:** The only school resource associated with this program is the time commitment required of the professionals who will prepare for and deliver the curriculum to the youth.

**Evaluation findings:** The program has never been formally evaluated.

**Advice to others interested in starting this type of program:** One of the developers of the program strongly suggests that this type of program should not be implemented in isolation. Professionals and other adults in frequent contact with youth should be adequately trained in intervention and postvention skills. Furthermore, it also is important to focus on raising children's self-esteem and to develop activities that celebrate life.

**Available reports and materials:**

- Presenter's guide Let's Talk About It!
- Booklet on suicide awareness for students
- Pamphlet for parents

## A Place to Start

### Programs

**CHOICES: Youth suicide awareness program**

CHOICES is an internationally award-winning youth suicide awareness program designed to teach young people (grades 8-12) about the warning signs of suicide as well as how to best help a suicidal peer. The CHOICES program includes a 16-minute video and a facilitator's manual. The video tells the story of an adolescent at risk, interspersed with real-life experiences from teenage suicide attempters and a family who lost their adolescent son to suicide. The facilitator's manual includes background information on youth suicide; pointers for teaching suicide education; a video transcript; a suggested seminar outline; an optional facilitator's "script" along with all visuals; and a brochure which can be photocopied and handed out to participating youth. The one-hour CHOICES program can be facilitated by suicide prevention professionals, trained crisis centre volunteers, teachers, counsellors, mental health professionals, or other committed community members. The content of the program can also be adapted for younger children.

For more information, contact:
Crisis Intervention and Suicide Prevention Centre of B.C.
763 East Broadway
Vancouver, BC
V5T 1X8
Telephone: (604) 872-1811
Fax : (604) 879-6216
E-mail: info@crisiscentre.bc.ca
Website: www.crisiscentre.bc.ca

### Suggested reading

Abbey, K., Madsen, C., & Polland, R. (1989). Short-term suicide awareness curriculum. *Suicide and Life Threatening Behavior*, 19(2), 216-227.

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# Youth/Family Strategies

## *Family Support*

**What are family support programs?**

Family support programs provide a variety of services designed to help parents fulfill their childrearing responsibilities. These services, such as parent support groups, parenting classes, family counselling, or emergency assistance, empower and strengthen parents with the aim of enhancing the overall health and well-being of family systems.

In the context of suicide prevention, family support programs act to strengthen a number of protective factors within the family unit. Examples of such protective factors include warm and caring parent-child relationships, healthy adult modelling, and the establishment of high and realistic parental expectations. At the same time, family support programs work to reduce the negative impact of certain risk factors for youth suicide, such as social isolation, family instability, and a family history of depression or other psychiatric disorder. Providing parents with the tools and skills to create a home where children can succeed is at the heart of family support programs.

**Goals**

More specifically, the goals of the family support strategy are to:

- enhance parental knowledge, self-esteem, and problem-solving capabilities
- enhance parenting skills
- promote healthy physical, emotional, and social development of children
- improve family functioning including family cohesion, communication, and joint problem-solving ability
- prevent various child and family dysfunction such as abuse and neglect
- strengthen family and community support networks
- facilitate access to community resources

**Target population**

Most family support programs target families within a community that may be “at-risk” or in need of active support and assistance. However, family support services are also very valuable in strengthening families in general, even in the absence of any specific or identifiable risk.

**Brief description**

There are hundreds of programs in Canada that are found under the umbrella of family support. These programs all vary in terms of their objectives, settings, and types of services offered. This diversity is not surprising given the fact that family support programs are usually structured to meet the specific needs of families within a community and are designed to complement existing community services and resources. The common theme running through all of these programs, however, is that they are based on the assumption that the provision of information, emotional support, and

practical assistance to families will have a positive impact on parents, and children, as well as family systems.

Family support programs can be planned and operated by a number or organizations including Band offices, service agencies, recreation centres, mental health offices, schools, health centres, service clubs, or cultural organizations. Providers of family support services include professionals and other trained individuals as well as volunteers. Services can be provided from a central location, such as a family resource centre, or may be offered in settings where families and parents naturally gather, such as schools or even their own homes. Finally, families may use available services for a short time period or for several years, depending on their own situation.

There are a number of services that family support programs offer. Here are some examples:

- parent education classes focusing on child development and traditional parenting concepts and techniques
- life skills training that may include employment and vocational training, or personal development skills such as problem-solving, stress reduction, and communication
- support groups that provide opportunities for parents to share their experiences and concerns with peers
- preventive health care that may include education in health and nutrition for parents, and developmental checks or health screening for infants and children
- parent-child groups and family activities that promote healthy family relationships
- a drop-in centre that offers unstructured time for families to be with other families and program staff, time away from challenging home responsibilities, and a network for finding playmates, referral sources, or parenting information
- educational day care or preschool for infants and toddlers
- information and referral service to other services in the community
- practical assistance such as clothing exchanges, emergency food, and transportation
- advocacy for individual families or for all families within the community
- critical support for parents when a youth is in trouble but is refusing treatment or help

## Why should we provide family support programs?

***Aboriginal families are facing many challenges***

In Aboriginal society, the family unit has always been regarded as the main institution of the community where networks of parents, grand-parents and other community members provided a safe place for children to find comfort and identity. Today, however, many would agree that the Aboriginal family is under threat mainly as a result of the residential school system and other oppressive forces that were imposed on Aboriginal people. Other significant issues facing today's Aboriginal families include single parenthood (single parents are found twice as often among Aboriginal people), high rates of teenage pregnancies, family violence, sexual abuse, as well as drug and alcohol abuse. The institution that once protected children is now one that poses a potential risk for suicide.

***There is a link between family distress and risk for suicide***

With few exceptions, unhealthy families cannot support the healthy development of young people. Youth who grow up in homes where emotional and physical nurturance is lacking, where parental care is inconsistent and where marital relationships are strained, are often at greater risk for a range of social problems, including suicide. Mental health problems suffered by family members can also heighten the risk. The result of ineffective parenting is young people who suffer from low self-esteem, poor attachments skills, and the unwillingness or inability to trust.

Suicide is also associated with a history of childhood physical and sexual abuse and with a family history of violence or assault, imprisonment, and harmful use of alcohol or other drugs. More specifically, it is estimated that young people who had been physically abused in childhood were almost 5 times more likely to attempt suicide than other young people who were not abused and 9 times more likely if the abuse was both physical and sexual. Growing up in an abusive or alcoholic family leads to the internalization of anger and conflict, marked difficulties in expressing feelings, and a lack of effective interpersonal skills.

***There is a need to reconnect children with their parents and improve parenting skills***

In many Aboriginal families, the ability to parent effectively must be re-established or else the negative legacy will be passed on to the next generation. This begins by supporting and helping parents who are themselves in tremendous pain and may have little to give to their children, and it continues by taking steps to break the cycle of abuse and violence. Clear and consistent parenting expectations that blend traditional values and problem-solving approaches with contemporary community realities are also needed in order to encourage the development of appropriate family bonds. The need to improve parenting skills is especially relevant for that generation of adults who missed learning these lessons naturally at home because they were sent away to residential schools.

***Family support programs can help meet some of these goals***

By working with the extended family unit, family support programs aim at reducing these risk factors, while enhancing important protective factors such as warm and caring parent-child relationships and the modelling of healthy adjustment by parents and other adult caretakers. Whether focusing on parents themselves or on the parent-child relationship, family support programs work to heal and strengthen the family unit in order to create a healthy environment for children to live in. Family support programs represent a timely approach to suicide prevention since 40-60% of the population living on reserves is below the age of 21 years old and Aboriginal Canadians represent one of the fastest growing segments in this country.

## How do we know family support holds promise?

***Family support programs have shown positive results in the general population***
Evaluations of existing family programs have found a number of positive effects on children, parents, parent-child relationships, as well as family functioning. This mounting evidence suggests that family support programs can be effective in influencing the development of children as well as the familiar environments they live in. Having said that, it is important to note that the impact of any program will depend, of course, on the types of services it provides.

For example, programs specifically aimed at enhancing the healthy development of children have found positive cognitive outcomes, increased social competence, and reduced delinquent behaviour in later years. Programs with a strong focus on parental education and support have found positive parental outcomes including enhanced self-esteem and coping, greater sense of control and competence, and enhanced problem-solving. These programs have also observed better care giving behaviours and better communication from parent to child. Finally, a number of intensive and long-term family support programs have even reported a significant impact on family demographic variables such as quality of housing, educational advancement, and economic self-sufficiency.

***Experts recommend family support programs as a strategy to prevent suicide***
In the context of suicide prevention, many have called for increased primary prevention efforts that focus on improving parental capabilities and practices, strengthening family support networks, and improving the stability and continuity of children's relationships. These goals are embodied in the family support movement and research findings suggest that these programs are indeed capable of promoting these protective factors. So although family support programs have not been explicitly evaluated in terms of their effectiveness on the prevention of youth suicide, the evidence is compelling enough for experts to recommend this approach as a potentially effective prevention strategy.

## Setting up for success

To maximize the success of a family support program, you should consider the following steps:

1. **Learn more about how to develop and operate a family support program**
   As a first step, you should familiarize yourself with the issues involved in planning, implementing, and operating a successful family support program. To this end, we invite you to consult *A place to start* which highlights a number of publications dealing with the "how to" of family support programs. It is also a good idea to read about or visit actual family support programs as you prepare to develop your own (see *In our own backyard*).

2. **Learn more about your own community**
   As mentioned before, family support programs typically structure their services according to the needs and priorities of the communities they serve. Assessing a community's needs and resources is therefore an essential component of program

planning. Begin by researching the characteristics of the population in your community. Then, map out the resources and services that are already serving families in one way or another within your community. This exercise should allow you and your group to find out about any gaps in service delivery.

3. **Involve families**
   The heart of family support programs is the recognition that families can identify their own needs, design solutions to address these needs, and mobilize resources. Recognize the special role that extended family members – aunts, uncles, cousins, and in-laws – play in promoting the health and well-being of Aboriginal children and youth and make sure to consider them in your planning. Programs utilizing families in planning and development are typically richer and have services that encompass the diverse populations they serve.

4. **Recognize that setting up a successful program may take time**
   The program implementation literature indicates that new family support programs require significant amounts of time to reach a stable level of operation, generally from one to three years.

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

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

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

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

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

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

Methods to evaluate

| | Ask a Key Evaluation Question | Measure the Success |
|---|---|---|
| SHORT TERM* | Are participants in the program satisfied with the services received? | ➢ measure satisfaction with the various components of the program |
| | Are participating parents showing improvements in the following areas (depending on the type of family program)? | |
| | a) knowledge related to parenting options and strategies, and child development | ➢ measure knowledge (e.g. effective discipline techniques, normal and abnormal child behaviour) before and after participation in the program and compare results to determine whether the program has made a difference |
| | b) life skills | ➢ measure skills (e.g. problem-solving, communication, anger management) before and after participation in the program and compare results to determine whether the program has made a difference |
| | c) use of social support | ➢ measure perceived social support (e.g. from family member and group members) before and after participation in the program and compare results to determine whether the program has made a difference |
| | d) willingness to seek help | ➢ measure help-seeking patterns before and after participation in the program and compare results to determine whether the program has made a difference |
| MEDIUM TERM** | Are the children and youth of participating families being referred appropriately for professional help as needed? | ➢ measure number of youth being referred as a result of the program<br>➢ measure the appropriateness of these referrals |
| | Are parents appropriately being referred to professional help when needed? | ➢ measure number of parents being referred as a result of the program<br>➢ measure the appropriateness of these referrals |

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

Methods to evaluate

| | Ask a Key Evaluation Question | Measure the Success |
|---|---|---|
| MEDIUM TERM** | Are participating parents showing improvements in emotional well-being? | ➢ measure depression, self-esteem, stress level, and marital satisfaction in parents |
| | Are the children of participating families showing improvement in emotional well-being? | ➢ measure healthy adaptation among youth (e.g. school performance, peer relationships), depression, self-esteem, and stress |
| | Is the quality of parent-child interactions showing improvement? | ➢ measure parent-child interactions (e.g. observations, self-report) and family functioning (e.g. adaptability, cohesion) |
| LONG TERM*** | Are suicide and suicidal behaviours among youth decreasing? | ➢ measure the number of deaths by suicide and attempted suicides in the community and compare to previous statistics |

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


## Big Cove Family Workshop

**Location:** Child and Family Services
Big Cove Indian Band
P.O. Box 1078
Rexton, NB
E4W 5N6
Telephone: (506) 523-8224
Fax: (506) 523-8226

**Contact person:** Evangeline Francis, Family Wellness Coordinator

**Program description:** In the late 1980's, the community of Big Cove, New Brunswick, was experiencing high numbers of youth suicide. Concerned Child and Family Services staff started looking for innovative and proactive ways to address this problem. Support of families was identified as an important goal and staff began searching for a family program to implement. After reviewing a few different programs, the group settled on a program called Parents and Problems Parenting Program, which was developed in the United States by Fred Streit. Although the curriculum is not Aboriginal-specific, it was to be presented in the local language.

The goals of the program are to enable parents to better understand their own behaviour towards each other and their adolescent(s), how adolescents perceive the behaviour of their parents, and what makes adolescents behave as they do. In this way, the program aims to prevent mental health problems, drug and alcohol abuse, and criminal activity among adolescents. A total of seven topics are covered:

- Through the Eyes of Youth
- Do Adults Understand Me?
- Do my Parents Love Me?
- But They're My Friends
- Adolescent Sexuality
- Why Can't I Do It My Way?
- I Don't Have Two Parents (for single parents)

Participants in the program (both parents and adolescents) meet weekly for three hours to discuss one of the program topics. A maximum of three or four families take part in the training at a time (for a total of 9-14 participants). Sessions begin with a discussion of the materials covered the previous week, a review of the new session materials, and continue with a group discussion and exercises. Reading materials for the next topic (at the junior high school level) are distributed to the families who can then prepare for the next session.

The community hired a psychologist who was familiar with the Parents and Problems Parenting Program to train approximately 20 community members (social workers, teachers, and other health care workers) in the delivery of the program. Following the training, which took place in Big Cove, the participants began to deliver the curriculum to local parents in workshops. The trained community members were also asked to reach out to their own extended family and friends by using the program materials.

Over the years, the number of trained community members who were willing to facilitate workshops began to drop and the workshop has not been offered in the last few years. The community recently hired a psychologist and a Parenting Committee has been formed. One of the goals of the Parenting Committee is to revive the Parents and Problems Parenting Program and perhaps implement other initiatives in an effort to support parents. Harry Sock, Director of Child and Family Services would like to see workshops like the Parents and Problems Parenting Program being offered throughout the year.

**Target groups:** The target groups of the Parents and Problems Parenting Program workshop include parents and their teenagers.

**Partners involved:** Child and Family Services

**Years in operation:** Began implementation in early 1990's.

**Program costs:** The main costs include the fee of the psychologist who trained the community members and the costs to copy the materials.

**Resources:** Financial resources come from the Family Wellness budget.

**Evaluation findings:** The program was never formally evaluated. Satisfaction questionnaires were completed by participants at the end of workshops.

**Advice to others interested in starting this type of program:** Harry Sock, Director of Child and Family Services mentions that a family support curriculum should be presented by trained community members.

**Available reports and materials:** The following Parents and Problems Parenting Program materials are available from the Big Cove Child and Family Services office for a small cost (to cover printing costs):

- Leader's manual
- Seven Parents and Problems pamphlets (for each topic)

## A Place to Start

### Programs

**Kise Wa To Ta To Win Aboriginal Parenting Program**

The Kise Wa To Ta To Win Parenting Workshop outlines the principles of traditional parenting methods and offers discussions on how to apply these guiding principles in contemporary society. The goal of this program is to enhance parenting skills, which strengthens family units and the community. Parenting workshops lead to discussions regarding the impact of Residential Schools and the devastating effect this legacy has on First Nations people. The workshop is always conducted with the guidance of Elders. The manual used during the workshop was developed from an Aboriginal perspective in 1993 and is available from the Aboriginal Parenting Program. This program is suitable for individuals with limited educational background.

The Aboriginal Parenting Program also offers Facilitator Workshops geared toward teaching participants how to run Parenting Workshops. The Facilitator Workshop runs for 5 days and is guided by the Kise Wa To Ta To Win handbooks and manuals.

For more information on the Parenting Workshop or the Facilitator Workshop, contact:
Aboriginal Parenting Program
#216, 335 Packham Avenue
Saskatoon, Saskatchewan
S7N 4S1
Telephone: (306) 665-3337
Fax: (306) 665-3299
E-mail: aboriginalparenting@shaw.ca

**Kishawehotesewin: A Native Parenting Approach**

This seven-session program targets First Nations parents and expecting parents and conforms to the seven traditional teachings. The sessions can be presented weekly or as a three-day workshop. Activities include sharing in a circle, readings, videos, role playing, discussion and assignments. The program assists and supports parents in identifying and realizing their goals, helps them listen to their children, encourages them to share their knowledge about First Nations traditions, provides general information on resources, allows parents to reappraise their parenting styles and situations, and provides culturally relevant materials. Resources required are a trained facilitator. The materials have been presented in First Nations languages with the use of a translator. The manual can be obtained from the Canadian Public Health Association.

To order manual (order number: 3-1BK01011), contact:
Canadian Public Health Association
Health Resources Centre
1565 Carling Avenue, Suite 400
Ottawa, Ontario
K1Z 8R1
Telephone: (613) 725-3769 (ask for the Health Resources Centre)
Fax: (613) 725-9826
E-mail: hrc@cpha.ca
Web site: www.cpha.ca/english/hrc/hrc.htm

**Nobody's Perfect**

Nobody's Perfect is a parenting education and support program for parents of children from birth to age five. It is designed to meet the needs of parents who are young, single, socially or geographically isolated, or who have low income or limited formal education. However, the program is not intended for families in crisis or those with serious problems. Participation is voluntary and free of charge.

Nobody's Perfect is offered as a series of 6 to 8 weekly group sessions. The program is built around 5 colourful, easy-to-read books which are given to the parents free of charge. The books address the body (health and illness), safety, mind (child development), behaviour, and needs of parents. During the meetings, trained facilitators support participants as they work together to discover positive ways of parenting. The program is offered in a broad range of settings in every Canadian province and territory. Although the program was developed for the general population, it has been used extensively with Aboriginal families. Across Canada, over 5,000 community workers, parents and public health nurses have been trained as Nobody's Perfect facilitators.

To obtain further information regarding the Nobody's Perfect or to find your provincial coordinator, contact:
Canadian Association of Family Resource Programs
National Office
707-331 Cooper Street,
Ottawa, ON
K2P 0G5
Telephone: (613) 237-7667
Fax: (613) 237-8515
E-mail: np-yapp@frp.ca
Web site: www.frp.ca

Workshops

**The family: Going at it together**

In order to move as families toward wellness, we need to know what a healthy family is like and more specifically, what our family would be like if it were truly healthy. Then we need to know exactly what our strengths and weaknesses are (mental, emotional, physical, spiritual) as families. Finally we need a plan for how to become healthier, and a process of learning to get us there.

This four day workshop is for families (grandparents, parents and children – or any combination that you consider "family") who want to take the wellness journey together. This workshop is limited to six to eight families per session (about 40 people) including children. Four Worlds trainers will travel to interested communities to deliver this workshop.

Working together with other families through a program of workshop and recreational challenge activities, families will:

- develop a working vision of what their family would be like if it were truly healthy
- complete a process of assessment to determine the actual levels of wellness of your family in all key wellness areas
- learn new skills, models, strategies and tools for growth
- develop new, healthier patterns of interaction between family members
- begin to address key healing issues
- make a one-year plan for continuing family development after the workshop that includes continued learning, family activities and outside support for continued development in all key wellness areas.

For more information, contact:
Four Worlds International Institute for Human and Community Development
347 Fairmont Boulevard
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**Leading The Way To Becoming A Better Parent**

This workshop was developed and is being offered by Dave Jones, an Ojibway of the Garden River First Nation through his company, *Turtle Concepts: Options for People*, located in Garden River, Ontario. The sessions focus on the need to understand the level of maturity and the level of development that children are at throughout their lives. Importance is stressed on how each child may follow the example that may have been set as "normal" behaviour. This normal behaviour then becomes acceptable and a routine is developed until new behaviour is introduced. The workshop focuses on three critical

areas: positive communication, setting positive boundaries and establishing positive routines. Each area is examined in detail, clarified, and applied to everyday situations. Role playing and activity-based learning are applied throughout the workshop. Discussion is promoted amongst participants to share their experiences, both positive and negative, and solutions are suggested.

For more information, contact:
Turtle Concepts: Options for People
580B, Highway 17 East
Garden River First Nation, ON
P6A 6Z1
Telephone: (705) 945-6455 or 1-877-551-5584
Local: Fax: (705) 945-7798
E-mail: info@turtleconcepts.com
Web site: www.turtleconcepts.com

## Resource

*Parenting Today's Teens: A Survey and Review of Resources* (1999). This resource is published by Health Canada. The document is designed to help professionals who work with parents of teens or parents themselves to identity and locate resources specifically designed to help families at this stage of parenting. You can view the document (in pdf) at www.hc-sc.gc.ca/dca-dea/publications/pdf/teens_e.pdf . To order a copy, contact:

Publications
Health Canada
Postal locator 0900C2
Ottawa, Ontario
K1A 0K9
Telephone: (613) 954-5995
Fax: (613) 941-5366

## Organizations

**Canadian Association of Family Resource Programs**
This organization promotes the well-being of families by providing national leadership, consultation and resources to those who care for children and support families. The organization assists new and existing family resource programs by providing up-to-date information and resource materials, making available regional lists or existing family resource programs and related services, and organizing workshops and conferences. A number of useful publications can be ordered online through the organization's web site. For example, the document *Caring About Families: the "How To" Manual for Developing Canadian Family Resource Programs* contains all the information you need to develop a family resource program in your community.

For more information, contact:
Canadian Association of Family Resource Programs
707 - 331 Cooper Street
Ottawa ON
K2P 0G5
Telephone: (613) 237-7667 or (613) 728-3307
Fax: (613) 237-8515
E-mail: info@frp.ca
Web site: www.frp.ca

## Suggested reading

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# Youth/Family Strategies

## *Support Groups for Youth*

**What are support groups for youth?**

This strategy brings together vulnerable youth in a caring and comfortable group environment where they receive the support of peers and practice valuable life skills. Support groups serve the purpose of counteracting a number of early risk factors experienced by vulnerable youngsters, while enhancing important protective factors.

It is important to note that these programs should not be confused with those that are more clinical in nature. Psychotherapy groups and the provision of services to young psychiatric patients-while often key components in the prevention of youth suicide-are more appropriately classified as "treatment" efforts and these types of clinical strategies are not included in this manual.

**Goals**

The goals of support groups for youth are to:

- extend the social support available to at-risk youth both within and outside of the group
- assist youth to develop decision-making, interpersonal, and coping skills
- provide opportunities for youth to develop personal skills to reduce the negative impact of various suicide risk factors such as unresolved and accumulated losses, anger and alienation, impulsive behaviour, and substance misuse

**Target population**

The target population for this strategy is youth who may be at early risk for suicide based on a variety of potential risk factors and conditions including depression, recent or recurrent loss, prior suicidal ideation, alcohol and drug use, and exposure to a suicide of a friend or family member. Low risk youngsters can be referred by parents/guardians, teachers, community members, mental health professionals, or themselves. This strategy is not recommended for high risk youth who are more appropriately assisted by on-going treatment and/or crisis intervention services.

**Brief description**

Support groups can be conducted in a variety of settings common to at-risk youth including schools, community centres, youth centres, young offender centres, shelters for homeless/runaway youth, and organizations serving gay and lesbian youth.

Typically, the groups are small (10-15 individuals) and meet on a regular basis over a relatively short period of time ranging from six weeks to six months. Group leaders include counsellors, teachers, nurses, social workers, or other health professionals. Youth who have "graduated" from a support group can work alongside the group

facilitator, serving as peer leaders of future on-going groups. Support groups for youth typically incorporate two key program components:

1. **Social support.** This component is designed to provide group participants with a greater and improved social support network consisting of peers, supportive and caring adults, and family members. The group environment provides youngsters with an opportunity to share their feelings and experiences in an atmosphere of trust and friendship.

2. **Skill-building.** This component is designed to enhance personal resources in the form of life skills which may include decision-making, personal control, coping, and communication. In many cases, participating youth will also acquire the knowledge and skills to seek help and access the physical and mental health systems. The life skills component can be made more relevant by providing participants with the opportunity to apply the skills to current problems and concerns being experienced by the group members.

## Why should we provide support groups for youth?

Young people at-risk for suicide tend to exhibit a number of risk factors, including depression, hopelessness, unresolved losses, alcohol and other drug use, family distress, and other stresses related to school. In addition, lack of coping skills (e.g. problem solving) or maladaptive coping strategies (e.g. withdrawal) are also considered major risk factors. On the other hand, certain factors such as positive self-esteem, a sense of personal control, peer and family support, and school bonding are known to protect children and adolescents against suicidal tendencies.

By enhancing personal resources, increasing social support networks, and decreasing maladaptive behaviours, this strategy aims at reducing the negative impact of a number of risk factors for suicide, while bolstering important protective factors.

## How do we know support groups for youth hold promise?

***Promising results have been noted***

Evaluation of skilled-based support groups has demonstrated very promising results. Participants in these programs have consistently shown improvements in emotional well-being. More specifically, youngsters show a decrease in depression, hopelessness, stress, anger, and an increase in self-esteem and personal control. These gains have also been shown to be maintained or to increase over time.

This type of strategy has also been successful in the prevention of other adolescent problems such as drug abuse, delinquency, school failure, and school dropout. Among adolescents, these high-risk behaviours (including suicidal behaviours) are often interrelated. The success of support groups in reducing the risks for other maladaptive behaviours adds to the evidence that this strategy holds very promising potential in reducing risks for youth suicide.

***Experts recommend this strategy***

The available evidence has prompted a number of suicide prevention experts and organizations such as the U.S. Centers for Disease Control & Prevention (CDC) to recommend the implementation of this strategy for the prevention of suicide among at-risk youth.

## Setting up for success

There are three steps that should be addressed in setting up a support group for youth.

1. **Decide how you will organize and structure your support group program**
   When planning a support group for youth, you may decide to design your own program or implement a tested curriculum that is available for purchase. If you opt to develop your own program, it may be useful to consult with existing support programs (even if designed for adults) to see how they are structured and what makes them successful. We also invite you to consult *In our own backyard* for a description of one such program. Finally, remember that community mental health workers can be of great assistance in the development phase of a support group for youth.

   On the other hand, there are a number of tested curricula that you can purchase and implement to fit your own needs. One support group curriculum that has proven to be very effective is highlighted in *A place to start*. Above all, remember that a support group should address, as much as possible, a number of suicide risk and protective factors.

2. **Involve the family or guardians of high-risk youth**
   Families of participating youth should be well informed about the purpose and content of a support group. It is also recommended that a component designed to strengthen family support be incorporated into all support group programs. Family members or guardians should be engaged as "partners" from the onset so that they may understand the process, be prepared for any interim negative impact on family life, contribute where appropriate, and reinforce and reward the youth's participation and successes. If handled delicately, involving families may also provide an opportunity to address certain risk factors in the family such as alcoholism and lack of family support.

3. **Ensure that high-risk youth do not feel "labeled" because of their participation**
   Efforts must be made to ensure that youngsters do not feel negatively "labeled" because of their participation in support group programs. This may be especially relevant when the support groups are organized within a school setting where it may be easy for the general student population to find out who is attending. For example, you may consider giving the group a non-stigmatizing or fun name that reflects its primary focus on well-being and health promotion.

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

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

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

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

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

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

## Methods to evaluate

| | Ask a Key Evaluation Question | Measure the Success |
|---|---|---|
| SHORT TERM* | Are youth satisfied with the program? | ➢ measure participant feed-back regarding the support group, their satisfaction with the materials presented, and the teaching methods used |
| | Are participating youth demonstrating that they are capitalizing on available support? | ➢ observe peer interactions before and after participation in the program and compare<br>➢ measure perceived social support from friends, family members, and other adults before and after participation in the program and compare |
| | Are participating youth showing increased use of personal resources? | ➢ measure skills for managing mood, stress, and anger before and after the implementation of the program and compare results to determine whether the program has made a difference<br>➢ measure life skills competencies (e.g. skills in decision-making, personal control, communication, coping) before and after participation in the program and compare results to determine whether the program has made a difference |
| MEDIUM TERM** | Are participants showing improvement in the following areas? | |
| | a) emotional well-being | ➢ measure depression, self-esteem, stress and suicide ideation |
| | b) school performance | ➢ measure attendance, academic performance, and antisocial behaviour |
| | c) reduced alcohol and drug abuse | ➢ measure alcohol and drug use |
| LONG TERM*** | Are suicide and suicidal behaviours among youth decreasing? | ➢ measure the number of deaths by suicide and attempted suicides in the community and compare to previous statistics |

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

## A Place to Start

### Programs

**The Breakfast Club**

The Breakfast Club, which began in 1992, is part of the Suicide Prevention Resource Centre of Grande Prairie, Alberta. It is a support program for adolescents 12 to 17 years of age who are having trouble coping with problems in their lives. This includes teens that are depressed, involved in drugs or alcohol, having suicidal thoughts or behaviours, at risk for criminal behaviour, or making poor decisions. The goals are for adolescents to identify and express their feelings, understand their personal circumstances, develop coping skills, improve communication with others, and make healthier choices.

The program includes an initial interview, a weekend group retreat, a four to six week follow-up support group, monthly recreation support meetings, and individual support with the Program Coordinator. The support group that meets once a week (for four to six weeks) concludes with a Parent Appreciation Night for parents and guardians. The adolescent is also involved in individual testing and assessment by qualified facilitators and the Program Coordinator. Referrals can be made by anyone in the community: school counsellors, teachers, principals, community agencies, physicians, pastors, parents, concerned friends and family members or adolescents themselves.

The Program Coordinator reports that local Aboriginal youth often participate in the Breakfast Club program. There are usually two or more Aboriginal young people involved in each retreat and follow-up support group, so every effort is made to ensure that at least one of the facilitators is of Aboriginal background. In addition, Aboriginal activities are often integrated in the retreat and follow-up support group.

For more information, contact:
The Breakfast Club
202, 10118-101 Avenue
Grande Prairie, Alberta
T8V 0Y2
Telephone: (780) 539-7142
Fax: (780) 539-6574
E-mail: cispp@telusplanet.net
Web site: www.telusplanet.net/public/cispp

**Youth Net**

Youth Net/Réseau Ado is a bilingual, community based, youth mental health promotion and early intervention program run by youth for youth. The core program has been operating since 1994 throughout Eastern Ontario and Western Quebec. Based on the

success of the program, the Youth Net Satellite program has recently been set up to facilitate the expansion of this program to other communities across Canada.

The main goal of Youth Net is to provide a forum for young people to express, explore and discuss their views and concerns about mental health. The program works to develop strategies for making current mental health services more youth-friendly and empowering and to help youth develop connections with a safety net of youth-friendly professionals. The program focuses on two main activities:

- **Focus groups**
  Youth Net holds focus groups (90 minutes long), which are run by two older youth facilitators (aged 20 to 30), and involve 8-12 youth who are between the ages of 13 and 20. Through these focus groups, youth can discuss the mental health issues they are facing, their views about the mental health system, and how the system could better meet their needs. Youth are reached in schools, community centres, treatment centres, detention centres, drop-ins, and any place where youth are found in rural and urban areas. Although this program was developed to meet the needs of the general youth population, focus groups have also been held with Aboriginal youth at the Odawa Native Friendship Centre in Ottawa. In addition, the Youth Net satellite program located in the Owen Sound area (a few hours from Toronto) has trained an Aboriginal youth facilitator and plans to hold focus groups on the Saugeen Reserve in the near future.

- **Therapeutic support groups**
  Youth Net also provides longer-term therapeutic support groups for youth having difficulties. These groups were initiated as a result of youth expressing a need for more practical supports delivered through a continuing group format where they could explore and discuss their life issues and problem-solve together to find solutions. Support groups are led by young graduate students and/or experienced Youth Net facilitators, who are supervised by a clinical psychologist and a child psychiatrist. Two distinct models have been implemented:

  The **"depression model group"** targets those youth with significant depressive symptomatology and include individual pre and post-assessments. This group runs for 12 weeks and addresses a variety of issues related to depression and suicide.

  The **"support group model"** is more general in focus and participants discuss problematic life issues in a supportive environment. The length of this support group varies depending on the needs of the youth.

For more information on setting up a Youth Net program, contact:
Lynn Chiarelli
Youth Net Satellite Coordinator
Children's Hospital of Eastern Ontario
401 Smyth Road
Ottawa, Ontario
K1H 8L1
Telephone: (613) 738-3239
E-mail: chiarelli@cheo.on.ca
Web site: www.youthnet.on.ca

## Resources

**Reconnecting Youth: A Peer Group Approach to Building Life Skills**

*Reconnecting Youth* (written by Leona Eggert, Liela Nicholas, and Linda Owen) is a step-by-step leader's guide designed for use by a facilitator in a small group setting, with high-risk students from grades 7-12. The curriculum is based on the integration of two key components: social support and life-skills training. Four life skills areas are emphasized: self-esteem, decision-making, personal control, and interpersonal communication. The guide contains 80 lessons that can be presented in sequence, selectively, or integrated into other curricula. Each lesson contains key concepts, learning objectives, preparations, materials, activities, reproducible handouts, overheads, and step-by-step suggestions for presentation.

This curriculum has proved effective in helping high-risk youth achieve in school, manage their anger, and decrease drug use, depression, and suicide risk. The program was piloted for five years with over 600 public high school students in Seattle, WA and has since been successful in alternative schools, private schools, and many other educational settings.

To order this curriculum (quoting item number: BKF00034), contact:
National Educational Service
304 West Kirkwood Avenue, suite 2
Bloomington, IN
47404
USA
Telephone: (812) 336-7700 or 1-800-733-6786
Fax: (812) 336-7790
E-mail: nes@nesonline.com
Web site: www.nesonline.com

**Youth helping youth: A guide to starting a self-help group**
This 30-page guide was created specifically to meet the needs of youth who want to start their own self-help group. As such, the guide was written with input from youth who participated in a focus group. Following a description of self-help and the benefits of self-help groups for youth, the guide describes the necessary steps in setting up such a group. Here are some of the topics that are explored in the guide: Where to start; Building your team; How a meeting might go; Ground rules; Space; Avoiding burn-out; Money; and Forming an organization. The guide can be purchased from the Self-Help Connection for a small cost.

The Self-Help Connection also produces the Starter's Kit: Tips for starting a self-help group. This 6-page document provides a number of tips for starting a self-help group but is not specific to youth.

For more information on either of these resources, contact:
Self-Help Connection
63 King Street
Dartmouth, NS
B2Y 2R7
Telephone: (902) 466-2011
Fax : (902) 466-3300
E-mail: selfhelp@att.ca

## Suggested reading

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

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Orbach, I. & Bar-Joseph, H. (1993). The impact of a suicide prevention program for adolescents on suicidal tendencies: Hopelessness, ego identity, and coping. *Suicide and Life-Threatening Behavior*, 23(2), 120-129.

Thompson, E.A., Horn, M., Herting, J.R., & Eggert, L.L. (1997). Enhancing outcomes in an indicated drug prevention program for high-risk youth. *Journal of Drug Education*, 27(1), 19-41.

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

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

# Chapter 5: A Community-Wide Approach to Suicide Prevention

A comprehensive, community-wide approach to youth suicide prevention that recognizes the complexity of the problem and capitalizes on the skills and talents of a broad range of community partners, professional disciplines, organizations, and government departments, has the greatest likelihood for success.

While each community is unique and each will be at a different stage of organizational readiness for developing a community-wide approach to suicide prevention, there are some key broad level considerations that can guide program development and community organization in this area.

The step-by-step guidelines presented in this chapter are designed to assist communities in the development or enhancement of a community-wide approach to youth suicide prevention, reflecting a coordinated approach to implementing the 17 promising strategies. The seven guidelines are as follows:

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

## Remember our focus

***on "before-the-fact" suicide risk prevention***

*It is important to be reminded that the promising strategies that have been included in this manual are all "before-the-fact" in nature (see chapter 3). As such, this chapter on community-wide organization does not specifically refer to any clinical or treatment strategies designed to be implemented with individuals at clear risk for suicide, even though these are obviously essential components in any comprehensive youth suicide prevention effort. Suffice it to say that individual assessment, treatment, and other clinically-based efforts take place in a range of settings including mental health centres, hospitals, treatment facilities, and private practitioners' offices, and the planning and delivery of these services should obviously be well-linked to the "before-the-fact" promising strategies.*

**1. Check out your community's assets**

What is your community's current status with respect to the articulation, development, and implementation of a community-wide plan for suicide prevention? This could range from having no current plans or strategies in place to the presence of a well-established, highly organized community-wide approach to suicide prevention. Most communities fall somewhere in between these two extremes.

The following checklist can serve as a reference point for assessing your community's current status in the development of a community-wide suicide prevention effort, based on the 17 promising strategies. Please indicate below the key elements of your community's current suicide risk prevention effort (check all that apply):

***Community renewal efforts***

- cultural enhancement
- traditional healing practices
- community development
- interagency communication and coordination

***Community education efforts***

- peer helping
- youth leadership
- community gatekeeper training

- public communication and reporting guidelines
- means restriction

***School Efforts***

- school gatekeeper training
- school policy
- school climate improvement

***Youth/Family Efforts***

- self-esteem building
- life skills training
- suicide awareness education
- family support
- support groups for youth

**2. Capitalize on the expertise of a range of community partners**

What community partners, organizations, and agencies are committed to participating in your community-wide suicide prevention effort?

**a) Generate a list that reflects the current situation**

These may include the agency and individual representatives who are currently participating in a suicide prevention effort, but could also include those professionals working within the community who have a specific mandate for responding to at-risk individuals.

**b) Who is missing?**

Use the list below to identify key groups/representatives with which you would like further involvement.

- tribal administrators
- council members
- mental health professionals
- child, youth and family serving agencies
- schools
- youth
- parents
- survivors (family members or friends who have lost a loved one to suicide)
- emergency personnel
- police/RCMP
- spiritual leaders
- clergy
- physicians
- crisis/distress centres
- hospitals/health centres

- public health
- media
- policy makers/government
- volunteer associations
- other (specify)_____

**3. Gather pertinent information**

**a) What does the available information reveal about the needs of your community?**

Gathering information about the specifics of your community will help you tailor your community suicide prevention initiative. The kind of information that is useful includes: demographics of the community, health status, as well as suicide statistics (deaths by suicide and attempts by age group). Remember that death by suicide is a relatively rare occurrence within a particular community, so do not rely exclusively on mortality data to guide your planning efforts. You can use a variety of information sources to determine the unique profile and particular needs of your community including:

- regional suicide statistics (Vital Statistics)
- health determinants data
- community-wide survey data; stakeholder consultation feedback

**b) What are the strengths of your community?**

You should take the time to analyze and outline the strengths found in your community (e.g. commitment to upholding family and cultural values) that may be utilized in program activities. It may also be important to identify some potential barriers to the development of a suicide prevention program (e.g. denial of suicide among community members).

**c) Consider holding a community consultation meeting**

Ask members of your community what they think about the issue or undertake a survey of caregivers in the community regarding their perceptions about the problems and potential solutions, to build further commitment and fill in potential gaps in information (see box, *Community consultation guidelines*).

## Community consultation guidelines

*Provide an opportunity for broad public input and solicit the opinions and perceptions of a broad range of community members. For example hold public meetings, establish small focus groups or conduct a telephone survey, in order to receive feedback from a variety of groups within your community.*

***Questions to consider include:***

- *Do they perceive suicide and self-destructive behaviour among youth to be a problem?*
- *If so, what leads them to believe this, or according to them, what is the evidence?*
- *If it is not perceived to be a problem for this community, what is a more pressing or urgent problem that needs to be addressed?*
- *Can the issue of youth suicide be approached from another perspective or through the efforts of other prevention initiatives (e.g. youth violence, injury prevention, substance abuse prevention, health and well-being promotion)?*
- *What are community members' perceptions about what needs to be done?*
- *What are the strengths/capacities of the community in responding to this problem or issue?*
- *What gets in the way?*
- *Can some consensus be reached regarding what are perceived to be community priorities?*

*If the issue of suicide it is not viewed as a priority area for the community at present, and cannot be integrated with other current initiatives, then it is not advisable to "force the issue." This does not mean, however, that the work of suicide prevention needs to be abandoned altogether.*

## Community consultation guidelines

*Work on those areas that the community perceives to be the most important and pressing concern. Meanwhile, continue to be strategic by taking advantage of opportunities to educate and heighten awareness about the issue of youth suicide; by helping others to make the links between suicide prevention and other prevention/ health promotion efforts; and by lending your explicit support to community-based efforts that seek to enhance the protective conditions within the community, including increasing social support and reducing isolation; building opportunities for youth to become involved in decisions that affect them; strengthening families; and creating supportive school environments.*

**4. Do your front-end work**

Based on responses to the issues identified earlier, take the time to think through some of the following questions, prior to sketching out a preliminary workplan:

a) Which of the 17 promising strategy areas which have been described throughout this manual does your community want to develop or enhance? *Ideally*, a community should be developing and implementing efforts in all of the strategy areas simultaneously, but given the reality of limited resources, strategies may need to be developed and undertaken more slowly, with an aim towards building them up over time.

b) How does the available information, knowledge of your community, and current literature support or justify strategy development in this area?

c) In order to undertake further strategy development, which community partners need to be involved? How can you increase the likelihood of their commitment? What information or data could help you to "build a case" for their continued involvement?

d) Can the community-wide suicide prevention mandate be advanced through an existing interagency body by forming a sub-committee?

e) Who will take responsibility for providing the local leadership for this effort? A core working group? A particular agency? A rotating chairperson?

**5. Set up an interagency planning body**

While the overall goal of any community-wide suicide prevention effort must necessarily be the reduction of suicides and suicidal behaviours among youth, this is not a goal that can be achieved by any one particular agency acting in isolation. Reducing suicides and suicidal behaviour is not something that can be achieved overnight, nor will one single strategy be enough. It is therefore ideal to establish an interagency body that can coordinate specific results-oriented suicide prevention strategies, which are designed to be implemented across an array of settings and maintained over time.

For communities interested in establishing a formal interagency body for suicide prevention, some key considerations should be kept in mind:

***Build on the existing structure***

Build on the existing community infrastructure wherever possible. It is neither necessary nor efficient to create a new organizational structure for every particular youth problem or issue, including suicide. Rather, create a youth suicide prevention sub-committee from an existing intersectoral body.

***Work with the local governing bodies***

The community-wide approach to suicide prevention is more likely to be successful if it is part of an established and legitimate body that has been given an explicit mandate to promote the well-being of youth and reduce risks to their overall health. Furthermore, by including the work of suicide prevention in broader youth health promotion and prevention efforts, some important links between youth suicide prevention and other related issues will be fostered, for example substance abuse prevention, school drop-out prevention, or youth participation projects.

***Advocate and coordinate***

The role and corresponding duties of the local suicide prevention interagency group include:

- providing a strong voice for suicide prevention
- spearheading key initiatives
- ensuring the coordination of various suicide prevention efforts
- sharing and collecting key information
- establishing functional links across agencies
- advocating for services/community approaches that are known to reduce suicide
- monitoring the effectiveness of the combined community efforts

***Facilitate key linkages***

Individual agencies, hospitals, and mental health professionals will clearly be contributing to the overall goal of reduced suicidal behaviour through the provision of assessment, crisis intervention, and treatment services. While it will be up to each of these organizations/practitioners to monitor the effectiveness of their own

individual efforts, the interagency body can facilitate important linkages, assist with identifying community priorities, and coordinate/aggregate information across organizations.

## What's been said so far

*At this stage, if you have attended to each of the above considerations, it is assumed that:*

- *an interagency planning body has been established to provide the direction and leadership for a community-wide suicide prevention initiative*
- *the interagency planning body is ideally a sub-group of a larger community-wide planning structure which has been given a specific mandate to improve the health and well-being of youth and/or improve the coordination of services to this population*
- *priorities for action have been identified based on the information available*
- *the "right players" and community partners are on-board*
- *the interagency body understands its role*
- *an organizational structure has been established for "getting on with the work"*

### 6. Develop an interagency action plan

a) It is wise for the interagency planning body to set some long-range goals as well as some more intermediate targets, always keeping in mind that the ultimate goal is the reduction of fatal and non-fatal suicidal behaviour.

b) Try to plot out your workplan according to a timeline (e.g. one to three year workplan).

c) Whatever strategy does get implemented, ensure that it is results-oriented. For example, what would you expect to change as a result of your intervention: individual attitudes, knowledge, behaviours; agency practices; level of community coordination; media reporting; policies, etc.

d) Identify who is going to take responsibility for what, by agency and/or by individual.

e) Monitor your results based on previously identified indicators of success (see *How will we know if we are making a difference?* for each of the 17 strategies).

f) Share your findings with a broad range of community partners and stakeholders as well as those implementing suicide prevention strategies in other areas of the province.

g) Refine and build on previous efforts, based on the results achieved.

h) Celebrate your successes and learn from those things that did not work.

Please keep in mind that these ideas are meant to serve as broad planning guidelines only. Hopefully they will enable you to begin planning or will enhance the efforts you already have underway. Be aware, however, that there is no one single approach that will work best for every community. Draw on the expertise of your community to determine what will be the best course of action or "best fit."

**7. Evaluate your community-wide suicide prevention efforts**

Evaluation is a way of measuring whether a program is doing what it is supposed to do and it provides an opportunity for you to improve the program. It means asking questions and gathering information in order to: assess how a program is coming along (process evaluation) and compare the program objectives with the actual results (outcome evaluation).

## It's not easy to evaluate prevention programs...

*Community-wide efforts that have as their ultimate goal the prevention of suicide and suicidal behaviour are difficult to evaluate for a number of reasons:*

1. *Deaths by suicide are fairly infrequent events when considered at the local or community level, which makes it difficult to detect changes that may be due to specific program efforts or strategies.*
2. *It is very difficult to measure a "non-event," in this case the prevention of suicide.*
3. *Many of the promising strategies described in this manual are designed to target children and youth and their environments through such efforts as building their social competencies, strengthening their families, and improving conditions within the school and community. The effects of such programs on later suicidal behaviour may not be known for several years after the intervention.*
4. *Suicide and suicidal behaviour are not outcomes that follow a straight line or simple path, with specific markers leading predictably to a suicidal crisis or death. This makes it challenging to identify the appropriate intermediate targets for change and the corresponding outcome measures that would be most suitable for evaluation purposes.*

***...but it's not impossible***

*As we have already noted, suicidal behaviour is multiply determined, and there are a wide range of risk conditions that interact with one another, serving to create a vulnerability for suicidal behaviour. Evaluating the effectiveness of youth suicide prevention efforts means having an appreciation for the complexity of the behaviour, understanding the multiple paths that lead to conditions of risk or vulnerability among youth, and identifying appropriate short, intermediate and long-term indicators of success (as described for each strategy in Chapter 4). By identifying the traits, events and conditions that increase suicide risk or enhance competencies in youth across a range of settings, and by explicitly measuring those things, we are no longer faced with having to place exclusive reliance on suicide rates as our only outcome measure.*

Here are five steps that you can follow when evaluating your program:

1. **Identify the purpose of the evaluation**
   In this first step, you should clarify what you need and expect from the evaluation process to ensure that the evaluation will be useful to you and your group. Begin by answering the following questions: Why do you want to evaluate? Who is the evaluation intended for? What do you want to evaluate? How will the evaluation be carried out? and Who will carry out the evaluation?

2. **Prepare your evaluation plan**
   This is the opportunity to develop a more specific evaluation plan. At this stage, you will use what was decided in the first step to finalize your evaluation goals and objectives, prepare the evaluation plan, decide on the evaluation method, and prepare a timetable. Remember to refer back to the examples of short, medium, and long-term indicators of success that were presented for each strategy in chapter 4 (see the box below).

## Short, medium, and long-term indicators of success

***Short, medium, and long-term indicators of success***
*In chapter 4, examples of short, medium, and long-term indicators of success were presented for each of the 17 promising strategies (see the sections titled How will we know if we're making a difference?). While these do not represent the only measures of progress for each strategy, they should give you a good sense of some of the key areas to monitor in your evaluation plan.*

*In reading through each of the 17 strategies, you will have noticed the following:*

- *short-term indicators are those changes that the strategy itself is designed to produce, (for example, increased knowledge);*
- *medium-term indicators of success capture changes that you might come to expect further down the road (for example, increased help-seeking among adolescents or referrals of their at-risk peers);*
- *the ultimate outcome or long-term indicator of success is a reduction in suicidal behaviour and death by suicide.*

**3. Gather the appropriate information**

You now have a more precise idea of what you need to know and you also know how you will gather that information. Begin by reviewing existing information which might help answer your evaluation questions by talking to people and reviewing project documents and other sources of information. If your review of existing materials does not answer all of your evaluation questions, you may need to gather new information to get a complete picture. This may involve the use of information-gathering tools like questionnaires, interviews, and observation.

**4. Make sense of the information**

By now, you have gathered all the information you need to answer your evaluation questions. Your next step will be to compile and analyze that information and draw conclusions from it. Your conclusions may deal with the process (how things are going in the program) or they may deal with the outcome (the extent to which the expected results or program objectives were achieved).

**5. Use the results**

In this step, you will go ahead and make recommendations, write the report, make the results known, and take appropriate action. People involved in the program as well as community members will be interested in knowing and talking about the results of the evaluation. You may want to organize a feedback session to give people a chance to learn about and comment on the findings. Don't forget that you may want to use part of your report in funding requests. Depending on the evaluation results, you will now go ahead and strengthen or modify certain components of your program to make it even more successful.

## Check these out...planning and evaluation resources

***Check these out…planning and evaluation resources***
*Several books and manuals have been prepared to assist communities to develop high-quality proposals, secure funding, and establish sound evaluation practices. Naturally, some are more "user-friendly" than others. Noteworthy resources that provide good solid advice in a very practical and easy-to-read format are:*

- *Health Funding Arrangements Division (n.d.).* A guide for First Nations on Evaluating Health Programs, *Ottawa, Ontario: Health Funding Arrangements Division, Program Policy Transfer Secretariat and Planning Directorate, Medical Services Branch (MSB), Health Canada. You can view or download this document at: www.hc-sc.gc.ca/msb/pptsp/hfa/publications/evaul_e.htm*

- *Health Canada (1999).* Community Action Resources for Inuit, Métis and First Nations: Evaluating. *Ottawa, Ontario: Health Canada. You can view this document (in PDF) on the Health Canada web site at: www.hc-sc.gc.ca/hecs-sesc/cds/pdf/evaluating.pdf*

- *Holt, J. (1993).* How about…Evaluation: A handbook about project self-evaluation for First Nations and Inuit communities. *Ottawa: Medical Services Branch, Department of National Health and Welfare Canada*

- *Ewles, L. & Simnett, I. (1992).* Promoting health: A practical guide. *London: Scutari Press*

## The final word

The value of generating specific, results-oriented findings through the systematic monitoring and evaluation of our community-wide suicide prevention efforts cannot be overestimated. Committing to such a process will allow us to learn from each other and will allow us to focus our energies on those areas that hold the greatest chance for success. By increasing our commitment to evaluating our youth suicide prevention efforts we will also be adding value to our existing knowledge base, which in turn will refine our understanding about what constitutes best practice in youth suicide prevention.

## Suggested Reading

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

Boldt, M. (1985). Toward the development of a systematic approach to suicide prevention: The Alberta model. *Canada's Mental Health*, 33, (2), 2-4.

Centers for Disease Control (1988). CDC recommendations for a community plan for the prevention and containment of suicide clusters. *Morbidity and Mortality Weekly Report*, 37, (5), 1-12.

Dyck, R., Mishara, B., & White, J. (1998). *Suicide in children, adolescents, and seniors: Key findings and policy implications*. Ottawa: National Forum on Health.

Hinbest, J. (2001). *Evaluation report. Youth suicide prevention in British Columbia: Putting best practices into action.* Vancouver: Suicide Prevention Information & Resource Centre, Mheccu, UBC.

Kretzmann, J. & McKnight, J.L. (1993). *Building communities from the inside out: A path towards finding and mobilizing a community's assets.* Evanston, Illinois: Center for Urban Affairs and Policy Research.

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

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

Royal Commission on Aboriginal Peoples (1995). *Choosing life: Special report on suicide among aboriginal people*. Ottawa: Minister of Supply and Services Canada.

Simons-Morton, D.G., Simons-Morton, B.G., Parcel, G.S., & Bunker, J.F. (1988). Influencing personal and environmental conditions for community health: A multilevel intervention model. *Family Community Health*, 11(2), 25-35.

# Appendix A

## Aboriginal youth: Suicide risk and protective factors

In this Appendix, the suicide risk and protective factors most relevant to Aboriginal youth are highlighted. For the purpose of this discussion, the risk factors have been organized into four categories: individual factors; family/peer-related factors; community/societal factors; and cultural factors.

### How good is the best available evidence?

*It is important to mention that while scientific studies can identify the factors that contribute to suicide, no scientific study can explain why a particular person acts to end his or her life. The literature on suicide identifies and discusses many risk factors for suicide and suicide behaviour, but almost all of the assumptions made about causality are based on "association factors." Therefore, we remain on shaky ground when we try to use this information to actually predict which particular individuals will go on to die by suicide. In spite of the imperfection of our present knowledge, the information that has been accumulated to date regarding the risk and protective factors for suicide among youth is very useful and can serve to guide our ongoing prevention efforts.*

**1. Risk factors at the individual level**

**Summary of the risk factors at the individual level:**

- *mental health issues*
- *personality traits (e.g. impulsivity)*
- *low self-esteem*
- *absence of personal purpose*
- *previous history of a suicide attempt*
- *alcohol and substance abuse*
- *sexual orientation or two-spirited issues*
- *conflict with the law*

***Mental health issues***

There is very strong evidence that having a mental disorder places a person, regardless of their age, at considerably higher risk for suicide than the general population. "Psychological autopsy" studies (investigations done following suicides) have found that a significant proportion of people who died by suicide had a mental disorder. In the case of Aboriginal people, a recent case-control study of death by suicide among the Inuit of Northern Quebec showed that case subjects were 4.3 times more likely to have had a psychiatric diagnosis in their lifetime, the two most common being depression and personality disorder.[1] Another study of a small Arctic Inuit community found a strong association between anxiety disorders and suicidal behaviour.[2]

The prevalence of mental disorders in the Canadian Aboriginal population has been poorly documented, making it difficult to determine what proportion of suicides are associated with major mental disorders. The few studies examining mental disorders in North American Aboriginal populations have reported varying rates from levels comparable to those found in the general population to levels twice those found in the general population.[3] Reports from clinicians working in Aboriginal communities suggest high rates of depression in many communities. Schizophrenia, bipolar disorders, and possibly panic

[1] Boothroyd, Kirmayer, Spreng, Malus & Hodgins, 2001
[2] Manzer, 2001
[3] Kirmayer, Brass & Tair, 2000

disorder, may also be important contributors to suicide in Aboriginal communities.[4] It is important to mention, however, that Aboriginal people in general, and youth in particular, rarely seek out mental health services and, when they do, their condition is often misdiagnosed or under-diagnosed.

***Personality traits***

Studies in the general population have shown that certain temperaments may contribute to suicide risk. More specifically, there is evidence that social withdrawal, hypersensitivity (being extremely sensitive to others' anticipated judgments and being highly self-critical), personal rigidity (having difficulty generating alternatives when faced with problems and being very fixed in one's perspectives), and impulsivity (acting or reacting with no thought or attention paid to the consequences) are common temperamental traits of people who die by suicide. Individuals who die by suicide but who have no apparent mental health problems tend to show excessive performance anxiety and perfectionism along with a poor response to stress.

***Substance abuse***

Studies show that suicide and suicidal behaviours are clearly linked with substance abuse (including alcohol) in Aboriginal and non-Aboriginal people. A high blood alcohol level at the time of death may reflect an association between acute alcohol intoxication and suicidal behaviour. Alternatively, the association may be due to a relation between sustained alcohol use and psychological distress (for example, depression). Studies of adult Aboriginal suicides in British Columbia., Alberta, and Manitoba have estimated that between 75% and 90% of the victims are intoxicated at the time of their death.[5] [6] Among non-Aboriginal adults, measured rates of intoxication in those who attempt or die by suicide can vary from a low of 25% to a high of 66%.

Substance abuse also represents a relevant factor in Aboriginal youth suicide. A study done in Manitoba found that alcohol was involved in 60.7% of the young Aboriginal/Métis suicides and 42.9% of the young non-Aboriginal suicides. The study also found that substance abuse was a higher risk factor among Aboriginal/Métis (44.4%) than among non-Aboriginal suicides (23.8%).[7] Another study of solvent abuse in Inuit youth found that individuals who had used solvents were eight times more likely than non-users to have made a suicide attempt.[8]

Alcohol and drug consumption by young people remains a significant problem in many Canadian Aboriginal communities. Compared to the general population of youth,

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[4] Kirmayer, 1994
[5] Cooper, Karlsberg, & Pelletier, 1992
[6] Malchy, Enns, Young, & Cox, 1997
[7] Sigurdson, Staley, Matas, Hildahl, & Squair, 1994
[8] Malus, Kirmayer, & Boothroyd, 1994

Aboriginal youth report that they begin drinking earlier and that they drink more heavily.[9] They are also more likely than their counterparts to consume alcohol on their own, away from the company of peers. Aboriginal youth also abuse other substances such as gasoline and glue more frequently than non-Aboriginal youth.

***Sexual orientation or "two-spirited" issues***

Traditionally, two-spirited persons (lesbian, gay, transgendered and bisexual) were valued in many Aboriginal communities as they were considered to have a great gift of vision that went beyond most people's abilities. Two-spirited people were not only considered normal, but a crucial and much needed part of the natural world and of the community as a whole. Like the non-Aboriginal community, First Nations, Inuit and Métis communities have grown to fear and reject members who are sexually different. As a result, most two-spirit and transgendered Aboriginal young people live with high levels of discrimination and intolerance which often prompts them to leave their community and move to a larger urban setting where they experience loneliness, isolation and are vulnerable to victimization.

We know that gay, lesbian, and bisexual youth are at greater risk for suicide problems than their heterosexual counterparts.[10] Recent studies in Canada and the United States suggest that homosexuality issues are involved in up to one third of young men under 24 who die by suicide. Relevant data also suggest that Aboriginal gay youth are often subjected to high levels of homophobia and have serious suicidality problems.[11]

**2. Risk factors at the family and peer levels**

**Summary of the risk factors at the family and peer levels**

- *friends or family members attempting or completing suicide*
- *change of caretaker during childhood or adolescence, history of non-parental caretakers, chronic family instability, or disrupted relations (e.g. multiple foster placements or adoptions, arrest or hospitalization of caretakers)*
- *family or caretaker history of mental health problems, including alcoholism, drug abuse, or depression*
- *physical or sexual abuse*
- *interpersonal isolation*

[9] Gotoweic & Beiser, 1994
[10] Remafedi, 1999
[11] Bagley & Tremblay, 1997

***Suicide in family members or friends***

There is a proven link between losing a friend or family member to suicide and a higher risk for subsequent suicidal behaviours. A recent study found that the most powerful risk factor for a past suicide attempt among American Indian and Alaska Native male and female youth was having a friend who attempted or died by suicide. The study also found that having a family member who attempted or died by suicide was also a significant risk factor for a past suicide attempt among both male and female adolescents.[12] An earlier study conducted with Navajo adolescents found the same associations.[13] Tragically, a high number of Aboriginal young people are confronted to at least one, if not several suicides in the course of their young lifetimes, because of the high rates experienced by many Canadian Aboriginal communities.

***Childhood separation and loss***

Suicide is associated with a history of early separations, losses, and emotional deprivation. Examples include the early loss of important nurturing figures in the family through death, divorce, or desertion. Children living with their parents also suffer if the parents have a serious alcohol or chemical dependency problem and are unavailable to provide a nurturing environment for their children. Studies have also found that youth who die by suicide are more likely to have had a change of caregiver during their childhood or teenage years.

Childhood separation and loss is an issue for Aboriginal children and adolescents as many live in single parent families (32%) or with adult caregivers that are not their natural parents (11%).[14] This is not to say that all children coming from single parent families or living in foster care are at risk for suicide. The degree of support by extended family, relatives, elders and other members of the community will also have an impact on the emotional well-being of these young people.

***Family violence***

A number of studies have shown that a history of physical and sexual abuse represent risk factors for suicide attempts among American male and female Aboriginal youth.[15] [16] Although it is difficult to know the full extent of physical and sexual abuse in Aboriginal communities, most agree that it is a serious intergenerational problem occurring both on and off reserves in many communities across the country.

Suicide in young people is also associated with a family history of violence or assault, imprisonment, and harmful use of alcohol or other drugs. Unfortunately, it is often difficult to disclose and confront family violence and abuse in small communities. This

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[12] Borowsky et al., 1999
[13] Grossman, Milligan, & Deyo, 1991
[14] Data obtained from Statistics Canada
[15] Borowsky et al., 1999
[16] Grossman, Milligan, & Deyo, 1991

can contribute to the stress level and distress of the victims. Mental health problems suffered by family members can also heighten the risk for suicide in the young people living in the same household. Many Aboriginal adults have faced a series of losses, forced separations from their families, and physical and sexual abuse as a result of their attendance at residential schools, leaving many members of this particular generation ill-equipped for parenting their own children.

**3. Risk factors at the community and societal levels**

**Summary of risk factors at the community and societal levels:**

- *access to methods with high lethality (i.e. firearms)*
- *poverty*
- *community instability or lack of prosperity*
- *limited opportunities for employment*
- *lack of proper housing and inadequate sanitation and water quality*
- *isolated geographic location*

***Access to lethal methods of self-injury***

Between 1989 and 1993, data from the Medical Services Branch, First Nations and Inuit Health Program Directorate, indicated that firearms were used by 31% of suicides among First Nations people in Canada, the second most common method after hanging. We know that the availability of a lethal method, particularly firearms, increases the likelihood of that method being used for self-destructive purposes. In the general population, studies have shown that the risk of suicide is five times higher in homes with guns than in those without them and guns are twice as likely to be found in the homes of suicide victims and attempters.[17] [18] Although data regarding firearm ownership among Aboriginal people in Canada is scarce, it is probably safe to suggest that it is high.

***Poverty***

In studies of Native Americans in the U.S. and Aboriginal people living on reserves in Alberta, suicide rates have been shown to be strongly correlated with the percentage of population living below the poverty level. A recent study of American Indians found

[17] Brent, Perper, & Allman, 1987
[18] Brent, Perper, Allman, Moritz, Wartella, & Zelenak, 1991

that, among the variables studied, economic deprivation was the most important contributor to suicide risk.[19]

Aboriginal people were once self-reliant and effectively lived off the land. However, through the process of colonization, the opportunities to engage in traditional subsistence activities were taken away. The living conditions have now become similar to those found in some Third World countries. Statistics show that 84% of Aboriginal households live below the Canadian poverty line. For the on-reserve Aboriginal population, the average income was 56% below the Canadian average.[20] In 1996, it was estimated that approximately 52% of Aboriginal children (0-14) lived under the poverty line, compared to 23% of all Canadian children.[21]

***Unemployment***

Most studies done in the general population show that suicide attempts are strongly associated with unemployment (in both men and women). Rising unemployment is also related to increased suicide rates, more so for men. Rates of unemployment are significantly higher for Aboriginal Canadians when compared to the general population (19.4 % compared to 10%). Unemployment is especially widespread for Aboriginal people living on reserves. Approximately 42% of Aboriginal people living on reserve rely on social assistance, compared to 25% of Aboriginal individuals living off reserve.[22]

In trying to find work, Aboriginal people are often faced with numerous obstacles. Jobs in their own communities may be limited at times, due to a lack of natural resources upon which to base local economic development. When Aboriginal people move to urban centres, they can be confronted with discrimination in the labour market and can find that their education and skills may be insufficient to compete successfully in the job market. Although most young people may not be seeking employment, they witness the impact unemployment is having on their family members and other members of the community. Adolescents see little opportunity for work and may begin to feel helpless and hopeless about their future.

***Housing conditions***

The inadequate infrastructure of some Aboriginal communities contributes to physical, mental, emotional, and social dysfunction. Housing, water, sanitation, fire and emergency services, communication and transportation systems, as well as recreational, education and health facilities can be below standard or inaccessible to everyone in the community. Statistics show that 29% of Aboriginal people live in overcrowded housing, compared with 2% of the general Canadian population. Houses occupied by Aboriginal people are twice as likely to be in need of major repairs as those of other Canadians. In addition, 23% of on-reserve houses have neither piped or well water.[23]

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[19] Bachman, 1992 (cited in Kirmayer, 1994)

**4. Risk factors at the cultural level**

**Summary of risk factors at the cultural level:**

- *breakdown of cultural values and belief systems*
- *loss of control over land and living conditions*
- *negative attitude of the predominant non-Aboriginal culture*

***Cultural disruption***

Cultural disruption comes about when the complex interaction of relationships, knowledge, languages, social institutions, beliefs, values, and ethical rules that unite a people and give them a collective sense of belonging is forced to change. Over decades, significant pressure from governmental, educational, medical and religious institutions to assimilate Canada's Aboriginal peoples into the mainstream culture has resulted in tremendous cultural disruption. Residential schools, relocation and confinement to reserves, inappropriate foster placement and adoption policies, and political marginalization are all examples of the kinds of oppressive experiences that have been imposed on Aboriginal people by mainstream institutions. The legacy of these experiences has been the breakdown of cultural ways and a loss of identity.

There is some evidence of a relationship between cultural disruption and suicide. First, other indigenous populations around the world that have undergone similar stresses to their cultural foundations also tend to show higher rates of social disorder and suicide. Second, research has shown that a return to cultural roots and a strengthening of a community's self-determination has a tendency to lower the rate of suicide in that community.

***Marginalization***

The literature often uses the term "marginalization" when referring to individuals who do not acquire the skills, values, and tradition of either the mainstream or traditional culture. This situation is very relevant for many Aboriginal youth who are "caught between two cultures" and have difficulty relating to either of them. This failure to become integrated in either culture may represent a risk factor for today's Aboriginal youth.

### 5. Protective factors

**Summary of protective factors:**

- *support from family and friends*
- *perceived connectedness to family and friends*
- *strong cultural ties*
- *good physical and mental health*
- *strong spiritual ties, regular attendance at spiritual events*
- *good school performance*
- *positive attitude towards school*
- *skills in stress management, communication and problem solving*
- *fear of suicide and moral objections to suicide*
- *sense of belonging*
- *positive self-esteem*
- *early identification and appropriate treatment of psychiatric illness*

***Cultural continuity***

Achieving a high level of local community control (or cultural continuity) and identity seems to offer some protection from suicide in certain communities. A recent study found that the extent to which communities in British Columbia are actively engaged in a process of rebuilding or maintaining their cultural continuity is directly related to the rate of suicide of that community. As such, Aboriginal communities that have taken active steps to preserve and rehabilitate their own cultures are shown to be those in which youth suicide rates are lowest.[24] The concept of cultural continuity may protect youth against suicide by sustaining a sense of self and a will to live, especially when faced with adversities.

***Social networks and connectedness***

Generally, it has been convincingly demonstrated that social support and good social relations are important to one's mental health. A study focusing on American Indian/ Alaskan young people (male and female) found that a willingness to discuss problems with friends and family, emotional health, and connectedness to family were all protective factors that reduced the risk for suicide attempts. A recent large American study showed that a strong connection to family and school, and perceived caring and

[24] Chandler & Lalonde, 1998

connectedness to others, protected mainstream teenagers against a range of health risk behaviours, including suicidal thinking and behaviours, as well as harmful drug use. More specifically, the study identified the following protective factors: family support and parents who are involved in activities with their children and adolescents, are present in the home, and have high expectations for educational success.[25]

***Spirituality***

Spirituality, encompassing traditional spiritual knowledge and different religious affiliations, represents another important protective factor against suicide. Spirituality has always played an important part in the lives of Aboriginal people. Aboriginal spirituality is seen as a philosophy and a way of life and is based on the fundamental inter-connectedness of all natural things and all forms of life. Although the traditional lifestyle of Aboriginal people is no longer possible, there has been, in recent years, a revival of interest in many of the old traditions. For Aboriginal people, understanding these spiritual traditions is an important part of understanding one's self.

Although we are not aware of any research looking specifically at the association between strong traditional spirituality and its impact on Aboriginal suicide, we know that healthy and strong spiritual ties are generally linked to good mental well-being. There is, however, some indication that religion or regular attendance to religious ceremonies acts as a protective factor. One study of Inuit youth found that regular church attendance was associated with less likelihood of suicide attempts.[26] It may be that strong religious ties reduce the suicide rate by strengthening social ties and networks through participation in community activities.[27]

[25] Resnick, Harris, & Blum, 1993
[26] Malus, Kirmayer, & Boothroyd, 1994
[27] Kirmayer, 1994

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# Appendix B

## Glossary of terms

**Aboriginal population:** refers to people who are First Nation, Métis or Inuit.

**At-risk individual:** person who has been identified as having certain suicide risk factors (e.g. previous suicide attempt and/or has been exposed to certain risk conditions (e.g. recent suicide of a close peer).

**Caregiver:** Someone who offers care, support, and direction to an individual who is having problems.

**Cluster:** Term used to describe two or more suicides or suicide attempts that take place close to one another in time and space and may involve imitation.

**Contagion:** A process by which one suicide may facilitate others

**Community gatekeepers:** Members of the community who have significant contact with young people as part of their regular professional duties or volunteer responsibilities.

**Contributing factors:** factors which act to exacerbate an existing risk for suicide (e.g. substance abuse).

**Coping skills:** attitudes and skills that an individual can use to handle a stressful situation.

**Early intervention:** interventions targeting groups of young people who are exhibiting signs of early risk (precursors of risk) to suicide and suicidal behaviour, but where a specific risk for suicide has not yet been identified; may also include efforts to develop supportive environments and improve the response capacity of various systems.

**Gatekeeper:** refers to an individual who typically comes into contact with the target population (i.e. youth) as part of their daily routine.

**Goal:** A goal is a broad statement that describes what a program or activities should achieve.

**Lethal means:** typically refers to those methods of suicide that are most likely to result in immediate death (e.g. firearms, poisons, bridges/high places).

**Long-term indicators:** Long-term indicators are signs that may take many months or years to show progress.

**Mental health promotion:** universal interventions targeting the general population, designed to improve personal well-being through strategies aimed at increasing personal strengths and competencies and/or system-focused interventions aimed at increasing social support and belonging.

**Objective:** An objective states exactly what a program should do. Objectives are identifiable and measurable actions to be completed by a specific time.

**Postvention:** describes the activities that help to reduce the aftereffects of loss by suicide.

**Protective factors:** factors describing those conditions which act to lessen the risk for suicide (e.g. availability of at least one significant adult who can provide warmth, care, and understanding).

**Risk condition:** refers to an event or social context (e.g. social alienation) which potentially elevates the risk for suicide and suicidal behaviour.

**Risk factor:** refers to an individual trait (e.g. hypersensitivity) or demographic factor which potentially elevates the risk for suicide and suicidal behaviour.

**Short-term indicators:** Short-term indicators are signs that appear within a few weeks or months after programs or activities start and that show progress toward meeting objectives.

**Stage-setting factors:** factors which set the stage for a vulnerability to suicide (e.g. family history of suicide).

**Suicide:** death caused by self-inflicted, intentional injury.

**Suicide attempt:** potentially self-injuring behaviour motivated by an intent to die with a non-fatal outcome.

**Suicidal behaviours:** a broad spectrum of behaviours which include suicidal gestures, threats, and attempts (sometimes also referred to as non-fatal suicidal behaviours).

**Suicide ideation:** thoughts about suicide.

**Suicide rates:** the total number of deaths by suicide divided by the total population and converted to a rate per 100,000.

**Trigger factors:** factors which act as a trigger for persons predisposed to suicide (e.g. sudden loss or failure).

**Youth:** used in this document to refer to children and adolescents.