The Suicide Prevention, Intervention and Postvention (PIP) Initiative for British Columbia was established in February 2008. The initiative was co-chaired by Ian Ross (Executive Director, Crisis Intervention and Suicide Prevention Centre of BC) and Dammy Damstrom-Albach (Coordinator, Suicide Attempt Follow-up, Education & Research, Vancouver Coastal Health).
Acknowledgements: The project team extends their appreciation to the BC Ministry for Children and Family Development, BC Mental Health and Addiction Services (an agency of the Provincial Health Services Authority) and the Fraser Health Authority for providing funding for this project. We also gratefully acknowledge the in-kind support of the Crisis Intervention and Suicide Prevention Centre of BC and SAFER (Vancouver Coastal Health) for providing the time for co-chairs to provide leadership to the initiative.

We would also like to extend our thanks to Mary-Doug Wright, Elaine Shearer, Lise Olsen and Lynne Hsu for their contributions to this project. We appreciate the advisory support of the Ministry of Health, Ministry of Education and Ministry of Healthy Living and Sport, who were members of the Executive Committee. We are appreciative of the guidance and feedback provided by all project stakeholders and the workgroups: Steering Council, Content Experts and Community Stakeholders.

Suicide PIP Initiative for BC

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The goal of the Suicide Prevention, Intervention and Postvention (PIP) Initiative for BC was to develop and promote a Framework and Planning Template for local, regional and provincial initiatives addressing suicide prevention, intervention and postvention across the lifespan.

This initiative was grounded in a Community Development approach where the knowledge and experience of stakeholders at all levels (academics, decision-makers, practitioners and users) from communities throughout the province was actively sought and integrated.

The evidence-informed practice review and snapshot survey were central to the development of the Framework and Planning Template.

The evidence-informed practice review synthesized information from 60 research review studies to gather an understanding of best and promising practices.

The snapshot survey obtained feedback from 77 respondents across BC who provided information about their suicide related services, programs and supports, which informed our understanding of current and desired practice.

Information from the evidence-informed practice review and snapshot survey were used to develop 16 recommendations for suicide prevention, intervention and postvention in BC.

Through the implementation of a survey, recommendations were presented to 42 project stakeholders who determined which areas are priority areas for suicide PIP in BC.

The following six priorities and development opportunities were identified for suicide prevention, intervention and postvention in BC:
School-based programs focusing on mental health promotion and preventing substance use for children and youth that integrate behavioural changes, coping skills and social supports

School districts are uniquely positioned with opportunities to implement programs by choice at the district and/or school level. Given the high levels of autonomy, at any given time, many schools have programs in place to promote the wellbeing of students and some programs may already have mental health promotion and/or substance use prevention components that could be expanded or strengthened. Any effort to engage in school-based programming will require collaboration and efforts to engage with school and/or district personnel and community partners. In addition, efforts will also require a ‘whole school’ approach that goes beyond a single prevention or intervention strategy.

Part of the process for school based programming involves:
- Understanding what aspects of mental health and substance use prevention already exist within school programs
- Building on existing programs or
- Identifying where gaps exist and mental health programs could be implemented
- Considering elements for implementation
- Engaging in a ‘whole school’ approach involving students, teachers, parents, counsellors and principals

Gatekeeper training for all populations including:

a) Peers, health professionals, community leaders, spiritual advisors, within school and post-secondary settings, the workplace, acute care settings, long term care facilities and justice system
b) How to identify at-risk individuals and improve access to suicide intervention and mental health and substance use resources

A critical component of gatekeeper training is ensuring linkage to appropriate, evidence-informed training. It is imperative that the gatekeeper is provided training to promote their awareness of suicide risk and how to access community resources for an at risk person. Gatekeeper training can be implemented across a broad range of settings – virtually any setting in which a group/community structure and the potential exists to encounter a person who may be at risk of suicide.

Part of the process for gatekeeper training involves:
- Understanding what aspects of mental health care and support exist within a given setting
- Identifying and recruiting key participants for gatekeeper training
- Training these key persons on how to identify someone who is suicidal or in distress including what questions to ask, and what resources they can then refer to within their communities
- Consideration of persons who might access at risk populations but are not involved in the health care sector
Physician and health professional education on early recognition, risk assessment, clinical assessment, mental health conditions and comorbidities and treatment of suicidal behaviour and/or ideation across the lifespan.

a) Education efforts include addressing depression, other mental health conditions and concurrent disorders as well as the interpretation of policies around treatment provision (BC Mental Health Act, Infants Act, Freedom of Information and Protection of Privacy Act).

Health professionals are often called upon to address a person who is acutely or chronically at risk of suicide. To support their efforts in addressing suicide, education strategies on early recognition, risk assessment and clinical assessment may be beneficial. It has also been indicated that physicians require support and information on the interpretation of freedom of information and protection of privacy policies.

Part of the process would include:
- Understanding the existing risk and clinical assessment practices
- Identifying gaps in existing risk and clinical assessment practices to improve consistency and comprehensiveness
- Assessing comorbidities in mental health and substance use
- Involving the caregiver, family and/or concerned others in risk assessment and treatment plans

Culturally appropriate services, cultural safety and diversity training for service providers regarding suicide prevention, intervention and postvention including:

a) Improved translation services, expanded language capacity or improved awareness of existing services
b) Coping skills training and workshops for emotion regulation and coping
c) Providing stigma reduction, mental health awareness and education messages through TV, newspapers and radio
d) Gay, lesbian, bisexual and transgendered (GLBT) resiliency training administered by GLBT agencies and/or service providers

A number of strategies have been suggested to improve accessibility and the quality of services for local and regional service providers for ensuring culturally appropriate services and cultural safety. Part of the process for providing culturally appropriate services and promoting cultural safety includes:
- Understanding what aspects of culturally appropriate mental health services and substance use prevention services and/or health services already exist within the organization and community
- Understanding the unique concerns of the culturally diverse population the program intends to serve or access
- Exploring the extent to which current services meet the needs of a culturally diverse population
- Identifying where gaps exist and what culturally appropriate programs or training could be implemented at the organizational and/or community level
- Identifying partnership opportunities locally, regionally and provincially with the goal of ensuring cultural safety
- Engaging with media to provide stigma reduction and mental health awareness messages
Coordination of services for suicide prevention, intervention and postvention in the mental health system, health care system, school/postsecondary systems and community including:

a) Interdisciplinary teams and case approaches such as active case management, assertive community teams and integrated case management
b) Possible development of day programs to address suicidality and/or concurrent disorders and crisis stabilization teams/units to address people in acute crisis or suicide states and/or provide ongoing support
c) Improved access to psychiatrists and psychiatric services
d) Promotion of a trauma informed response to suicidal people and their families

Partnerships and collaborations are imperative among policy makers on the coordination of services to promote systems-level changes that would have local, regional and provincial impacts. As they exist currently, systems of care are fragmented and inconsistent, which ultimately impacts the person at risk of suicide seeking care. Case approaches that may improve support of a suicidal person include active case management, integrated case management and assertive community teams.

Part of the process involves ensuring that the suicidal person has seen the appropriate team of professionals and/or specialists to address suicidal behaviour and underlying health concerns in a holistic, trauma informed manner. Efforts also need to be made to ensure the person at risk of suicide is proactively provided with opportunities to access the needed care.

Development and enhancement of postvention bereavement programs, services and supports for persons touched by a suicide including:

a) Educational workshops, support groups, group therapy and survivor groups for those bereaved by a suicide related death
b) Postvention response protocols involving referral practices, community response teams, critical incident management and treatment

Postvention efforts are a necessary step in the continuum of care for suicidal individuals, their families and their communities. These efforts ensure that those affected by suicide are provided with appropriate support and care during the bereavement and grieving process. Implementing and strengthening postvention services can contribute to a reduction of future suicidal behaviours.

Postvention efforts provide opportunities for engaging various agencies and organizations, both locally and regionally, to work collaboratively to accommodate the needs of the individual, the family and their communities. Education efforts on grief and bereavement that integrate the opportunity for survivors to share their experiences can play a role in supporting survivors. Proactively developing protocols for postvention with community supports and resources is also an important component for supporting survivors.
The Framework and Planning Template are key resources that can be used as planning tools for suicide PIP.

As such, these planning tools offer strategic and program level guidance on stakeholder defined priorities for suicide in the province.

The Suicide PIP Framework includes information on targeted audiences, impacted audiences, key partnerships, suggested systems-level and program-level activities, development opportunities, signs of success and examples of programs.

The Planning Template is an action-oriented tool that integrates priorities from the Suicide PIP Framework and provides a detailed description of how objectives will be achieved.

It provides guidance for programs from development through implementation, improvement and evaluation in a specific priority area.

For Aboriginal communities, open, flexible and non-prescriptive processes were suggested to engage in suicide prevention, intervention and postvention.

A range of options for Aboriginal Communities included: Building consensus through consultation; Community asset mapping; and Looking directly to the evidence for planning purposes.

The next phase of the project involves knowledge exchange to promote the adoption and uptake of the Framework and Planning Template at community, regional and provincial levels.

The Framework and Planning Template can play a role in catalyzing action on suicide prevention, intervention and postvention in BC.
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<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>AAS</td>
<td>American Association of Suicidology</td>
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<td>ACM</td>
<td>Active Case Management</td>
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<tr>
<td>ACT</td>
<td>Assertive Community Teams</td>
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<tr>
<td>AHS</td>
<td>Alberta Health Services</td>
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<tr>
<td>AMHNB</td>
<td>Alberta Mental Health Board</td>
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<tr>
<td>ASIST</td>
<td>Applied Suicide Intervention Skills Training</td>
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<tr>
<td>CARMHA</td>
<td>Centre for Applied Research in Mental Health and Addictions</td>
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<tr>
<td>CASP</td>
<td>Canadian Association for Suicide Prevention</td>
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<tr>
<td>CARS</td>
<td>Cultural Assessment of Suicide Risk</td>
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<tr>
<td>CBT</td>
<td>Cognitive behavioural therapy</td>
</tr>
<tr>
<td>CCSMH</td>
<td>Canadian Coalition for Seniors Mental Health</td>
</tr>
<tr>
<td>CYMH</td>
<td>Child and Youth Mental Health</td>
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<tr>
<td>DBT</td>
<td>Dialectical Behaviour Therapy</td>
</tr>
<tr>
<td>FNIH</td>
<td>First Nations and Inuit Health</td>
</tr>
<tr>
<td>FOIPPA</td>
<td>Freedom of Information and Protection of Privacy Act</td>
</tr>
<tr>
<td>GLBT</td>
<td>Gay, Lesbian, Bisexual and Transgendered</td>
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<tr>
<td>ICM</td>
<td>Integrated Case Management</td>
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<tr>
<td>IPT</td>
<td>Interpersonal Therapy</td>
</tr>
<tr>
<td>KE</td>
<td>Knowledge Exchange</td>
</tr>
<tr>
<td>MCFD</td>
<td>Ministry for Children and Family Development</td>
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<tr>
<td>MST</td>
<td>Multi-systemic Therapy</td>
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<tr>
<td>NAHO</td>
<td>National Aboriginal Health Organization</td>
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<tr>
<td>NAYSPS</td>
<td>National Aboriginal Youth Suicide Prevention Strategy</td>
</tr>
<tr>
<td>NICE</td>
<td>National Institute for Clinical Excellence</td>
</tr>
<tr>
<td>PIP</td>
<td>Prevention, Intervention and Postvention</td>
</tr>
<tr>
<td>PHSHA</td>
<td>Provincial Health Services Authority</td>
</tr>
<tr>
<td>PST</td>
<td>Problem Solving Therapy</td>
</tr>
<tr>
<td>QPR</td>
<td>Question, Persuade, Refer</td>
</tr>
<tr>
<td>RANZCP</td>
<td>Royal Australian &amp; New Zealand College of Psychiatrists</td>
</tr>
<tr>
<td>SAHMSA</td>
<td>Substance Abuse and Mental Health Services Administration</td>
</tr>
<tr>
<td>SSRI</td>
<td>Selective Serotonin Reuptake Inhibitor</td>
</tr>
<tr>
<td>SFU</td>
<td>Simon Fraser University</td>
</tr>
<tr>
<td>UBC</td>
<td>University of British Columbia</td>
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</tbody>
</table>
CHAPTER 1:

INTRODUCTION TO THE SUICIDE PREVENTION, INTERVENTION AND POSTVENTION INITIATIVE FOR BC
Suicides and suicidal behaviour are significant public health concerns with widespread social impacts (peers, families, communities) and economic consequences for the health care system. Suicides are the triumph of pain, fear and loss over hope (Canadian Association for Suicide Prevention, 2004). Suicides are most often the result of pain, hopelessness and despair and are almost always preventable through caring, compassion, commitment and community (Canadian Association for Suicide Prevention, 2004). While it is impossible to quantify the pain, hopelessness, and despair that most often underlie suicidality or suicide-related deaths, and that become part of the traumatic legacy left to loved ones, it is possible to consider the impact of investing in measures to reduce suicide and suicidality. Investment in suicide prevention, intervention and postvention hold great potential to decrease the costs to society and the health care system that are the result of suicide and suicidal behaviour.

**Suicide Related Data**

For suicide prevention, intervention and postvention there are presently little data available beyond mortality data and hospitalization data to monitor the problem and provide indicators and measures of changes in suicidality. In BC, 470 deaths by suicides occurred in 2007 or 10.7 deaths per 100,000 population (BC Coroners Service, 2008). Suicides accounted for 6.2% of all deaths in BC in 2007.

Of the suicide deaths, 125 females and 345 males lost their lives in 2007 (BC Coroners Service Annual Report, 2008). From Health Authority regional data, the Northern accounted for the highest suicide rates (16.2 deaths per 100,000 or 47 deaths), followed by Vancouver Island (12.3 deaths per 100,000 or 92 deaths), Vancouver Coastal (11.4 deaths per 100,000 or 124 deaths), Interior Health (11.3 deaths per 100,000 or 82 deaths) and Fraser (8.2 deaths per 100,000 or 125 deaths).

In BC, 3,120 hospital separations\(^1\) occurred in 2007/08 or 71.2 per 100,000 population (BC Injury Research and Prevention Unit, 2009). The estimated total length of stay for hospital separations in BC was 19,219 days and direct costs associated with length of stay data were approximately $18,165,521.14 (BC Injury Research and Prevention Unit, 2009). Males have demonstrated high rates of death by suicide and females have demonstrated high rates of hospital separations associated with suicide attempts (BC Vital Statistics, 2006; BC Ministry of Health, 2008).

Youth aged 15-24 are at particularly high risk for suicidal behaviour (White, 2005). Suicide is the second leading cause of death among youth aged 12-18 in BC (McCreary Centre Society, 2009). The most recent Adolescent Health Survey in 2008 found that 12% of youth surveyed seriously considered suicide and 5% attempted suicide (McCreary Centre Society, 2009).

---

1. Hospital separations occur any time a patient leaves the hospital due to death, discharge, leaving against medical advice or transfer to another facility.
While limited data are available on suicide ideation, behaviour and an attempt for the population, this material is fragmented, suggesting that as a public health issue, deaths by suicide represent the tip of an iceberg. For example, a recent report on the Economic Burden of Injury in Canada (2009), indicates that suicide and self harm in B.C. accounted for 465 deaths, 3,233 hospitalizations, 5,438 non-hospitalizations, and 676 people were permanently partially disabled and 33 people were permanently totally disabled in 2004 (Smartrisk, 2009). The associated costs of suicide and self harm in 2004 were $346 million ($121 million in direct costs and $225 million in indirect costs) (Smartrisk, 2009). This information on the economic impact of suicide and suicidality assists in our understanding of how deaths by suicide might be one of many aspects of these complex phenomena.

**FIGURE 1.1:**
Suicide Related Data
– Tip of The Iceberg

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**Mental Health in British Columbia**

In BC, mental disorders are the third largest contributor to the province’s overall disease burden (after cancer and cardiovascular disease) (Ministry of Health, 2001). Mental disorders are also the largest contributor to disease burden among British Columbians between the ages 15–34 (Ministry of Health, 2001). Suicides and suicidal behaviour are one of many potential outcomes for an individual confronted by mental illness and can be a strong indication that the person needs help with a mental health issue. Research has shown that mental health issues are strongly associated with suicide and suicidal behaviour (Alberta Mental Health Board, 2005). When a person is suicidal the mental health care system is often involved in prevention, intervention and/or postvention capacities.

Significant efforts have been made provincially to address populations with mental health issues. Some of the efforts to address mental health during the period 2003-2008 are summarized below.

The Child and Youth Mental Health Plan was developed in 2003 by the Ministry for Children and Family Development. The Child and Youth Mental Health Plan consisted of 4 components (MCFD, 2008):

- **Risk reduction** – Formal efforts to prevent or delay onset of mental health problems in children and youth, or mitigate the impact of mental health problems;

- **Capacity building** – Strengthening the positive influence of families and communities to promote and support the mental health of children and youth;

- **Treatment and support** – Ensuring access to a continuum of timely, evidence-based, and effective services for children and youth with mental health problems and their families; and

- **Performance improvement** – Strengthening the infrastructure to support a responsive, efficient and accountable child and youth mental health system.

Since development of the Child and Youth Mental Health Plan for BC (2003), significant progress has been made on the 4 components. Responses to the progress of the Child and Youth Mental Health Plan are reported as positive, based on a great vision with a strong foundation, and with positive impacts on children’s mental health services (MCFD, 2008). Some short-term recommendations provided in the progress update report, Promises Kept, Miles to Go (MCFD, 2008) included:

- Strengthening mental health promotion and risk reduction initiatives;

- Embedding client and family resources into infrastructure;

- Working closely and collaborating with different BC Ministries;

- Improved management of concurrent disorders;

- Improving wait times;

- Providing additional resources for residential facilities; and

- Regional leadership and accountability for child and youth mental health services.
BC Mental Health and Addiction Services: Strategic Plan (2007)

The BC Mental Health and Addiction Services (BCMHAS) Strategic Plan has placed **system wide improvements** (linking providers to improve quality, safety, consistency and accessibility) at the core of the following efforts:

- **Specialized and one of a kind service delivery** – Delivering one of a kind services and a clear leadership role in service coordination
- **Mental health and substance use research** – Strengthening capacity and building partnerships
- **Knowledge exchange** – Strengthening existing capacity and enhancing continuing mental health education for professionals
- **Health promotion and illness prevention** – Focusing resources on specialized services to improve secondary and tertiary prevention

BCMHAS are also developing an “Integrated Provincial Strategic Plan to Improve Health Literacy in Mental Health and Addiction”. For mental health and substance use, health literacy refers to knowledge and beliefs which assist in the recognition, management or prevention of mental health or substance use issues or disorders. The development of health literacy in mental health and substance use is a collaborative process involving stakeholders throughout the province who are actively involved in the provincial health literacy network.

BC Ministry for Healthy Living and Sport: Model Core Program Paper for Mental Health Promotion and Mental Disorders Prevention (2009).

The BC Ministry for Healthy Living and Sport have defined core public health functions for BC. The core public health functions define and describe the public health activities of a comprehensive public health system. The process included:

- Establishing a set of evidence-based core programs (based on model core program papers);
- Implementing a continuous quality improvement mechanism for their delivery through the health authorities; and
- Strengthening the provincial infrastructure to support public health capacity to deliver effective services.

The model core program paper for the mental health disorders and the prevention of mental disorders describes the following objectives:

1) Enhance protective factors that contribute to positive mental health in individuals, families, workplaces and communities.

2) Prevent and/or reduce the social, environmental, and individual risk factors that influence the occurrence of mental disorders.

3) Reduce the incidence, prevalence and recurrence of mental disorders as well as the severity and impact of the illness on individuals, families and society.
BC Mental Health Strategy (Ongoing)
The 2008 Throne Speech emphasized interest in renewing BC's mental health plan, calling for a continued focus on vulnerable populations and an added priority of promotion, prevention and early intervention for mental health (BC Coroners Service, 2008). The 2008 Throne Speech indicated that the government mental health strategy that is currently under development highlights a commitment to mental health and substance use issues in the province.

In 2007, in partnership with the BC Ministry of Health, the Center for Applied Mental Health and Addictions Research (CARMHA) developed a comprehensive manual entitled “Working with the Client Who Is Suicidal”. The manual aimed to improve clinical competency in addressing adults who are suicidal. The manual was divided in 4 categories:

1) General considerations for working with suicidal clients
2) Identifying and assessing suicidal risk
3) Safety and treatment planning and ongoing monitoring of suicidality and
4) Enhancing linkages between adult mental health and addiction services in the community.

This comprehensive resource provides extensive guidance to support clinicians and service providers who are involved in working with suicidal persons.

BC Ministry of Public Safety and Solicitor General: Looking for something to look forward to... A five year retrospective review of child and youth suicide in BC (2008).
Recently, efforts have been taken to address suicides among children and youth in British Columbia. The Child Death Review Unit of the BC Coroner's Service completed a death review of suicides among children from the period 2003-2007. The review process resulted in 17 recommendations developed and targeting provincial ministries and provincially focused organizations to engage in activities geared towards suicide prevention, intervention and postvention for children and youth. Critical components of the strategy were that responses to the recommendations needed to be: collaborative; youth- and family-centred; culturally safe; multi-level, and informed by current knowledge.

Connection to the Suicide Prevention, Intervention and Postvention Initiative for BC
Using these efforts as a foundation, an initiative addressing suicide prevention, intervention and postvention makes an important contribution to mental health efforts. Recognizing that suicide exists as a potential outcome of mental illness and substance use, suicide prevention, intervention and postvention efforts are a necessary component of the mental health and substance use continuum of care in BC.

Suicide is a multi-faceted and complex problem; therefore activities targeting multiple risk and protective factors and operating in multiple settings are likely to be more effective than activities based on a single approach (White, 2005; Government of New Brunswick, 2007; Commonwealth of Australia, 2008). A multi-faceted effort is consistent with recommendations to view suicide prevention, intervention and postvention using a systems-level approach. Such an approach seeks
to understand and measure the impact of interventions on multiple programs or total populations, not merely as the outcome of a single program (Goldner & Bilsker, 2007). While the impact of the Suicide PIP Framework and Planning Template may well impact at the program-level, the Framework is designed with a systems-level approach in mind. In addition, a systems-level approach provides opportunity to build upon the considerable work in BC that is ongoing in suicide prevention, intervention and postvention and provides the basis for continued networking and collaboration among individuals and organizations.

Definitions
Suicide prevention, intervention and postvention are a part of a continuum of services whose ultimate aim is to prevent death and risk of death by suicide while raising awareness about reducing stigma about suicide (Dafoe & Monk, 2005).

**Suicide prevention** focuses on strengthening resilience, reducing risk factors, and improving protective factors at the individual and community levels (Government of Nova Scotia, 2006). Prevention approaches include but are not limited to:

1) Education and Awareness;
2) Family, Peer Education and Support;
3) Gatekeeper Training;
4) Life Skills Support;
5) Means Restriction; and
6) Mental Health Promotion.

**Suicide intervention** refers to the identification, treatment and care of a suicidal individual (Dafoe & Monk, 2005). Interventions are conducted with the goal of reducing the likelihood that the individual will die of a suicide (Dafoe & Monk, 2005). Intervention approaches include but are not limited to:

1) Counselling (including Cognitive behavioural therapy, Dialectical behaviour therapy, Interpersonal therapy, Multi-systemic therapy, Problem Solving Therapy);
2) Crisis and distress hotlines;
3) Education and awareness;
4) Family education and support;
5) Follow-up care;
6) Screening and early identification;
7) Pharmacotherapy; and
8) Psychotherapy.
Suicide postvention refers to support for those bereaved by a death from suicide. Postvention involves all activities undertaken after a death including addressing traumatic after-effects among survivors, bereavement and trauma recovery and education to reduce the risk of further suicides (Dafoe & Monk, 2005). Postvention approaches include but are not limited to:

1) Bereavement support (Families, Peers & Communities);
2) Postvention teams;
3) Postvention protocols; and
4) Media reporting guidelines.

Risk Factors
Suicide and suicidal behaviour involves some considerations around risk factors at multiple levels. To address the risk factors and conditions associated with suicide and suicidal behaviour, the social ecologic model has been used. The social ecologic model considers the impact of society, community and relationships on the individual (Krug et al., 2002).

FIGURE 1.2:
Social Ecologic Model*

*Skrug et al., 2002
For the purposes of our work we adapted, a summary of risk and protective factors for suicide and suicidal behaviour by White & Jodoin (1998) and the Commonwealth of Australia (2008). It should be noted that White & Jodoin (1998) provided a consideration of predisposing factors, contributing factors, precipitating factors and protective factors across contexts for youth suicide, whereas the conceptualization in Table 1.1 considers risk factors across different populations.

### TABLE 1.1:
**Risk Factors for Suicide and Suicidal Behaviour**

<table>
<thead>
<tr>
<th>Individual Level: Biologic and Personal History</th>
<th>Relationship Level: Proximal Social Relationships</th>
<th>Community Level: Social Relationship Contexts</th>
<th>Societal Level: Broader Social Influences</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Sex</td>
<td>• Poor interpersonal relationships</td>
<td>• Socioeconomic disadvantage</td>
<td>• Economic depression</td>
</tr>
<tr>
<td>• Age</td>
<td>• Interpersonal loss</td>
<td>• Cultural background</td>
<td>• Unemployment</td>
</tr>
<tr>
<td>• Mental illness</td>
<td>• Family history of suicide</td>
<td>• Stigma</td>
<td>• Media representation</td>
</tr>
<tr>
<td>• Previous attempts</td>
<td>• Concerns about sexuality</td>
<td>• Barriers to health care access</td>
<td>• Political disenfranchisement</td>
</tr>
<tr>
<td>• Substance use</td>
<td>• Burdensomeness</td>
<td>• School Issues</td>
<td>• Multiple suicides</td>
</tr>
<tr>
<td>• Physical illness (chronic or acute; e.g. global insomnia)</td>
<td></td>
<td>• Workplace Issues</td>
<td>• Homelessness</td>
</tr>
<tr>
<td>• Isolation</td>
<td></td>
<td></td>
<td>• Delinquency</td>
</tr>
<tr>
<td>• Abuse</td>
<td></td>
<td></td>
<td>• Colonization</td>
</tr>
</tbody>
</table>

Beyond the biological risk factors of age and sex, other risk factors are also associated with vulnerability and an increased risk of engaging in suicide and suicidal behaviour. Some risk factors are strongly associated with social conditions and influences. Vulnerability and/or high risk groups for suicide and suicidal behaviour include populations with the following characteristics: Aboriginal, gay/lesbian/bisexual and transgendered, mentally ill, suicide survivors (bereaved), chronically or terminally ill, the elderly, the homeless, persons in custody, those living in rural and remote areas, substance users, previous suicide attempters and abuse survivors (AMHB, 2005). Efforts to reduce the harms associated with suicides and suicidal behaviour have been undertaken in a number of areas; however, for these efforts to be successful, it is important to consider the potential of developing evidence-informed approaches with these groups. In addition to high risk approaches, the Canadian Association for Suicide Prevention also reminds us that the vast majority of those who die by suicide are not in identified high risk groups but are representative of the widest crossection of Canadians, with the greatest numbers being older males and middle aged women.

Suicide is a statistically rare outcome or event (Beautrais, 2006; White, 2008, personal communication); therefore, approaches that also consider suicidal ideation, behaviour and plans are important. As a result, programs are often developed and implemented by adapting evidence-based practice under the theoretical understanding that if a multifaceted approach is used, there will likely yield a net benefit on lesser studied outcomes (e.g. suicidal ideation, behaviour and plans) (White, 2008, personal communication).
Federal and Provincial Efforts towards Suicide Prevention

Frameworks and planning tools are not unique notions for suicide prevention. Frameworks have been highlighted in a number of suicide prevention strategic initiatives to identify priority areas and goals for suicide prevention.

From a national perspective, the *Blueprint for a National Suicide Prevention Strategy* (2004) by the Canadian Association for Suicide Prevention (CASP) has identified the following areas as priorities:

1) Awareness and understanding
2) Prevention and intervention
3) Knowledge development and transfer and
4) Funding and support.

Through the objectives of the project, the Suicide PIP Initiative for BC addresses the following goals from the CASP Blueprint for a National Suicide Prevention Strategy:

- Developing and promoting effective clinical and professional practice (effective strategies, standards of care) to support clients, families and communities; and
- Promoting and supporting the development of effective evaluation tools.

Under this broad, national examination of suicide prevention in Canada, a number of provincial strategies were developed prior to the development of the Suicide PIP Initiative for BC.

In **New Brunswick**, the *Connecting to Life: Provincial Suicide Prevention Program* is built on goals incorporating community action, continuous education and interagency collaboration (Government of New Brunswick, 2007).

In **Nova Scotia**, the *Strategic Framework to Address Suicide* (2006) has identified six priority areas:

1) Leadership, partnership and infrastructure
2) Awareness and understanding
3) Prevention
4) Intervention
5) Postvention
6) Knowledge development and transfer

In **Quebec**, *Quebec’s Strategy for Preventing Suicide: Help for Life* (1998) has identified seven objectives including:

1) Providing and consolidating essential services and put an end to the isolation of caseworkers
2) Increasing professional skills
3) Intervening with groups at risk
4) Fostering promotion-prevention programs among young people
5) Reducing access to and minimize risks associated with the means of suicide
6) Counteracting the trivialization and the sensationalization of suicide by developing a sense of community and responsibility
7) Intensifying and diversifying research
In Manitoba, the *Framework for Suicide Prevention Planning for Manitoba* (2006) lists five components as priority areas:

1) Assessment and planning
2) Mental health promotion
3) Awareness and understanding
4) Prevention, intervention and postvention
5) Data surveillance, research and education

Recently, the Government of Manitoba has developed a youth specific suicide strategy known as “Reclaiming Hope”.

In Alberta, *The Suicide Prevention Strategy* contains an overarching vision, goals and objectives all with the ultimate goal of suicide prevention (AHMB, 2005). Among the goals of the Alberta strategies are:

1) Securing sustainable funding
2) Enhancing mental health and wellbeing
3) Improving intervention and treatment for high risk populations
4) Improving intervention and support for those affected by suicide
5) Reducing access to lethal means
6) Increasing research activities
7) Improving surveillance systems
8) Increasing evaluation and continuous quality improvement activities

The Alberta Suicide Prevention Strategy underwent systems-level evaluation by Goldner & Bilsker (2007). The systems-level evaluation framework reported considerations on how the strategy could be determined to have an impact on Albertans. The authors reviewed each goal of the strategy and their associated evaluation purpose, levels of stakeholder involvement, program logic model, evaluation design, measurement, knowledge exchange and policy implications of the strategy’s goals (Goldner & Bilsker, 2007).

In Nunavut, the Government of Nunavut developed a strategy entitled “Annirusuktugut – A Suicide Intervention and Prevention Strategy for the Government of Nunavut” (2007). Through this strategy, four key objectives are:

1) Establishing continuity in government suicide intervention efforts
2) Reviewing existing government programs and services using Inuit societal values as a foundation
3) Collecting and maintaining up-to-date research
4) Elevating public and internal government awareness of suicide intervention and healthy living promotions

The *National Aboriginal Youth Suicide Prevention Strategy* – NAYSPS (Cousins & Chouinard, 2007; First Nations & Inuit Health – FNIH, 2008) provides an evaluation framework to guide ongoing evaluation activities at the program-level with key components being success indicators, data sources and data collection methods for local, regional and federal suicide prevention programs for Aboriginal youth.
In British Columbia, seminal work by Dr. Jennifer White on youth suicide prevention has made a major contribution to the field. Dr. White’s work highlights the importance of promoting a community-wide, comprehensive approach to this complex and multi-faceted issue. Dr. White’s research on youth suicide prevention includes working with Aboriginal youth, consideration of the diverse ways of knowing, challenging notions of evidence-based practice and conducting qualitative research. Selected publications of Dr. White’s can be found in Appendix 1.

The BC Council for Families developed the Postvention is Prevention workshop program in 2005 (Dafoe & Monk, 2005). The workshops bring together communities to build a collaborative system for dealing with child and youth suicide and preventing ripple effect suicides.

Common themes from other provincial strategies relating to suicide include a focus on best or evidence-based practice, use of interdisciplinary approaches and stakeholder engagement processes. The Suicide PIP Initiative for BC builds on the strengths of these strategies by utilizing similar methodologies and has added the evaluation as a core component of this initiative. The Suicide PIP Initiative for BC has drawn on the work and experience of all these contributors in developing the Framework and Planning Template.

**Goals of the Suicide PIP Initiative for BC are:**

1) To develop and promote a Framework and Planning Template for local, regional and provincial initiatives across the lifespan.

2) To ensure that the Suicide PIP Initiative for BC is grounded in a Community Development approach where the knowledge and experience of stakeholders at all levels (academics, decision-makers, practitioners and users) from communities throughout the province is actively sought and integrated.

**Objectives of the Suicide PIP Initiative are:**

1) To complete a snapshot survey of key informants to gather information on existing suicide prevention, intervention and postvention services, programs and projects across BC.

2) To complete an evidence-informed practice review (including international, national and provincial expertise) of academic and non-academic literature.

3) To identify suicide prevention, intervention and postvention priority areas through the snapshot and evidence-informed practice reviews.

4) To incorporate snapshot survey, evidence-informed practice review findings into a Framework and Planning Template. The Framework should consider process and outcomes for groups to plan, improve and evaluate their programs, services or supports.

5) To create a representative working group of key BC stakeholders who will advise on the development of a PIP Project Charter for BC, Vision and Framework.

6) To develop a work plan for the project, and secure multi-year funding to support a project manager and the operation of a Provincial Suicide PIP Steering Committee.
Organization of this Report

This report describes the activities involved in the development of the Suicide PIP Framework and Planning Template. The chapters are:

**CHAPTER 1:** Introduction to the Suicide PIP Initiative for BC

**CHAPTER 2:** Towards the Development of a Framework and Planning Template

**CHAPTER 3:** The Evidence-informed Practice Review

**CHAPTER 4:** The Snapshot Survey

**CHAPTER 5:** Stakeholder Survey for Suicide Prevention, Intervention and Postvention in BC

**CHAPTER 6:** The Suicide PIP Framework and Planning Template

**CHAPTER 7:** Other Recommendations for Suicide Prevention, Intervention and Postvention

**CHAPTER 8:** Developing an Understanding of Aboriginal Health and Wellness Perspectives

**CHAPTER 9:** Knowledge Exchange and the Suicide PIP Initiative

Who Can Use this Report?

A Report on the Suicide PIP Initiative for BC could be useful for anyone who wants to engage with the suicide-related research and practice evidence for program planning purposes.

Examples of audiences who may find the report useful include:

- **Policymakers:** BC Government ministries, managers, Regional Health Authorities medical health officers, municipal governments, ombudsmen, other policy structures

- **Practitioners:** Service providers, clinicians, nurses, counsellors, physicians, community health workers

- **Researchers:** Academics, epidemiologists, public health staff, advocates

- **Consumers:** Advocates, service users, media
References


CHAPTER 2:

TOWARDS DEVELOPING A FRAMEWORK AND PLANNING TEMPLATE
A number of conceptual and practical considerations have guided development of the Framework and Planning Template. As an initial step, the vision for the Framework and Planning Template was synthesizing research evidence and practice evidence to gather an understanding of priorities for suicide prevention, intervention and postvention. The priorities would then form the foundation of collaboratively developed planning tools.

Using the broadest definition, a Framework is a simplified conceptual structure used to solve or address a complex issue. The Suicide PIP Framework provides a set of collaboratively developed priorities for suicide prevention, intervention and postvention in BC. The Framework also provides strategic-level discussion of goals, target audiences, key partnerships, suggested systems-level and program-level activities, development opportunities, signs of success and examples of programs for specific priority areas.

A Planning Template is an action oriented document or tool that provides a detailed roadmap for achieving objectives. The Planning Template integrates priorities from the Suicide PIP Framework and provides guidance for programs from development through implementation, improvement and evaluation. In essence, the Planning Template indicates how to move through a planning cycle as described below:

FIGURE 2.1: Elements of the Suicide PIP Planning Template
Context Considerations
The development of the Suicide PIP Framework and Planning Template was a complex task requiring consideration of multiple perspectives. The information can be viewed through numerous lenses or approaches, including:

- a lifespan approach
- a high risk group approach
- an evidence-informed approach
- a practice-informed approach
- a priorities and gaps approach
- a research, practice and policy approach
- a prevention, intervention and postvention approach
- a geographic approach (e.g. local, regional and provincial)

To ensure that the relationships between many of the potential approaches were considered, the context of the Suicide PIP Framework and Planning Template has incorporated 3 different perspectives:

- Analysis
- Scope of Services
- Populations

FIGURE 2.2:
Context for the Suicide PIP Framework and Planning Template
The Suicide PIP Framework and Planning Template provide an overview of the types of contextual factors by examining 3 perspectives: **Scope of Services, Populations and Analysis.**

- **The Scope of Services** perspective highlights the importance of considering the scope of prevention, intervention and postvention activities as well as the local, regional and provincial contexts as a part of the background information.

- The **Populations** perspective considers the lifespan (children and youth, adult, older adult) as well as vulnerable groups and/or high risk groups. By exploring 3 perspectives encompassing multiple layers, the Suicide PIP Framework and Planning Template provides reflection on targeted areas of importance. The 3 perspectives also provide an analytic frame for the interpretation of the data collected in the snapshot survey and evidence-informed practice review.

- The **Analysis** perspective considers the data collection activities and the sources of information and analyses informing the development of the Framework and Planning Template.

To illustrate the complexity of the elements involved in the Suicide PIP Framework and Planning Template, consider the relationships illustrated in Figure 2.2. If an element is selected from each axis, for example “evidence-informed practices”, “local”, “prevention” and “children and youth”, these four elements describe a distinct project that uses evidence-informed practices to provide prevention services to children and youth at the local level.

**Assumptions**
The assumptions underlying the Framework and Planning Template are that:

- While not all suicides are preventable, many are, and supports and services addressed in the Framework and Planning Template can positively impact both suicide and suicide attempts.

- Suicide prevention, intervention and postvention are on a continuum and are iterative, (e.g. postvention is prevention).

- Suicide occurs across the lifespan and affects all cultures in some way.

- Evaluation of suicide prevention, intervention and postvention programs, services and supports can inform the ongoing development of best practices.

- One particular prevention, intervention or postvention approach may not lead to the prevention of suicide however; a multifaceted, collaborative and interdisciplinary approach towards suicide that considers local, regional and provincial contexts may work.

**Principles**
The underlying principles of the Suicide PIP Framework and Planning Template are community development and evidence-informed practice. These principles provide the backdrop for the Suicide PIP Initiative for BC.
Community Development

Community development has been defined as a process of social action in which people of a community come together to identify their common needs and concerns, make plans to meet their needs and solve their problems and execute the plans with a maximum reliance on community strengths and resources (Gardiner & Gaida, 2002). The Suicide PIP Initiative for BC works within a community development model where the power and authority for the uptake of the Framework exists at local, regional and provincial levels. The Suicide PIP Initiative also strives to balance both ‘top down’ and ‘bottom up’ representation and incorporates the actively sought input of all project stakeholders.

While a community development approach is necessary to develop a comprehensive strategy for suicide prevention, intervention and postvention, a tension exists between community development and evidence-informed practice. In a research paper on youth suicide prevention, White (2007) suggested that a re-conceptualization of evidence-based practice may be required where culture, contexts, values and relationships in everyday practice are considered. Other research has acknowledged this tension by recognizing that it is unrealistic to demand that every decision made about programs are based on robust scientific evidence from research and systematic reviews (Anderson et al., 2005). As a result where evidence-informed practice is unavailable or does not exist, there has been a proliferation of practice-informed evidence, representing ways of knowing derived from the lived experience of practitioners and consumers. For the Suicide PIP Framework and Planning Template, practice-informed evidence is used as one source of information to determine prevention, intervention and postvention priority areas.

Evidence-informed Practice

An examination of provincial strategies on suicide prevention has underscored the importance of understanding and incorporating available evidence-informed practices into the work of prevention, intervention and postvention for suicide and suicidal behaviour. The Suicide PIP Initiative for BC uses an evidence-informed review as one of the sources of information that guides understanding of prevention, intervention and postvention priority areas and our subsequent Framework development.
Stakeholder Engagement

From its inception, the Suicide PIP Initiative has evolved through using a community development approach. This approach has ensured that mechanisms exist to support stakeholders and communities in the identification and application of practices for suicide prevention, intervention and postvention to their local, regional and provincial contexts. The community development approach has also promoted the engagement of stakeholders in the design of the initiative. Key principles for stakeholder engagement are:

- **Collaboration**: Working together to pool knowledge, resources and expertise surrounding suicide prevention, intervention and postvention
- **Community Ownership**: Developing a Framework and Planning Template that resonates and meets the needs of relevant decision-makers, researchers, practitioners and users
- **Responsiveness**: Two-way communication mechanisms to incorporate feedback into the development of the Framework and Planning Template
- **Transparency**: Initiative processes are visible and accessible
- **Quality Improvement**: Commitment ensuring that the feedback of stakeholders are integrated into all stages of project development as well as into the final product

To maximize engagement with stakeholders, 4 workgroups have existed in the following roles:

- **The Executive Committee** has provided strategic direction and guidance at the provincial levels
- **The Steering Council** has provided oversight on the completion of deliverables including consultation at milestones and advice to planning and process work
- **The Content Experts** has provided ongoing in-depth knowledge of suicide prevention, intervention and postvention specific to a particular area of expertise (e.g., children and youth)
- **Community Stakeholders** has consisted of persons from all across the province actively interested in how the Suicide PIP Initiative outcomes can inform the work in their region or practice, and who support the initiative by providing feedback and insights.

While all workgroups have been involved in the project, levels of engagement differed according to workgroup membership. Figure 2.3 provides a summary of the levels of engagement by workgroup.
For the Suicide PIP Initiative, a logic model has been developed to describe how knowledge would be used and the associated outcomes for the initiative.

- Inputs refer to the types of resources required including fiscal resources, material resources, human resources, partnership resources and technical/knowledge resources.
- Targets of the initiative refer to populations across the lifespan: children and youth, adults, older adults, and vulnerable and/or high risk populations.
- Components refer to the scope of the initiative as addressing suicide prevention, intervention and postvention.
- Outcomes, Activities, Anticipated Results and Possible Indicators are explored in Table 2.1.
### TABLE 2.1: Mapping Outcomes for the Suicide PIP Initiative for BC Logic Model

<table>
<thead>
<tr>
<th>Type of Outcome</th>
<th>Activities</th>
<th>Anticipated Results</th>
<th>Potential Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Short Term</strong></td>
<td>Evidence-informed Practice Review</td>
<td>• Improved knowledge and awareness around evidence-informed practice and&lt;br&gt;• Increased engagement with evidence to support programs and policies&lt;br&gt;• Improved knowledge and awareness of available programs, services and supports&lt;br&gt;• Buy-in among internal and external audiences&lt;br&gt;• Networking and collaboration&lt;br&gt;• Authority and ownership over the Framework and Planning Template</td>
<td>• # of stakeholders reporting use of evidence&lt;br&gt;• # of stakeholders reporting increased awareness of programs, services and supports&lt;br&gt;• # of stakeholders reporting plans to use the Framework and Planning Template&lt;br&gt;• # of conferences, workshops and presentations involving dissemination&lt;br&gt;• # of requests for PIP presentations, workshops and documents&lt;br&gt;• # of attendees of Suicide PIP related events&lt;br&gt;• # of local, regional and provincial advisory committees and/or councils developed as a result of the PIP project</td>
</tr>
<tr>
<td></td>
<td>Snapshot Survey</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Stakeholder Engagement</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Longer Term</strong></td>
<td>Framework and Planning Template</td>
<td>• Encouraged engagement with evidence-informed practice&lt;br&gt;• Stimulated policy change to improve programs, services and supports&lt;br&gt;• Support systems changed to reduce fragmentation and inconsistencies in the quality of suicide prevention, intervention and postvention programs, services and supports&lt;br&gt;• Enhanced collaboration among individuals, consumers, families, service providers, organizations, communities, regional health authorities, ministries</td>
<td>• # of new or improved programs or program components in priority areas (at least one per region)&lt;br&gt;• # of suicide prevention, intervention and postvention supports and services increased&lt;br&gt;• # of stakeholders self-reporting practice change&lt;br&gt;• Increased collaboration between and within organizations, programs, services, supports&lt;br&gt;• Decreased wait times for services</td>
</tr>
<tr>
<td><strong>Ultimate</strong></td>
<td>Framework and Planning Template</td>
<td>• Reduction in suicides and suicidal behaviour,&lt;br&gt;• Improved accessibility and quality of services and&lt;br&gt;• Improved postvention resources and supports for people touched by a suicide</td>
<td>• Decreased mortality, hospitalization and emergency department visits and a reduction in associated hospital costs&lt;br&gt;• Increased service use for suicide prevention, intervention and postvention&lt;br&gt;• Increased numbers of organizations reporting postvention services and supports</td>
</tr>
</tbody>
</table>
A number of potential sources of information could support the measurement of indicators. When measuring indicators of success, it is most important to assess for a baseline data measurement (or before implementing a program measurement) and a post-implementation measurement after use of the Framework and Planning Template. Indicator data sources could include:

- Mortality data
- Hospitalization data
- Emergency department visit data
- Crisis centre data (call volumes, content)
- Health services data (Local Health Area, Health Services Delivery Area, Regional Health Authority)
- Consumer satisfaction data from different programs
- Health survey data (Adolescent Health, Community Health Surveys)
- Organizational surveys on practice change
- Follow-up surveys regarding postvention services and supports
- Postvention information in BC through the survivor advocates network
### FIGURE 2.4: Suicide PIP Initiative for BC Logic Model

<table>
<thead>
<tr>
<th>Inputs</th>
<th>Targets</th>
<th>Components</th>
<th>Activities</th>
<th>Outputs</th>
<th>Shorter-Term Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fiscal Resources</td>
<td>Children and Youth</td>
<td>Fiscal Resources</td>
<td>Conducting evidence-informed practice review of suicide research</td>
<td>Improved knowledge &amp; awareness of evidence-informed practices</td>
<td>Supporting &amp; encouraging evidence-informed practice</td>
</tr>
<tr>
<td>Material Resources</td>
<td>Adults</td>
<td>Material Resources</td>
<td>Conducting snapshot survey on suicide related programs, services &amp; supports</td>
<td>Increased engagement with evidence to support policies &amp; programs</td>
<td>Policy change to improve programs, services &amp; supports</td>
</tr>
<tr>
<td>Human Resources</td>
<td>Older Adults</td>
<td>Human Resources</td>
<td>Engagement with stakeholders for support of initiative processes</td>
<td>Improved knowledge &amp; awareness of available programs, services and supports</td>
<td>Systems change to reduce fragmentation &amp; inconsistencies in the quality of suicide PIP programs, services &amp; supports</td>
</tr>
<tr>
<td>Partnership Resources</td>
<td>Vulnerable and/or High Risk Populations</td>
<td>Partnership Resources</td>
<td></td>
<td>Promoting buy-in among internal &amp; external audiences</td>
<td></td>
</tr>
<tr>
<td>Technical/Knowledge Resources</td>
<td></td>
<td>Technical/Knowledge Resources</td>
<td></td>
<td>Improved networking &amp; collaboration opportunities</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Authority &amp; ownership</td>
<td></td>
</tr>
</tbody>
</table>

| Ultimate Outcomes               |                             |                             |                                                                                       |                                                                                                          |                                                                                      |
|                                 |                             |                             |                                                                                       | Reduction in suicide & suicidal behaviour                                                          |                                                                                      |
|                                 |                             |                             |                                                                                       | Improvement of the accessibility & quality of suicide intervention services               |                                                                                      |
|                                 |                             |                             |                                                                                       | Improvement in postvention resources & supports for persons touched by a suicide               |                                                                                      |

**Context and External Factors**
References


Introduction
Evidence-informed practices have often provided the foundation for provincial strategies on suicide prevention, intervention and postvention in other parts of Canada. Evidence-based medicine is defined as the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients (Sackett et al., 1996). Evidence-based practice is defined as an extension of evidence-based medicine where the provision of care and service utilizing evidence-based decision-making and a continuous quality improvement approach are focused on achieving the best health outcomes using available resources (AMHB, 2005). For the Suicide PIP Initiative for BC, the term evidence-informed practice is used to highlight contributions of both best and promising practices in suicide research literature.

In health research, evidence is usually a narrowly constructed term where primacy is typically placed on systematic reviews and randomized controlled trials as a gold standard. This way of thinking has translated to a concept of effectiveness that is dependent on methodology rather than real world practice (White, 2007). While these hierarchal considerations may be helpful in some contexts, they are problematic in others (White, 2009). In fact, in a 2009 keynote address to the American Association of Suicidology in San Francisco, a leading expert in the field called for a pluralistic methodology in suicide research where quantitative studies are not an end point but are followed by qualitative work (Hjelmeland, 2009). In the field of suicide prevention, intervention and postvention, where multi-layer, complex strategies are known to be most likely to yield promising results, notions of evidence should be broader and more inclusive than the typical hierarchies of evidence.

Some critiques regarding the application of evidence-based practice in the suicide research and prevention field include the following considerations (White, 2009):

- Assumptions that knowledge generated through scientific experiments is neutral and thus applicable to all clients and contexts; and
- Suggestions that preventative interventions can be understood as analogous to drug treatments and that studies on the “effects” of a preventative intervention could use the same types of methodologies as drug treatment studies.

Based on these critiques and others in the literature, a reconceptualization of evidence-based practice has been suggested, one that recognizes the place of culture, values and relationships and everyday practice and one that also acknowledges the credibility of qualitative research (White, 2009). For the Suicide PIP Initiative for BC, an evidence-informed practice review is one of multiple sources of information guiding the development of the Suicide PIP Framework and Planning Template. Other sources of information are practice informed evidence and stakeholder expertise and lived experience.

Research Question
The research question guiding the evidence-informed practice review was: Which suicide prevention or intervention or postvention approaches have been shown among different populations to lead to direct or indirect change in suicide risk and behaviours?
Methods

Definitions
Suicide risk and behaviours were defined as death by suicide; suicide attempt; suicidal ideation or repeated self harm.

The relationship between suicide prevention, intervention and postvention were well described by Dafoe & Monk (2005) who suggested that since postvention is prevention, suicide prevention, intervention and postvention flow through on a continuum and form a circular connection.

Target Population
Research studies involving the general population across the lifespan were targeted. Vulnerable and/or high risk populations included youth aged 15-24 years, Aboriginal populations, mentally ill, survivors, chronically ill or terminally ill, elderly, homeless, in custody, rural and remote, ethnic populations, gay/lesbian/bisexual and transgendered persons, abuse survivors and substance abusers (Government of Nova Scotia, 2006; Alberta Mental Health Board, 2004; Government of Manitoba, 2006).

Types of Studies
The types of studies from the synthesis literature were systematic reviews, narrative reviews, meta-analyses, evidence-based guidelines and evidence-based strategies. Primacy was placed on examining and evaluating synthesis literature in this evidence-informed practice review. Experimental and observational literature filled gaps of understanding in areas that were not covered or addressed in the synthesis literature. Experimental study designs consisted of quasi-experimental studies, randomized control trials and controlled clinical trials. Observational studies consisted of cohort, case control, cross sectional, pre and post, controlled before and after and case series studies.

Outcome Measures
Outcomes were categorized as primary (directly) or intermediate (indirectly) associated with change in suicide risk and/or behaviour. Primary outcomes assessed in the literature that considered as directly associated with change in suicide risk or behaviours were:

- Reduction in suicide risk or behaviours
- Increased knowledge and awareness regarding suicide risk or behaviours including screening and identification
- Reduction of the impact of suicide risk or behaviours on suicidal persons, peers and families
- Reduction of contagion and exposure to suicide risk or behaviours

2. For a comprehensive explanation of the definitions for suicide prevention, intervention and postvention, please see Chapter 1.
Intermediate outcomes assessed in the literature considered as indirectly associated with change in suicide risk or behaviours were:

- Reduction of conditions having comorbidity with suicide risk and behaviours including mood disorders, psychosis, personality disorders, substance abuse, stress, hopelessness, impulsivity
- Increased protective factors including coping, self esteem and social support

Search Strategy

A systematic search was conducted to identify key literature in English published during the last 5 years (2003-2008) discussing various approaches to suicide prevention, intervention, and postvention. The 5 year period of searching was selected due to the large volume of literature and significant overlap among primary studies (included within synthesis literature) during a 10-year search. Jurisdictions included were Canada, United States, Great Britain, Australia and New Zealand. The search was conducted from 2008 July to 2008 October.

PubMed was searched first to identify peer-reviewed literature. Key concepts were searched using MeSH (Medical Subject Headings) and text words. Other databases were searched using terminology appropriate to each resource, but based on terminology used for the PubMed search. A selection of relevant organization, government, and research institute websites, grey (on non-academic) literature repositories, and free Internet-accessible databases were searched for the grey literature such as books, reports, and unpublished material. A summary of terminology used and resources is provided in Appendix 3.

Inclusion and Exclusion Criteria

All studies met the following eligibility criteria for inclusion:

- Studies included synthesis literature in the form of systematic review, narrative reviews, meta-analyses, best practice guidelines, evidence-based strategies.
- Types of studies in targeted searches included experimental (quasi-experimental; randomized control trials) and Observational (cohort, case control, cross-sectional, before and after, case series)
- Studies included prevention, intervention or postvention approaches
- Studies reported at least one direct or indirect outcome associated with change in suicide risk and behaviour
- Studies were in the English Language
- Studies were published during the period 2003-2008
- Studies were applied to a target population between ages 0 and 90+ years old
- Studies included research, service provision, policy, programs, protocols and practices
- Studies included vulnerable and/or high risk populations
Studies with the following characteristics were excluded:

- Studies reported in non-English languages
- Studies that reported on risk and protective factors only
- Studies that involved treatment of underlying mental illnesses without citing an explicit link to suicide risk or behaviour
- Studies on terrorism and terrorist acts involving suicide
- Studies on homicide and violence involving suicide
- Studies on assisted suicides and euthanasia
- Studies that consisted of editorials or commentaries only

**Identifying Studies for Review**

A comprehensive review process (Figure 3.1) was applied to all retrieved articles derived from the search. A research librarian (MW) conducted the searches and provided abstracts and citations to the research team. One reviewer (PJ) screened the titles and abstracts of all retrieved articles to exclude articles clearly irrelevant to the scope of the review. Where abstracts were not available, the full-text articles were retrieved and examined for inclusion. The literature screening tool is provided in Appendix 4.

**Data Extraction**

Following title and abstract review, full articles included in the study were obtained for data extraction and review. Data extraction tools were piloted by two independent reviewers (PJ, LO) to test for reliability on approximately 10 research studies to ensure that the level of detail extracted from a study were comparable. Data elements extracted from the potential relevant/included studies were:

1) Study Year, Authors, Title
2) Notes
3) Targeted Population
4) Setting
5) Study Design, Study Quality Assessment
6) Approach (Prevention, Intervention or Postvention)
7) Search Strategy, Number of Studies Included
8) Outcomes
9) Results
10) Conclusions
11) Reviewer Interpretation
12) Quality Assessment (By Reviewer)
Quality Assessment
Methodological quality assessment was completed by two reviewers (PJ & LO). Study quality for synthesis literature was assessed using the Oxman Guyatt Tool, a 10-item checklist for the quality of review literature (Shea et al., 2002; Oxman & Guyatt, 1991). The Oxman Guyatt Tool assesses the quality of the search methods, inclusion criteria, validity and synthesis.

Data Synthesis
The literature was too heterogeneous to combine using any form of pooled analyses; therefore, narrative synthesis of results was conducted. Narrative synthesis determined which practices demonstrated a change in suicide risk and behaviours. Within synthesis literature studies, review articles reported on several methods to prevent, intervene or postvene for suicide risk and behaviours. The results and conclusions by the authors of synthesis literature were examined and collated to develop an understanding of evidence-informed practice for suicide prevention, intervention and postvention. Where synthesis literature for a suicide prevention, intervention or postvention approach was unavailable, experimental and observational studies were used and the authors’ conclusions were examined for face validity.

Interpretation
A hierarchy of evidence adapted from the National Collaboration Centre for Methods and Tools- Compendium of Critical Appraisal Tools for Public Health Practice (Gliska et al., 2008) was used to evaluate the research evidence. A hierarchy of evidence provided a way to assess the relative contributions of the quality of evidence, where a research question was studied using a variety of methodologies and approaches (Gliska et al., 2008). The hierarchy of evidence considered both quantitative research (systematic reviews, experimental and observational studies) and pre-proccessed evidence (practice guidelines, evidence-based strategies, narrative reviews).

TABLE 3.1: Hierarchy of Quantitative Research

<table>
<thead>
<tr>
<th>Relative Strength of Evidence (with 1 being strongest)</th>
<th>Type of Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Systematic review of randomized control trials</td>
</tr>
<tr>
<td>2</td>
<td>Systematic review of observational studies</td>
</tr>
<tr>
<td>3</td>
<td>Single randomized trial</td>
</tr>
<tr>
<td>4</td>
<td>Single observational study</td>
</tr>
<tr>
<td>Relative Strength of Evidence (with 1 being strongest)</td>
<td>Type of Research</td>
</tr>
<tr>
<td>--------------------------------------------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>1</td>
<td>Systems</td>
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<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Synopses of syntheses</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Syntheses</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Synopses of single studies</td>
</tr>
<tr>
<td>5</td>
<td>Single Studies</td>
</tr>
</tbody>
</table>
**RESEARCH QUESTION:**
Which suicide prevention, intervention and postvention approaches have been shown among different populations to lead to direct or indirect change in suicide risk and behaviours?

**Summary of Methodology and Procedures**

**FIGURE 3.1**
Evidence-informed Practice Review Summary

- **Confirmation of Study Eligibility**
  - **Citations Excluded**
    - No
  - Yes

- **Systematic search for relevant stations of literature (2003-2006)**
  - **Gap analysis of literature**
  - **Targeted search for Primary Literature where gaps exist (2003-2006)**
  - **Scanning titles and abstracts**

- **Application of Literature Applicability Screening Tool**
  - **Citations Excluded**
    - No
  - Yes

- **Data Extraction**

- **Quality Assessment**

- **Data Synthesis and Results Reporting**
Results

The initial searches yielded 260 studies (116 synthesis studies, 144 primary studies). After initial abstract and full text screening of the synthesis literature, 60 synthesis studies were found to be relevant (56 studies were excluded as either not relevant or duplicates). From the primary studies, many were captured within the synthesis literature. Therefore, studies that were assessed as primary literature targeted the vulnerable and or/high risk populations (see figure 3.2) and consisted of studies addressing ethnic populations and substance using populations. Nine primary studies were included in this review.

Of the synthesis studies that were included, studies targeting all populations represented 30% \((n = 18)\) followed by populations with mental health conditions at 16.7% \((n = 10)\) and Aboriginal populations at 15% \((n = 9)\). Lesser represented categories included studies specifically targeting children and youth, adults and older adults.

**FIGURE 3.2:**

*Synthesis Studies by Populations*

Of the synthesis studies that were included, 65% \((n = 39)\) were narrative reviews followed by systematic reviews at 18% \((n = 11)\). Lesser represented categories included clinical practice guidelines, evidence-based strategies and meta-analysis.

**FIGURE 3.3:**

*Synthesis Studies by Types of Studies*
From the hierarchy of quantitative research, only seven included studies were systematic reviews of randomized controlled trials and observational studies. Other systematic reviews that were included were reviews of synthesized research and were categorized in the hierarchy of preprocessed evidence as synopses of syntheses. From the primary research, nine studies were included.

**TABLE 3.3:**  
**Studies by Hierarchy of Quantitative Research**

<table>
<thead>
<tr>
<th>Relative Strength of Evidence</th>
<th>Type of Evidence</th>
<th>Number of Studies</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Systematic review of randomized control trials</td>
<td>4</td>
</tr>
<tr>
<td>2</td>
<td>Systematic review of observational studies</td>
<td>3</td>
</tr>
</tbody>
</table>

**Primary Studies (n = 9)**

| 3                             | Single randomized trial                             | 4                 |
| 4                             | Single observational study                          | 5                 |

From the hierarchy of pre-processed evidence, 53 studies were identified. Synopses of single studies were most highly represented by 49% of pre-processed evidence studies. Synopses of single studies refer to the brief summaries of studies with key methodological details and results. The next highly represented category was single studies selected and pre-processed based on high relevance.

**TABLE 3.4:**  
**Studies by Hierarchy of Preprocessed Evidence**

<table>
<thead>
<tr>
<th>Relative Strength of Evidence</th>
<th>Type of Research</th>
<th>Number of Studies</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Systems</td>
<td>7</td>
</tr>
<tr>
<td>2</td>
<td>Synopses of syntheses*</td>
<td>4</td>
</tr>
<tr>
<td>3</td>
<td>Syntheses</td>
<td>2</td>
</tr>
<tr>
<td>4</td>
<td>Synopses of single studies</td>
<td>26</td>
</tr>
<tr>
<td>5</td>
<td>Single Studies</td>
<td>14</td>
</tr>
</tbody>
</table>

*Note:* Includes systematic reviews of synthesis research not captured in the hierarchy of quantitative research.
Best Practice Results

The terminology of ‘best practice’ was derived directly from the research literature where study authors referred to a given strategy as a best practice. For best practice findings, results were found for suicide prevention and intervention strategies. No postvention strategies were found to be best practices. Data extraction results of each individual study are provided in Appendix 5.

- Among **children and youth**, school-based programs, cognitive behavioural therapy (CBT), dialectical behavioural therapy (DBT), family support, interpersonal therapy (IPT) and skills training were found to be best practices.

- Among **adults**, means restriction, physician education, suicide awareness education, CBT, gatekeeper training, PST and skills training were found to be best practices.

- Among **older adults**, means restriction, physician, education, CBT, gatekeeper training, IPT and PST were found to be best practices.

- Among **all populations**, means restriction, physician education, CBT, and PST were found to be best practices.

- Among **vulnerable and/or high risk populations**, practices promoting cultural safety, CBT, DBT and PST were found to be best practices.

**TABLE 3.5:**

Best Practices for Suicide Prevention and Intervention by Populations

<table>
<thead>
<tr>
<th>Best Practices</th>
<th>Children &amp; Youth</th>
<th>Adults</th>
<th>Older Adults</th>
<th>All Populations</th>
<th>Vulnerable/ High Risk Populations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cultural safety</td>
<td></td>
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<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Means Restriction</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Physician Education</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>School-based Programs</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suicide Awareness Programs</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Cognitive Behavioural Therapy</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Dialectical Behavioural Therapy</td>
<td></td>
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<td></td>
<td>X</td>
</tr>
<tr>
<td>Family Support</td>
<td></td>
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<td>X</td>
</tr>
<tr>
<td>Gatekeeper Training</td>
<td></td>
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<td>X</td>
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<tr>
<td>Interpersonal Therapy</td>
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<td>X</td>
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<tr>
<td>Medications</td>
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<td>X</td>
</tr>
<tr>
<td>Problem Solving Therapy</td>
<td></td>
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<td></td>
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<td>X</td>
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<tr>
<td>Skills Training</td>
<td></td>
<td>X</td>
<td>X</td>
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</tbody>
</table>
Promising Practices

The terminology of ‘promising practice’ was derived directly from the research literature where study authors referred to a given strategy as a promising practice. Promising practice has been defined as an action, program, or process that leads to an effective and productive result in a situation. Promising practices are not necessarily evidence-informed and may be based on positive results of a given practice in the absence of evidence. Promising practices exhibited the following characteristics:

- Accumulation of applied knowledge about what is working and not working in different situations and contexts;
- Continually incorporation of lessons learned, feedback, and analysis to lead toward improvement/positive outcomes;
- Incorporation of expert review, feedback, and consensus from the public health field; and
- Has an evaluation component/plan in place for demonstration of effectiveness, however, it does not yet have evaluation data for demonstration of positive outcomes.

Among [children and youth](#), early screening and identification, means restriction, family education about suicide signs and symptoms, physician education on risk assessment and management, school-based programs, skills training, DBT, emergency contact cards, family support, gatekeeper training, group therapy, multisystemic therapy, peer recognition and response for at-risk youth, phone counseling, PST, risk assessment, group therapy, media education and postvention protocols were found to be promising practices.

Among [adults](#), suicide awareness programming, early screening and identification of those at risk, physician education, skills training, DBT, family support, group therapy, IPT, ongoing expressions of caring support through letter contact with those who have been suicidal, medications, phone counseling, referrals, risk assessment, safety planning, and treating substance use were found to be promising practices.

Among [older adults](#), cultural awareness, physician education, stigma reduction, family support, gatekeeper training, medications, and risk assessments were found to be promising practices.

Among [all populations](#), community education, early screening and identification, outreach, family education, skills training, DBT, family support, follow-up, IPT, medications, phone counseling, and media education were found to be promising practices.

Among [vulnerable and/or high risk populations](#), community education, cultural awareness, early screening and identification, means restriction, family education, school-based programs, skills training, stigma reduction, CBT, gatekeeper training, peer and youth support, phone counseling, risk assessment, treating substance use, and follow-up were found to be promising practices.
### Table 3.6: Promising Practices for Suicide Prevention, Intervention and Postvention by Populations

<table>
<thead>
<tr>
<th>Promising Practices</th>
<th>Children &amp; Youth</th>
<th>Adults</th>
<th>Older Adults</th>
<th>All Populations</th>
<th>Vulnerable/ High Risk Populations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Awareness Programming</td>
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<td>Community Education</td>
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<td>X</td>
<td>X</td>
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<tr>
<td>Cultural Awareness</td>
<td></td>
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<td></td>
<td>X</td>
</tr>
<tr>
<td>Early Screening and Identification</td>
<td>X</td>
<td>X</td>
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<td>X</td>
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<tr>
<td>Family Education</td>
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<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Means Restriction</td>
<td></td>
<td>X</td>
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<td></td>
<td>X</td>
</tr>
<tr>
<td>Outreach</td>
<td></td>
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<td>X</td>
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<tr>
<td>Physician Education</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>School-based Programs</td>
<td></td>
<td>X</td>
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<td>X</td>
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<tr>
<td>Skills Training</td>
<td>X</td>
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<td>X</td>
<td>X</td>
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<tr>
<td>Stigma Reduction</td>
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<td>X</td>
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<tr>
<td>Cognitive Behavioural Therapy</td>
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<td>X</td>
</tr>
<tr>
<td>Dialectical Behavioural Therapy</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Emergency Contact Cards</td>
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<tr>
<td>Family Support</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
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<tr>
<td>Follow-Up</td>
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<tr>
<td>Gatekeeper Training</td>
<td>X</td>
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<tr>
<td>Group Therapy</td>
<td>X</td>
<td>X</td>
<td></td>
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<tr>
<td>Interpersonal Therapy</td>
<td></td>
<td></td>
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<td>X</td>
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<tr>
<td>Letter Contact</td>
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<td>X</td>
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<tr>
<td>Medications</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Multisystemic Therapy</td>
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<tr>
<td>Peer and Youth Support</td>
<td></td>
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<td>X</td>
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<tr>
<td>Peer Recognition/Response</td>
<td></td>
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<tr>
<td>Phone Counselling</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
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<tr>
<td>Problem Solving Therapy</td>
<td></td>
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<tr>
<td>Referral</td>
<td></td>
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<tr>
<td>Risk Assessment</td>
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<td>X</td>
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<tr>
<td>Safety Planning</td>
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<td>X</td>
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<tr>
<td>Treating Substance Use</td>
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<td>X</td>
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<tr>
<td>Community Healing Plan</td>
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<td>X</td>
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<tr>
<td>Survivor Follow-Up</td>
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<td>X</td>
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<tr>
<td>Group Therapy</td>
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<td>X</td>
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<tr>
<td>Media Education</td>
<td>X</td>
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<td>X</td>
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<tr>
<td>Postvention Protocols</td>
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<td>X</td>
</tr>
</tbody>
</table>
Discussion

From the evidence-informed practice review, a high number of synthesis studies were identified and evaluated. Most of the synthesis studies were narrative reviews. In the literature, it has been suggested that “narrative reviews are generally comprised of comprehensive literature reviews and cover a wide range of issues within a given topic, but may not include necessarily include a systematic search for evidence” (Collins & Fauser, 2005). Often, typical narrative reviews do not reveal how the decisions were made about relevance of studies and the validity of included studies (Collins & Fauser, 2005). While there are inherent issues involved in the use of information based on the use of narrative reviews, it was necessary to consider that inclusion of this form of review allowed capturing of existing nuances within the literature.

The following provide a summary of findings relating to specific strategies for suicide prevention, intervention and postvention:

- Among all populations, cognitive behavioural therapy was a best practice.
- Reducing access to lethal means was highlighted in at least three populations as a best practice and two populations as a promising practice.
- Physician or health professional education regarding suicide and depression, and risk assessment and management was highlighted in three populations as a best practice and three populations as a promising practice.
- Promising practices found among at least three populations or more included: early screening and identification, family education, skills training, dialectical behaviour therapy, family support, gatekeeper training, phone counseling and risk assessment.
- Literature on postvention was notably absent and led to significant gaps in understanding of postvention practices that could be used. Media education was suggested to be a potentially promising practice in postvention.
- Due to the vulnerable and/or high risk nature of youth populations, best and promising practices identified in the literature for youth aged 15-24 years were: education for health practitioners and general practitioners, interpersonal therapy, cognitive behavioural therapy, modified DBT, psychodynamic group therapy, youth skill building, emergency contact cards, and media education.

Recently, the BC Ministry of Health Services and BC Ministry of Healthy Living and Sport developed a core program evidence review for the prevention of mental health disorders (BC Ministry of Health, 2009). In the core program evidence review, means restriction was cited as a best practice. Other practices in the core program evidence review with varying levels of support in the research literature included broad multifaceted school-based approaches, family support, health professional education and gatekeeper training. The results of Suicide PIP Initiative evidence-informed practice review are consistent with the findings of the core program evidence review.

Evidence from the research literature has been used as one of multiple inputs to developing recommendations for suicide prevention, intervention and postvention for the province. The best and promising practices were examined in conjunction with the results of the snapshot survey to determine where actions could be taken for suicide prevention, intervention and postvention.
References


CHAPTER 4:

SNAPSHOT SURVEY
**Introduction**

The purpose of the snapshot survey was to critically inform the development of the Framework and Planning Template by providing information on current practice and desired practice for suicide prevention, intervention and postvention programs, services and supports in BC. While the snapshot survey could not feasibly provide an exhaustive directory of suicide prevention, intervention and postvention programs, services and supports, it provided cross sectional data of the different current suicide related activities in the province.

**Research Question**

The research question guiding the snapshot survey was: What are the nature and characteristics of suicide prevention, intervention and postvention services across the lifespan that are currently available in British Columbia?

**Methods**

**Sampling & Recruitment**

The sampling technique employed for the survey was snowball sampling. Snowball sampling involved the use of existing respondents to recruit additional respondents over the 9-month period of June 2008 to March 2009.

Participants were identified through a three-wave snowball sampling approach. Initial sampling for the snapshot survey was conducted by inviting workgroup members from the Suicide PIP Initiative to provide contact information for potential respondents within or outside of their organizations that would likely participate.

Potential participants were contacted by email to determine whether they would participate in a telephone interview to discuss programs, services and supports they were currently providing relative to suicide prevention, intervention and postvention. Participants were initially emailed a letter of introduction and request for participation. In the letter of introduction, the initiative’s objectives and projected outcomes were outlined, along with a rationale for the snapshot survey. Approximately three attempts were made to contact participants by email and/or phone. After establishing initial contact, on average three additional emails/phone calls were required to book and confirm appointment times with each participant.

Once the first wave of individuals had been contacted and interviewed, they were then asked to provide the names of other individuals or organizations they believed would be interested in participating in the survey. Participants gathered at this time comprised the second wave of data collection. Upon completion of the second wave, coverage across age groups, regions, type of services, and vulnerable and/or high risk groups was assessed to determine representation and gaps across the province. Once gaps in representation and locale were determined, targeted recruitment took place in the third wave of data collection. For the third wave, participants were located through extensive internet searches, as well as requesting additional contact from previous participants, but with a more targeted focus on closing in on gaps.

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3. Services are defined as: Organizations or persons working directly to prevent, intervene in suicide risk and/or behaviour and/or provide follow-up with bereaved persons after a death by suicide has occurred.
Interview
All snapshot interviews were conducted over the phone, and hand-written notes were taken by the project assistant to document the conversations. Participants were asked to respond to questions as honestly as possible, with the option of refusing if they did not feel able or willing to answer. Interviews on average took 30 minutes to complete and ranged from 15 to 60 minutes.

Upon completion of the interview, participants were invited to ask any further questions they had about the initiative, asked if it would be alright to contact them again if any further information was required, and given contact information for the project if they had any more questions or concerns. Participants were also informed that their responses were confidential and that any data analyses presented to the public from the survey would be presented in aggregate form.

Participants
Participants were service providers or those involved with service delivery for suicide prevention, intervention and/or postvention services and/or mental health and substance use services. All participation was voluntary and participants were informed that they were able to withdraw at any time. Inclusion criteria for participation consisted of the following:

1) Programs, services and supports involved in suicide prevention, intervention or postvention
2) Programs, services and supports in an area that were not well geographically represented
3) Programs, services and supports targeting high risk and/or special interest populations
4) Programs, services and supports highly recommended for assessment by snapshot survey respondents

Survey
The snapshot survey was developed by the project assistant with input from Initiative Co-chairs and the Project Manager. Final approval for the survey came from the committee stakeholders. At the start of the interview, participants were asked to answer basic contact details for their organizations such as phone, email, address and catchment area. Participants were then asked to give a broad description of the programs, services and supports that they provide regarding suicide prevention, intervention and postvention, and to provide demographic information (types of service users, language capacity, referral practices, etc) about their service populations. Participants were also asked to give opinions on what worked best about their programs, services and supports, barriers to providing services and any plans for improvement and expansion. The snapshot survey is provided in Appendix 7.

Data Analyses
After interviews were completed, the project assistant entered data into an electronic database. Once a significant amount of the surveys were entered, themes were developed to assist with the categorizing and coding. For single response items, categories were used to code participant responses. For multiple response categories (e.g. services, barriers, supports and effectiveness), matrices were developed for each question, and responses were coded as yes or no for each category.
Descriptive analyses were conducted to provide frequencies on demographic information. Matrices were also developed describing current practice and desired practices. Response categories and percentages will be presented in aggregate for the services, barriers, supports and expansion categories. For the response categories, each response was tabulated out of 100%. A table of current and desired practice by populations is also provided.

**Results**

- Seventy-seven out of 134 potential respondents participated in the survey giving a response rate of 56.7%.

- The majority were government organizations at 48%, \((n = 37)\), followed by non-profit organizations at 36% \((n = 28)\), non-government organizations at 9% \((n = 7)\), professional organizations at 4% \((n = 3)\) and other at 2%, \((n = 2)\).

- By Regional Health Authority, the highest participation occurred in both the Vancouver Coastal Health Authority and Interior Health Authority each accounting for 22% \((n = 17)\). The Northern Health Authority accounted for 17% \((n = 13)\) of the sample followed by Vancouver Island Health Authority at 16%, \((n = 12)\) and Fraser Health Authority at 14%, \((n = 11)\). In addition, organizations providing province wide services and programs also participated at 9% \((n = 7)\).

- Participants ranged from senior management to frontline staff, although 52% of respondents were at the management level \((n = 40)\), 21% were government \((n = 16)\), 18% were coordinators/front line staff \((n = 14)\), 5% were from regional health authorities \((n = 4)\), 1% were advocates \((n = 1)\) and 3% were others \((n = 2)\).

- Approximately 39% of the respondents provided programs, services and supports for all age groups \((n = 30)\), followed by 31% for children and youth \((n = 24)\), 27% were for adults \((n = 21)\) and 3% were for older adults \((n = 2)\).

**FIGURE 4.1:**

*Program and Service Provision by Age Groups*

- All Ages, 30, 39%
- Children & Youth, 24, 31%
- Older Adults, 2, 3%
- Adults, 21, 27%
Participation by organization type indicated that 21% \((n = 16)\) of respondents were crisis lines, government organizations and regional health authorities. Community services accounted for 18% of the organizations \((n = 14)\) followed by school districts at 8% \((n = 6)\), post-secondary counselling at 5% \((n = 4)\), Aboriginal services at 5% \((n = 4)\) and advocates at 1% \((n = 1)\).

Forty three percent of respondents provided services in English only, 34% provided services in English but had access to translation services \((n = 26)\), and 12% depended on the dual language skills of employees to provide translation, if required \((n = 9)\). Only 9% of organizations reported formal multiple language capacity in the services \((n = 7)\).

Responses to the Question “What Kinds of Services Do You Provide”?

Respondents indicated that community education including public education and promoting awareness about suicide prevention, intervention and postvention was provided by 77% \((n = 59)\) of programs, services or supports.

Respondents also indicated that referrals to external resources were provided in 68% \((n = 52)\) of programs, services or supports.

Counselling, either short term or ongoing one-on-one and/or group therapy was provided by 61% \((n = 47)\) of programs, services or supports.

Outreach which refers to efforts initiated by an individual or organization to identify potential at risk and/or vulnerable populations (or their care givers) and encourage their use of existing services and resources was provided by 29% \((n = 22)\) of programs, services and support.

Phone support (e.g. providing telephone counselling services such as distress lines) were cited in 26% \((n = 20)\) of programs, services or supports.
Responses to the Question “What is most effective about your program or service?”

- Collaborations \((n = 37)\) referring to relationships between organizations and individuals within a community to address suicide and work together to provide a continuum of care was highly represented \((49\%)\).

- Therapeutic approaches such as those that promote symptom relief, changes in behaviour and improved functioning accounted for \(18\% \ (n = 14)\) of programs, services or supports.

- Capacity building referring to increasing awareness, skills and accessibility to care within communities for individuals, families and organizations to help them to become more self reliant accounted for \(16\% \ (n = 12)\) of programs, services or supports.

- Holistic approaches to care involving addressing the relationships between all aspects of a person’s life when providing services (e.g. mental, emotional, physical, spiritual) accounted for \(14\% \ (n = 11)\) of programs, services or supports.

- Trained and knowledgeable paid staff providing services accounted for \(13\% \ (n = 10)\) of programs, services or supports.

**FIGURE 4.3:**
Effective Aspects of Programs, Services or Supports Provided by Snapshot Survey Respondents
Response to the question “What are the barriers to providing your programs, services, or supports”?

- Funding issues were highly represented with 52% (n = 40) of programs, services or supports citing this as a barrier.

- Lack of coordinated services, which refers to the inability to provide timely services due to a service coordination issues was also cited by 40% (n = 31) of programs, services and supports.

- Accessibility issues, which refer to the inability of either the suicidal person to access the services or the organization to provide the necessary services was cited among 38% (n = 29) of programs, services or supports.

- Lack of public awareness regarding program or services was cited among 20% (n = 16) of programs, services or supports.

- Staffing issues were cited among 19% (n = 15) of programs, services or supports.

**FIGURE 4.4:**
**Barriers for Programs, Services or Supports Provided by Snapshot Survey Respondents**

![Barriers for Programs, Services or Supports Provided by Snapshot Survey Respondents](image-url)
Responses to the question “What are your planned areas of improvement or expansion?”

- Maintaining current service capacity was highly represented by 32% \((n = 25)\) of programs, services or supports.
- Expanding the service population was cited by 27% \((n = 21)\) of programs, services or supports.
- Plans to provide more prevention services were cited by 17% \((n = 13)\) of programs, services or supports and plans to provide more postvention services were cited among 14% \((n = 11)\) of programs, services or supports.
- Improving awareness regarding available programs and developing family and concerned other supports were represented by 11% \((n = 9)\) of programs, services and supports.

FIGURE 4.5:
Planned Improvement or Expansion of Programs, Services or Supports Provided by Snapshot Survey Respondents
Current Practices
Current practice consisted of current programs, services or supports and strengths of programs, services and supports as indicated by respondents.

- For **prevention**, capacity building, collaboration, and community education programs were highly represented across many populations.

- For **intervention**, gatekeeper training, peer or group support, phone counselling, and risk assessments were highly represented across many populations.

- For **postvention**, critical incident management and phone counselling were highly represented across different populations.

  Among **children and youth**, collaboration, capacity building, community education, cultural awareness, interdisciplinary teams, liaising with schools, outreach and physician education were all reported as current practices in **prevention**. Cognitive behavioural therapy (CBT), crisis stabilization, dialectical behavioural therapy (DBT), gatekeeper training, group therapy, peer or group support, phone counselling, risk assessments, use of specialists and safety planning were reported as current practices in **intervention**. Community response teams, critical incident management, school district protocols, referral to hospices, and referrals to other organizations and service providers (psychiatrists, general practitioners) were reported as current practices in **postvention**.

  Among **adults**, awareness programming, capacity building, collaboration, community education and outreach were reported as current practices in **prevention**. CBT, crisis stabilization, DBT, gatekeeper training, group or peer support, group therapy, use of specialists and safety planning were all reported as current practices in **intervention**. Advocacy, bereavement teams, phone counselling, support groups, and referrals were reported as current practices in **postvention**.

  Among **older adults**, capacity building, community education, and outreach were reported as current practices in **prevention**. Peer or group support, phone counselling, risk assessment, and referrals were reported as current practices in **intervention**. No current practices were reported for **postvention** among older adult populations.

  Among **all populations**, capacity building, collaboration, community education and outreach were reported as current practices in **prevention**. Phone counselling, risk assessment and referrals were reported as current practices in **intervention**. Advocacy, bereavement teams critical incident management, referral to hospices, phone counselling, referrals and support groups were reported as current practices in **postvention**.

  Among **vulnerable and/or high risk populations**, awareness programming, capacity building, community education, cultural awareness, interdisciplinary teams, liaising with schools and outreach were reported as current practices in **prevention**. Gatekeeper training, peer or group support, phone counselling, risk assessment and use of specialists were reported as current practices in **intervention**. Critical incident management was reported as one current practice in **postvention**.
# Table 4.1: Current Practices among Snapshot Survey Respondents

<table>
<thead>
<tr>
<th>Current Practices</th>
<th>Children &amp; Youth</th>
<th>Adults</th>
<th>Older Adults</th>
<th>All Populations</th>
<th>Vulnerable/ High Risk Populations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Awareness Programming</td>
<td>X</td>
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<td>X</td>
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<tr>
<td>Collaboration</td>
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<tr>
<td>Community Education</td>
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<tr>
<td>Cultural Awareness</td>
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<tr>
<td>Interdisciplinary Teams</td>
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<td></td>
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<td></td>
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<tr>
<td>Liaising with Schools</td>
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<tr>
<td>Outreach</td>
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<tr>
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<td>Dialectical Behavioural Therapy</td>
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<td>Gatekeeper Training</td>
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<tr>
<td>Group Therapy</td>
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<tr>
<td>Phone Counselling</td>
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<tr>
<td>Risk Assessment</td>
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<td>Referral</td>
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<tr>
<td>Safety Planning</td>
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<tr>
<td>Advocacy (Survivors)</td>
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<tr>
<td>Bereavement Teams</td>
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<td>Phone Counselling</td>
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<tr>
<td>Referral</td>
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<td>Support Group</td>
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</tbody>
</table>
Desired Practices

- Desired practice was informed by responses to questions regarding barriers and plans for expansion. For **prevention**, improving funding was highly represented across many populations.

- For **intervention**, improving accessibility of services, improving the coordination of services, and decreasing wait times were highly represented across many populations.

- For **postvention**, providing resources was highly represented across many populations.

- Among **children and youth**, addressing socioeconomic disadvantage, early identification, improving funding, outreach services, developing stigma reduction programs were reported as desired practices in **prevention**. Improving the accessibility of services, improving the coordination of services, providing concurrent disorders treatment, decreasing wait times, and providing family support services were reported as desired practices in **intervention**. Developing and providing **postvention** resources was also reported as a desired practice in intervention.

- Among **adults**, addressing socioeconomic disadvantage, cultural awareness and training, improving funding, outreach services, program awareness and stigma reduction programs were reported as desired practices in **prevention**. Improving accessibility of services, active case management, improving coordination of services, decreased wait times and staff retention were reported as desired practices in **intervention**. No desired practices were reported for **postvention**.

- Among **older adults**, accessibility of services was reported as a desired practice in **intervention**. No desired practices were reported for prevention or postvention however, only two respondents from older adult focused organizations participated in the survey.

- Among **all populations**, improving funding, program awareness and providing translation services were reported as desired practices in **prevention**. Improving accessibility of services, improving coordination of services, counselling services, decreasing wait times, providing follow-up, use of specialists, improving staff retention and providing support groups were reported as desired practice in **intervention**. Providing family support, providing follow-up, postvention resources, and survivor groups were reported as desired practices in **postvention**.

- Among **vulnerable and/or high risk populations**, cultural awareness and training, improving funding, stigma reduction programs and translation services were reported as desired practices in **prevention**. Improving accessibility of services, active case management, improving coordination of services, crisis stabilization, concurrent disorders treatment, providing day programs, providing family support and staff retention were reported as desired practices in **intervention**. Postvention resources (e.g. pamphlets, booklets, videos, workshops) were reported as a desired practice in **postvention**.
<table>
<thead>
<tr>
<th>Desired Practice (or Needs)</th>
<th>Children &amp; Youth</th>
<th>Adults</th>
<th>Older Adults</th>
<th>All Populations</th>
<th>Vulnerable / High Risk Populations</th>
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<tbody>
<tr>
<td>Addressing socioeconomic disadvantage</td>
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<td>Translation Services</td>
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<td>Day Programs</td>
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<td>Decreased Wait Times</td>
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<td>Family Support</td>
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<td>Follow-up</td>
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<td>Specialists</td>
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<td>Staff Retention</td>
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<td>Support Groups</td>
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<td>Family Support</td>
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<td>Follow-up</td>
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<td>Postvention Resources</td>
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<td>Survivor Groups</td>
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</table>
Discussion

Findings from the snapshot survey provided information regarding current practices and desired practices among respondents delivering programs, services and supports in BC.

- The sample included diverse respondents from different organizations and different geographic locations in BC. Programs, services and supports that were highly represented by respondents include community education, referrals and counselling.

- Collaborations, therapeutic approaches, and capacity building were highly represented as elements of effective programs, services and supports.

- Lack of funding, lack of coordinated services, and lack of accessible services were highly represented as barriers to providing programs, services and supports.

- Maintaining current service capacity and expanding service populations were highly represented as planned areas for expansion and improvement.

- These patterns of findings suggested that collaborative, interdisciplinary approaches with an emphasis on coordinating services and developing methods to more effectively share knowledge, resources, and promising practices were elements that should be considered in planning services for suicide prevention, intervention and postvention.

- Given that the survey provided a snapshot of services, there were populations that were overrepresented and underrepresented in the survey process.

- Highly represented populations included programs, services and supports among all populations (all ages) and child and youth populations. While these findings suggested that services for some populations are underrepresented, many respondents were providing services for individuals across the lifespan for multiple and overlapping populations.

- These findings suggested that a general population approach might be employed rather than provision of specialized services for specific populations and specific needs. Many respondents indicated that although they may see specific populations in their work, they did not feel properly prepared for the complex issues involved when addressing suicide.

- Respondents suggested that additional training and resources for vulnerable and/or high risk populations and specialized services for the referral of suicidal persons would be helpful.

- Due to children and youth’s connections to school districts and Child and Youth Mental Health, services for this age range were easily located throughout the province, although respondents suggested that gaps in service existed among acute care facilities and in access to psychiatrists. In some cases, community based organizations, services and programs for children and youth were integrated into adult services which suggested that gaps existed in specifically tailored strategies for child and youth populations.

- In addition, gaps also existed when locating respondents who served youth populations aged 18-24 years, which were ages that may be outside of the age range of 0-19 years by some child and youth serving organizations.
Generally services for adults were easy to locate although in many cases, these resources were burdened with long wait times.

There was a particular lacking of services for older adults as they were expected to obtain services from traditional adult organizations. Only two organizations (both in the Lower Mainland) worked specifically with older adult populations. Respondents serving all populations including older adults could be trained on addressing issues of particular concern for older adults such as lack of mobility, social isolation, grief and loss due to death of friends and family, physical ailments and financial concerns.

A listing of many organizations involved in suicide prevention, intervention and postvention services within the province is provided in Appendix 8. This is not an exhaustive list, and although efforts were taken to ensure the accuracy of information provided, the information may be outdated at the time of publication. Many of the included organizations participated in the snapshot survey; however, not all listed organizations were snapshot survey respondents.

Evidence from the snapshot survey was one of multiple inputs to developing recommendations for suicide prevention, intervention and postvention for the province. The current and desired practices were examined in conjunction with the results from the evidence-informed practice review to determine where actions could be taken for suicide prevention, intervention and postvention.
CHAPTER 5:

STAKEHOLDER SURVEY FOR SUICIDE PREVENTION, INTERVENTION AND POSTVENTION IN BC
To develop recommendations for the Suicide PIP Initiative, results of the evidence-informed practice review and snapshot survey were analyzed to provide recommendations for suicide prevention, intervention and postvention in the province. Part of the analytic process involved collating strategies from the evidence-informed practice review and practice based evidence results into a matrix examining scope of services (prevention/intervention/postvention) by populations (child & youth/adults/older adults/vulnerable groups/high risk groups). Through examining the matrices, recommendations for suicide prevention, intervention and postvention in the province were developed.

**Role of Project Stakeholders**

To develop the Framework and Planning Template, stakeholders played an integral role in determining priority areas for suicide prevention, intervention and postvention in BC. Stakeholders engaged in consensus processes which addressed how to move forward on suicide prevention, intervention and postvention.

Recommendation statements were distributed to more than 40 project stakeholders for evaluation and ranking in a Delphi survey. The Delphi survey is known as a group facilitation technique involving an iterative multistage process transforming group opinion into consensus (Hasson et al., 2000). Delphi survey research methods are used as change management tools in a variety of settings and most notably in nursing research (Sharkey & Sharples, 2001). Use of a Delphi survey provided methodology for alignment of evidence-based practice with the experience of the clinical practice environment (Sharkey & Sharples, 2001). Iterative presentation and representations of information procedures of the Delphi survey process used to facilitate consensus (Sharkey and Sharples 2001).

Stage 1 of the Delphi process involved presenting 22 draft recommendations to stakeholders for group discussion. Stage 2 involved revisions and the resulting 17 recommendations being sent to stakeholders and the Executive Committee for additional feedback. Stage 3 involved finalizing 16 recommendations and developing a recommendations survey for administration to stakeholders. A summary of stakeholder engagement and feedback procedures is provided in Table 5.1.

<table>
<thead>
<tr>
<th>Delphi Stage</th>
<th>Stakeholders Involved</th>
<th>Feedback Mechanism</th>
<th>Revisions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 1</td>
<td>All Stakeholders</td>
<td>In person meeting</td>
<td>22 Recommendations</td>
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<tr>
<td>Stage 2</td>
<td>Executive Committee</td>
<td>Email, Telephone</td>
<td>17 Recommendations</td>
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<tr>
<td>Stage 3</td>
<td>All Stakeholders</td>
<td>Email, Telephone</td>
<td>16 Recommendations</td>
</tr>
<tr>
<td>Stage 4</td>
<td>All Stakeholders</td>
<td>Online Survey</td>
<td>Applied to Recommendations</td>
</tr>
</tbody>
</table>

As a result of this process, a list of 16 recommendations were developed, finalized and evaluated by stakeholders in the recommendations survey. The stakeholder survey is provided in Appendix 9.
### Table 5.2:

**Recommendations for Suicide Prevention, Intervention and Postvention in BC**

(Recommendations 1-8)

1. **School-based programs** focusing on mental health promotion and preventing substance use for children and youth that integrate behavioural changes, coping skills and social supports

2. **Cultural safety and community renewal approaches** should be emphasized when engaging in suicide prevention, intervention and postvention with Aboriginal populations

3. **Media education and guidelines** for coverage and province-wide reporting on the issue of suicide prevention, intervention and postvention

4. **Gatekeeper training** for all populations including:
   a) Peers, health professionals, community leaders, spiritual advisors, within school and post-secondary settings, the workplace, acute care settings, long term care facilities and justice system
   b) How to identify at-risk individuals and improve access to suicide intervention and mental health and substance use resources

5. **Development of a clinician working group** to assess the relevance of recommendations on therapies for suicide intervention. Therapies include:
   a) Interpersonal therapy, cognitive behavioural therapy and problem solving therapy for interventions across the lifespan
   b) Dialectical behaviour therapy for youth (and their families), adults, and older adults with borderline personality disorder
   c) Selective serotonin reuptake inhibitors (SSRIs), clozapine and lithium for specific clinical populations

6. **Physician and health professional education** on early recognition, risk assessment, clinical assessment, mental health conditions and comorbidities and treatment of suicidal behaviour and/or ideation across the lifespan
   a) Education efforts would include addressing depression, other mental health conditions and concurrent disorders as well as the interpretation of policies around treatment provision (BC Mental Health Act, Infants Act, Freedom of Information and Protection of Privacy Act)

7. **Family-centred approaches** for involving families and concerned others in addressing suicide prevention, intervention and postvention through education, support groups and/or affordable family/individual counselling, safety planning, and outreach

8. **Culturally appropriate services**, cultural safety and diversity training for service providers regarding suicide prevention, intervention and postvention including:
   a) Improved translation services, expanded language capacity or improved awareness of existing services
   b) Coping skills training and workshops for emotion regulation and coping
   c) Providing stigma reduction and mental health awareness and education messages through TV, newspapers, and radio
   d) Gay, lesbian, bisexual and transgendered (GLBT) resiliency training administered by GLBT agencies and/or service providers
<table>
<thead>
<tr>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>9. Coordination of services for suicide prevention, intervention and postvention</strong> in the mental health system, health care system, school/post-secondary systems and community including:</td>
</tr>
<tr>
<td>a) Interdisciplinary teams and case approaches such as active case management, assertive community teams, and integrated case management</td>
</tr>
<tr>
<td>b) Possible development of day programs to address suicidality and/or concurrent disorders and crisis stabilization teams/units to address people in acute crisis or suicide states and/or provide ongoing support</td>
</tr>
<tr>
<td>c) Improved access to psychiatrists and psychiatric services</td>
</tr>
<tr>
<td>d) Promotion of a trauma informed response to suicidal people and their families</td>
</tr>
<tr>
<td><strong>10. Education and awareness on means restriction approaches</strong> with needs and feasibility analyses including restrictions on firearms, bridge installations of barriers and/or fences, restrictions on drug package sizes, restrictions on domestic toxic gases/provision of non-lethal substitutes</td>
</tr>
<tr>
<td><strong>11. Development and enhancement</strong> of postvention bereavement programs, services and supports among persons touched by a suicide including:</td>
</tr>
<tr>
<td>a) Educational workshops, support groups, group therapy and survivor groups for those bereaved by a suicide related death</td>
</tr>
<tr>
<td>b) Postvention response protocols involving referral practices, community response teams, critical incident management and treatment</td>
</tr>
<tr>
<td><strong>12. Outreach to promote access</strong> of suicide prevention, intervention and postvention services and resources with specific approaches targeting children &amp; youth, young adults, adults and older adults and rural populations including:</td>
</tr>
<tr>
<td>a) Building upon telehealth programs</td>
</tr>
<tr>
<td>b) Development of other rural services</td>
</tr>
<tr>
<td><strong>13. Safety planning tools, follow-up and outreach</strong> for suicidal individuals and for those who are in contact with suicidal individuals including family members, concerned others and health care providers</td>
</tr>
<tr>
<td><strong>14. Support for care providers</strong> working in the suicide and mental health and substance use including safety planning for their health and wellness</td>
</tr>
<tr>
<td><strong>15. Improved accessibility to local detoxification, substance use treatment and withdrawal management</strong> especially for those with concurrent disorders/dual diagnosis disorders</td>
</tr>
<tr>
<td><strong>16. Explore how public and private partnerships could support</strong> the sustainability of suicide prevention, intervention and postvention programs, services and supports</td>
</tr>
</tbody>
</table>
Survey Administration

Respondents were provided with a link to an online survey and participated during 2009 May and 2009 June. Respondents were provided with 2 separate email reminders for participation in the survey.

In the survey, recommendations statements were presented on a 5 point Likert scale and respondents were asked to rank their level of agreement where 1 = strongly disagree and 5 = strongly agree on the following criteria:

- Whether the statement was a priority for suicide prevention intervention and postvention
- Whether the statement was relevant to their work
- Whether the recommendation could be implemented in their work in 2 years

A final ranking exercise was presented where participants were asked to rank the top five priorities for suicide prevention, intervention and postvention in the province.

For analyses, the survey response categories were collapsed into three response categories (agree, neutral and disagree). Frequencies were analysed for each recommendation and presented in graph form. A summary of responses to all four categories was also developed.
Results
Of 43 potential respondents, 30 stakeholders participated in the survey for a response rate of 70%.

When respondents were presented with each recommendation and asked “whether the statement was a priority for suicide prevention, intervention and postvention?”:

- Recommendations that 100% of respondents \( (n = 30) \) agreed with were coordination of services and school-based programs.

- Recommendations that 97% of respondents \( (n = 29) \) agreed with included outreach, culturally appropriate services, family-centred approaches and health professional education.

- Recommendations that 93% of respondents \( (n = 28) \) agreed with included postvention programs and services and gatekeeper training.

- One recommendation that 90% of respondents \( (n = 27) \) agreed with was media education and guidelines.

FIGURE 5.1:
**Stakeholder Responses Regarding Priorities for Suicide Prevention, Intervention and Postvention**

![Stakeholder Responses Graph]
When respondents were presented with each recommendation and asked “whether the statement was relevant to their work?":

- Eighty percent of respondents (n = 24) agreed with culturally appropriate services, family-centred approaches, health professional education and gatekeeper training.
- Recommendations that 77% of respondents (n = 23) agreed with was Aboriginal cultural safety and community renewal strategies.
- One recommendation that 73% of respondents (n = 22) agreed with was postvention programs and services.

**FIGURE 5.2:**
Stakeholder Responses Regarding Relevance of Recommendations to Their Work

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Number of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>R16 – Public-private partnerships</td>
<td>24</td>
</tr>
<tr>
<td>R15 – Local detox and withdrawal mgnt</td>
<td>24</td>
</tr>
<tr>
<td>R14 – Support to care providers</td>
<td>23</td>
</tr>
<tr>
<td>R13 – Safety planning</td>
<td>26</td>
</tr>
<tr>
<td>R12 – Outreach</td>
<td>29</td>
</tr>
<tr>
<td>R11 – Postvention programs &amp; services</td>
<td>28</td>
</tr>
<tr>
<td>R10 – Means restriction education</td>
<td>21</td>
</tr>
<tr>
<td>R9 – Coordination of services</td>
<td>30</td>
</tr>
<tr>
<td>R8 – Culturally appropriate services</td>
<td>29</td>
</tr>
<tr>
<td>R7 – Family centred approaches</td>
<td>29</td>
</tr>
<tr>
<td>R6 – Health professional education</td>
<td>29</td>
</tr>
<tr>
<td>R5 – Clinician workgroup</td>
<td>24</td>
</tr>
<tr>
<td>R4 – Gatekeeper training</td>
<td>28</td>
</tr>
<tr>
<td>R3 – Media education &amp; guidelines</td>
<td>27</td>
</tr>
<tr>
<td>R2 – Aboriginal cultural identity &amp; renewal</td>
<td>26</td>
</tr>
<tr>
<td>R1 – School bsased program (MH)</td>
<td>30</td>
</tr>
</tbody>
</table>
When respondents were presented with each recommendation and asked “Whether the recommendation could be implemented in their work in 2 years?”:

- Sixty seven percent \((n = 20)\) respondents agreed with gatekeeper training and postvention programs and services.
- A recommendation that 60% of respondents \((n = 18)\) agreed with was school-based programs.
- A recommendation that 57% of respondents \((n = 17)\) agreed with was health professional education.
- A recommendation that 53% of respondents \((n = 16)\) agreed with was coordination of services.

**FIGURE 5.3:**
Stakeholder Responses Regarding Ability to Implement Recommendations in the Next 2 Years

![Figure 5.3](image-url)
Ranking Exercise
When respondents were presented with each recommendation and asked “which recommendations should be the top 5 priority areas for the Suicide PIP initiative?”:

- Seventy three percent of respondents (n = 22) agreed with school-based programs.
- One recommendation that 60% of respondents (n = 18) agreed with was coordination of services.
- One recommendation that 57% of respondents (n = 17) agreed with was gatekeeper training.
- One recommendation that 43% of respondents (n = 13) agreed with was health professional education.
- Recommendations that 40% of respondents (n = 12) agreed with were postvention programs and services and culturally appropriate services.

FIGURE 5.4:
Stakeholder Responses by Priority Ranking Exercise

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Number of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>R16 – Public-private partnerships</td>
<td>8</td>
</tr>
<tr>
<td>R15 – Local detox and withdrawal mgmt</td>
<td>7</td>
</tr>
<tr>
<td>R14 – Support to care providers</td>
<td>5</td>
</tr>
<tr>
<td>R13 – Safety planning</td>
<td>1</td>
</tr>
<tr>
<td>R12 – Outreach</td>
<td>5</td>
</tr>
<tr>
<td>R11 – Postvention programs &amp; services</td>
<td>12</td>
</tr>
<tr>
<td>R10 – Means restriction education</td>
<td>1</td>
</tr>
<tr>
<td>R9 – Coordination of services</td>
<td>18</td>
</tr>
<tr>
<td>R8 – Culturally appropriate services</td>
<td>12</td>
</tr>
<tr>
<td>R7 – Family centred approaches</td>
<td>11</td>
</tr>
<tr>
<td>R6 – Health professional education</td>
<td>13</td>
</tr>
<tr>
<td>R5 – Clinician workgroup</td>
<td>6</td>
</tr>
<tr>
<td>R4 – Gatekeeper training</td>
<td>17</td>
</tr>
<tr>
<td>R3 – Media education &amp; guidelines</td>
<td>7</td>
</tr>
<tr>
<td>R2 – Aboriginal cultural identity &amp; renewal</td>
<td>6</td>
</tr>
<tr>
<td>R1 – School based program (MH)</td>
<td>22</td>
</tr>
</tbody>
</table>
In examining responses to all four survey questions, the following six priority areas emerged:

- School-based programs
- Gatekeeper training
- Culturally appropriate services
- Health professional education
- Coordination of services
- Postvention services and programs

The summary provided in Table 5.3 was colour coded to illustrate organization of responses by each priority area. The ranking of responses is provided for each question asked in the survey.

**Table 5.3:**
Summary of Recommendations Survey Results

<table>
<thead>
<tr>
<th>Priority for Suicide PIP</th>
<th>Relevance to my work</th>
<th>Possible to implement in my work within 2 years</th>
<th>Priority ranking exercise</th>
</tr>
</thead>
<tbody>
<tr>
<td>School-based programs</td>
<td>Culturally appropriate services</td>
<td>Gatekeeper training</td>
<td>School-based programs</td>
</tr>
<tr>
<td>Coordination of services</td>
<td>Family-centred approaches</td>
<td>Postvention programs/services</td>
<td>Coordination of services</td>
</tr>
<tr>
<td>Culturally appropriate services</td>
<td>Health professional education</td>
<td>School-based programs</td>
<td>Gatekeeper training</td>
</tr>
<tr>
<td>Outreach</td>
<td>Gatekeeper Training</td>
<td>Health professional education</td>
<td>Health professional education</td>
</tr>
<tr>
<td>Family-centred approaches</td>
<td>Aboriginal cultural safety and renewal</td>
<td>Coordination of services</td>
<td>Culturally appropriate services</td>
</tr>
<tr>
<td>Health professional education</td>
<td>Postvention programs/services</td>
<td>Family-centred approaches</td>
<td>Postvention programs/services</td>
</tr>
<tr>
<td>Gatekeeper training</td>
<td>Support for care providers</td>
<td>Media education</td>
<td>Public private partnerships</td>
</tr>
<tr>
<td>Postvention programs/services</td>
<td>School-based programs</td>
<td>Outreach</td>
<td>Family centered approaches</td>
</tr>
<tr>
<td>Media education</td>
<td>Coordination of services</td>
<td>Culturally appropriate services</td>
<td>Media education</td>
</tr>
<tr>
<td>Aboriginal cultural safety and renewal</td>
<td>Outreach</td>
<td>Aboriginal cultural safety and renewal</td>
<td>Local detox and withdrawal mgmt</td>
</tr>
</tbody>
</table>
During the implementation of the recommendations survey, a subgroup of respondents \( n = 10 \) participated in the survey outside of the group of project stakeholders. The subgroup included representation from crisis centres and was a relatively homogenous group of service providers situated across the province. Analyses of subgroup results were consistent with findings from the stakeholder recommendations survey.

Some of the highest ranked emerging priorities from the subgroup of respondents were:

- School-based programs
- Gatekeeper training
- Culturally appropriate services
- Coordination of services
- Safety Planning

Safety planning was highlighted by the subgroup suggesting that ensuring suicidal persons have supports and mechanisms in place to assist in planning for safety should be examined closely.

**TABLE 5.4:**

**Summary of Recommendations Survey Results by Subgroup Analysis**

<table>
<thead>
<tr>
<th>Priority for Suicide PIP</th>
<th>Relevance to my work</th>
<th>Possible to implement in my work within 2 years</th>
<th>Priority ranking exercise</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety planning</td>
<td>Culturally appropriate services</td>
<td>Safety planning</td>
<td>Coordination of services</td>
</tr>
<tr>
<td>Coordination of services</td>
<td>Postvention services and programs</td>
<td>Culturally appropriate services</td>
<td>Gatekeeper training</td>
</tr>
<tr>
<td>Culturally appropriate services</td>
<td>Coordination of services</td>
<td>Support for care providers</td>
<td>Culturally appropriate services</td>
</tr>
<tr>
<td>Family-centred approaches</td>
<td>Gatekeeper Training</td>
<td>Gatekeeper Training</td>
<td>School-based programs</td>
</tr>
<tr>
<td>Health Professional education</td>
<td>Support for care providers</td>
<td>Media education</td>
<td>Safety planning</td>
</tr>
</tbody>
</table>
Discussion
As a result of the recommendations survey, the following six priorities emerged as the foundation for the Suicide PIP Framework and Planning Template.

**Table 5.5:**
**Priority Areas for Suicide Prevention, Intervention and Postvention in BC**

| School-based programs focusing on mental health promotion and preventing mental health and substance use problems and disorders for children and youth that integrate behavioural changes, coping skills and social supports |
| Gatekeeper training for all populations including: |
| a) Peers, health professionals, community leaders, spiritual advisors, within school and post-secondary settings, the workplace, acute care settings and long term care facilities, justice system |
| b) How to identify at-risk individuals and improve access to suicide intervention and mental health and substance use resources |
| Physician and health professional education on early recognition, risk assessment, clinical assessment, mental health conditions and comorbidities and treatment of suicidal behaviour and/or ideation across the lifespan |
| a) Education efforts include addressing depression, other mental health conditions and concurrent disorders as well as the interpretation of policies around treatment provision (BC Mental Health Act, Infants Act, Freedom of Information and Protection of Privacy Act) |
| Culturally appropriate services, cultural safety and diversity training for service providers regarding suicide prevention, intervention and postvention including: |
| a) Improved translation services, expanded language capacity or improved awareness of existing services |
| b) Coping skills training and workshops for emotion regulation and coping |
| c) Providing stigma reduction and mental health awareness and education messages through TV, newspapers and radio |
| d) Gay, lesbian, bisexual and transgendered (GLBT) resiliency training administered by GLBT agencies and/or service providers |
| Coordination of services for suicide prevention, intervention and postvention in the mental health system, health care system, school/university systems and community including: |
| a) Interdisciplinary teams and case approaches such as active case management, assertive community teams and integrated case management |
| b) Possible development of day programs to address suicidality and/or concurrent disorders and crisis stabilization teams/units to address people in acute crisis or suicide states and/or provide ongoing support |
| c) Improved access to psychiatrists and psychiatric services |
| d) Promotion of a trauma informed response to suicidal people and their families |
Development and enhancement postvention bereavement programs, services and supports among persons touched by a suicide including:

a) Educational workshops, support groups, group therapy and survivor groups for those bereaved by a suicide related death
b) Postvention response protocols involving referral practices, community response teams, critical incident management and treatment

Next Steps
The identification of priorities for suicide prevention, intervention and postvention in the province was vitally important stage for the initiative. While the Suicide PIP Initiative focused on the top 5 priority areas to develop a Framework and Planning Template, 6 key priorities emerged from the recommendations survey. As a result, the next steps was developing the Framework and Planning Template for all six identified priorities. A summary of procedures is provided in Figure 5.5.

FIGURE 5.5:
Summary of Procedures to Developing the Framework and Planning Template
References


CHAPTER 6:

THE SUICIDE PREVENTION, INTERVENTION AND POSTVENTION INITIATIVE FRAMEWORK AND PLANNING TEMPLATE
From a combination of research evidence, practice evidence and stakeholder engagement processes, a set of priority areas for suicide prevention, intervention and postvention in BC have been identified to serve as the basis for the Suicide PIP Initiative for BC Framework and Planning Template.

Framework
The Suicide PIP Initiative Framework provides a strategic discussion of each priority area. The Framework content includes:

- **Goal**: Aim of the Framework for a specific priority area
- **Target audiences**: Audiences that would be impacted by the Framework
- **Key partnerships**: A list of optimal collaborators at local, regional or provincial levels
- **Suggested activities at the systems-level**: Activities that could lead to some systems-level changes across programs, services and supports
- **Suggested activities at the program-level**: Activities that could lead to some program-level changes within programs, services and supports
- **Development opportunities**: A summary of processes involved in addressing a priority area
- **Signs of success**: Potential ways to measure change and how to show activities have made an impact
- **Examples of programs**: Different programs currently delivering services in a priority area

Planning Template
The Suicide PIP Initiative Planning Template is related to the Framework in that it is an action oriented document designed to provide practical guidance for programs, services and supports to work with priority areas. Essentially, the Suicide PIP Planning Template describes how to move through the stages in a planning cycle (development, implementation, improvement and evaluation) in a given priority area. The Planning Template provides a series of questions to be asked of a program at each stage of the planning cycle to determine areas where additional efforts are required. By answering the set of questions provided at a given stage, a program, service or support can be progressively strengthened.

The Planning Template includes:

- **Target audiences**: Audiences that would be impacted by the Planning Template
- **Purpose of the template**: To help programs identify their current stage and considerations required to move forward in the planning cycle
- **Development stage**: Considerations for developing a new program or explore adding the priority area to an existing program
- **Implementation Stage**: Considerations for implementing a specific program, service or support
- **Improvement Stage**: Considerations for improving an existing program that is already in place in a priority area
- **Evaluation Stage**: Process and outcome considerations to determine the impact or success of a program
Both the Framework and Planning Template are meant to be planning tools with the Framework providing strategic direction and the Planning Template providing practical direction on a priority area for suicide prevention, intervention and postvention in BC.

The six priority areas identified in Chapter 5 fit within the scope of suicide prevention, intervention and postvention and support the following ultimate outcomes:

1) Reduced suicide and suicidal behaviour among British Columbians;

2) Improved accessibility and quality of suicide intervention programs, services and supports; and

3) Improved postvention resources & supports for persons touched by a suicide.

The next section will provide for each priority statement an explanation of the associated research evidence, practice evidence and provide the corresponding Framework and Planning Template.

FIGURE 6.1:
Suicide PIP Initiative for BC Priority Areas
School-based programs focusing on mental health promotion and preventing mental health and substance use problems and disorders for children and youth that integrate behavioural changes, coping skills and social supports
Understanding this Statement
This recommendation suggests that school-based programs that have a broader mental health promotion and mental health and substance use disorder prevention could have an impact on suicide prevention, intervention and postvention among children and youth. School-based programming should consider a ‘whole school’ approach. A ‘whole school’ approach goes beyond a single prevention and intervention strategy and works to engage students, teachers, parents, counsellors and principals in a cooperative effort. Elements that programs need to include are:

- Development and promotion of a positive school climate or environment
- Promotion of a dialogue around positive mental and/or emotional health
- Teaching stress management, coping skills and emotion regulation practices
- Reinforcement of the importance of social and school connection and support among peers, teachers and families
- Discussion regarding early identification of mental health and substance use problems and disorders and where one could receive help
- Discussion regarding the prevention of mental health and substance use problems and disorders

Research Evidence
- One research review found that youth skill building was an important element of school-based programming efforts (White, 2005).
- Guo and Harstall (2004) and Crowley & colleagues (2004) identified studies where school-based suicide prevention programs focusing on behavioural change and coping strategies in the general school population were associated with lowered suicidal tendencies, improved ego identification, and enhanced coping skills.
- Among high-risk students, two studies on programmes focusing on skill training and social support demonstrated reduced risk factors and enhanced protective factors.
- Beautrais & colleagues (2007) also indicated that skill-enhancing programs are a promising practice.
- Specific program examples found in the research literature included:
  - The Signs of Suicide Program combined two strategies into a single program by combining curriculum to raise awareness of suicide and its related issues with a brief screening for depression and other risk factors (Aseltine & DeMartino, 2004).
  - At the core of the program was recognition of the signs of suicide and depression and teaching action steps to students (Acknowledge, Care, Tell – ACT).
  - Evaluation found lower rates of suicide attempts and greater knowledge and more adaptive attitudes about depression and suicide (Aseltine & DeMartino, 2004).
  - A replication study also found similar outcomes at 3 months after intervention across high school student of different ages, races, ethic backgrounds and sexes (Aseltine et al., 2007)
Clifone (2007) developed and evaluated the South Elgin High School Suicide Prevention Program was developed for students to 1) Learn appropriate responses to a peer at risk of suicide; 2) Increase willingness to inform adults about suicide for self and peers and 3) Change perceptions around suicide as an option.

Findings indicated that the program changed unwanted attitudes about suicide and reduced adolescent's reluctance to seek mental health treatment for them and peers (Clifone, 2007).

A psychoeducational peer-helping program was developed by Portzky & van Heeringan (2006) to increase knowledge and adaptive attitudes and impact on coping behaviour and levels of hopelessness.

The program demonstrated a positive effect on knowledge and attitudes but no impact on coping or helplessness (Portzky & van Heeringan, 2006).

Eggert et al. has developed a program entitled Counselors Care (CARE) is a school-based intervention for high-school students at risk for suicide. CARE is a two-part, four-hour program, beginning with a personalized computer-assisted assessment of risk and protective factors using Measure of Adolescent Potential for Suicide (MAPS) which provides a comprehensive and individualized assessment of direct suicide risk factors, related risk factors, and protective factors. Risk assessment was followed by a brief counselling intervention designed to enhance a youth’s personal resources and social network connections.

In two evaluation efforts, Eggert et al. (2002) and Randell, Eggert, and Pike (2001) reported a significant decreasing trend over time in suicide risk behaviors. Other findings included significant declines in depression over time and a steady decline in anger control problems.

**Practice Evidence**

- Fourteen snapshot survey respondents indicated they were involved in providing school-based programs, and 57% of those respondents indicated these programs and services were oriented toward both suicide prevention and intervention.

- Types of prevention programs and services included: anxiety education workshops; school-based education workshops; cultural camps; FRIENDS program; peer recognition and response programs; school outreach; and depression screening.

- When asked about what works about programs, respondents cited clear program mandates, contracting services, good relationships between community agencies and Child and Youth Mental Health individual case loads, mobile services and district development of tools as strengths of their respective programs and services.
FRAMEWORK: School-Based Programs

<table>
<thead>
<tr>
<th>Goal</th>
<th>To establish and maintain a broad, integrated mental health promotion and substance use prevention approach in school-based programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target Audiences</td>
<td>Children &amp; youth, parents, teachers, counsellors, principals, nurse, school district personnel, superintendents, community organizations, alcohol and drug counsellors, recreation workers, school youth workers</td>
</tr>
</tbody>
</table>
| Key Partnerships | - School personnel  
  - School district Superintendent and personnel  
  - Local and regional crisis centres  
  - Local/community organizations providing mental health services and supports  
  - Community health organizations  
  - Researchers  
  - Advocates  
  - Regional Health Authorities  
  - Crisis Line Association of BC  
  - Child and Youth Mental Health  
  - BC Ministry of Education  
  - BC Ministry for Children and Family Development  
  - BC Ministry of Health Services  
  - BC Ministry of Healthy Living and Sport  
  - BC Mental Health and Addiction Services (Health Literacy)  
  - BC School Superintendents Association |
| Suggested Activities at the Systems-Level | - Build on programs and services that already exist such as the FRIENDS program, School Wide Positive Behaviour Support Program, programs connecting youth with parents, education workshops, peer response programs, anti-bullying etc (L, R, P)  
  - Initiate collaborative dialogue between district and school personnel to explore and discuss implementing or improving programs (L)  
  - Continue and expand work by government and nongovernment partners on mental health programming in schools (P)  
  - Continue work on developing school connectedness and providing skill building programs as recommended by the BC Child Death Review Unit Report, *Looking for something to look forward to...* (2008) (P) |
| Local – L |  |
| Regional – R |  |
| Provincial – P |  |
| Suggested Activities at the Program-Level | - Determine which schools and/or school districts have mental health promotion and/or suicide prevention programs and the formal or informal outcomes of those programs (L, R, P)  
  - Determine which elements are most important for schools to consider promoting and how those elements are currently addressed (L, R, P)  
  - Determine readiness, capacity and awareness of mental health promotion programs among district personnel, school personnel, counsellors, parents and students (L) |
School districts are uniquely positioned with opportunities to implement programs by choice at the district and/or school level. Given the high levels of autonomy, at any given time, many schools have programs in place to promote the wellbeing of students and some programs may already have mental health promotion and/or substance use prevention components that could be expanded or strengthened. Any effort to engage in school-based programming will require collaboration and efforts to engage with school and/or district personnel and community partners. In addition, efforts will also require a ‘whole school’ approach that goes beyond a single prevention or intervention strategy.

Part of the process for school-based programming involves:

- Understanding what aspects of mental health and substance use prevention already exist within school programs
- Building on existing programs or
- Identifying where gaps exist and mental health programs could be implemented
- Considering elements for implementation
- Engaging in a ‘whole school’ approach involving students, teachers, parents, counsellors and principals

### Signs of Success

- Reduced suicide ideation and behaviour
- Increased openness and inclusiveness at school
- Increased feelings of school connectedness, engagement and attendance
- Increased feelings of emotional wellbeing among students
- Increased dialogue about mental health, mental illness and substance use
- Decreased conflict in the school

### Examples of Programs

- FRIENDS for LIFE program has been implemented with support by Child and Youth Mental Health, through the BC Ministry for Children and Family Development and the BC Ministry of Education
- Signs of Suicide Program (SOS)
- Zuni Life Skills Development Program
- Crisis centres throughout the province provide school-based education on mental health within communities
- Kids Matter, a mental health initiative in Australia
- Ministry for Children and Family Development work with school boards on implementing proven programs to improve cognitive behavioural and social outcomes, and social/emotional learning for middle to late childhood
- Ministry for Children and Family Development work on disseminating information about child and youth mental health to teachers and staff in schools and communities
- The Kelty Resource Centre provides information and resources regarding child and youth mental health and substance use to teachers and staff in schools and communities across the province
### Target Audiences

Children & youth, parents, teachers, counsellors, principals, school nurses, school district personnel, superintendents, community organizations, alcohol and drug counsellors, recreation workers, school youth workers

### Purpose of this template

To determine the stage of the current or potential program and which considerations might be required for developing, implementing, improving or evaluating a school-based program on mental health promotion and substance use prevention. These questions are key considerations for the program to help plan and move to the next stage of the planning cycle.

### Developing

<table>
<thead>
<tr>
<th>Currently providing programs:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• What kinds of programs are currently being provided?</td>
</tr>
<tr>
<td>• Who are the recipients of current programs (e.g. students, peers, counsellors, teachers, administrators, parents)?</td>
</tr>
<tr>
<td>• What are the important issues in this school (e.g. violence, abuse, sexual health, physical activity) addressed by this program or other programs?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Considering potential programs:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• How have programming efforts been received by principals, teachers, counsellors, parents and students at these schools?</td>
</tr>
<tr>
<td>• Is the program under consideration known to lead to any positive changes at an individual, classroom, grade or school level?</td>
</tr>
<tr>
<td>• What are the important issues in this school (violence, abuse, sexual health, physical activity) addressed by this program or other programs?</td>
</tr>
<tr>
<td>• What is the current dialogue about mental health and suicide among students, teachers, counsellors and principals at the school and district level?</td>
</tr>
<tr>
<td>• How will it be determined that the program has been successful?</td>
</tr>
<tr>
<td>• Are there any baseline measurements that could be used and monitored?</td>
</tr>
<tr>
<td>• What changes are desired at the individual, classroom, grade or school level?</td>
</tr>
<tr>
<td>• What kind of resources would be required for training, delivery (staffing, materials, space, equipment, etc)?</td>
</tr>
</tbody>
</table>

### Implementing

| • What partnerships are required for implementation? |
| • Who will be responsible for implementation and delivery of the program (e.g. a program provider, counsellor, teacher, community member, peer/student led models)? |
| • Will the program be mandatory or optional? |
| • How will the program fit within the school curriculum? |
| • Is there a particular time of day, week and/or school year where students, teachers, counsellors and administrators would want to have a dialogue about mental health? |
| • What learnings do the students and school staff have about other programs that could be applied to this program? |
| • How many workshops or classes will be required? |
### Improving
- What elements of a mental health program could be incorporated into existing programs?
- Have existing programs led to any positive changes in the school?
- Have existing programs led to any negative changes in the school?
- What are strengths of the existing program?
- What are areas of opportunity for the existing program?
- Who would make changes to an existing program?
- What do those changes look like?

### Evaluating

**Process considerations are:**
- Can all the details about the program be documented?; who delivered it, who received it, when they received it, how it was administered
- What changes were made to the program in other stages (developing, implementing and improving)?
- Are there opportunities to use research methods in the evaluation process?

**Outcomes considerations are:**
- What are the changes at school that could be attributed to this program?
- Where did the changes occur (e.g. individual, classroom, grade, school level)?
- Did any of the following changes occur at the school?
  - Reduced suicide ideation and behaviour
  - Increased openness and inclusiveness at school
  - Increased feelings of school connectedness, engagement and attendance
  - Increased feelings of emotional wellbeing among students
  - Increased dialogue about mental health, mental illness and substance use
  - Decreased conflict in the school
PRIORITY AREA 2:

Gatekeeper training for all populations including:

a) Peers, health professionals, community leaders, spiritual advisors, within school and post-secondary settings, the workplace, acute care settings, long term care facilities and justice system

b) How to identify at-risk individuals and improve access to suicide intervention and mental health and substance use resources
Understanding this Statement
Gatekeeper training refers to providing knowledge, skills and developing attitudes necessary to individuals in a community who have face-to-face contact with large numbers of community members as part of their usual routine so that they may be trained to identify persons at risk of suicide and refer them as appropriate. The gatekeeper role highlighted in the Framework underscores the notion of universal training to help intervene with persons at risk of suicide in any environment or situation. The role of the gatekeeper is to effectively identify individuals at risk and promote timely access to available resources for suicide intervention.

Research Evidence:
- A study of gatekeeper training in Australia found that the training was associated with increased knowledge, increased confidence in identifying those at risk, and increased intentions to help a suicidal person (White, 2005; White & Jodoin, 2003).
- A very recent systematic review of gatekeeper training in the suicide research literature found that gatekeeper training had a positive impact on increasing knowledge, building skills and changing attitudes about suicide and suicidal behaviour (Isaac et al., 2009).
- Gatekeeper training was suggested to have an impact across multiple populations, including military personnel, school staff, peer helpers, Aboriginal populations, clinicians (Isaac et al., 2009), different cultural populations (Proctor, 2005), the elderly (Heisel et al., 2006) and clergy (Goldston et al., 2008).
- Other reviews of research have cited gatekeeper training with a focus on providing education as a highly promising practice (Headley et al., 2006; Katz et al., 2006; Beautrais et al., 2007; Advisory Council on Youth Suicide, 2003).
- Elements of gatekeeper training programs include preparing for the learning experience, connecting with personal attitudes about suicide, understanding the intervention needs for someone at risk and developing a safety plan, assisting with suicide prevention and networking to identify local community resources (Isaac et al., 2009).

Practice Evidence:
- Eleven respondents of the snapshot survey indicated that they were providing gatekeeper training services within their programs, services and supports.
- Respondents providing gatekeeper services within their programs included Aboriginal health service providers, community service providers, crisis lines, government, schools and post-secondary institutions.
- When asked about what works about programs, respondents cited accessibility of the training, community connections, resources to meet with people and capacity building as key strengths of their work.
- When asked about barriers to providing programs respondents cited: lack of communication between facilities, lack of available funding, lack of mental health services, geographic isolation, and lack of holistic approaches as significant issues.
# FRAMEWORK: Gatekeeper Training

<table>
<thead>
<tr>
<th>Goal</th>
<th>To implement comprehensive gatekeeper training on identifying at-risk individuals for a range of populations and settings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target Audiences</td>
<td>Peers, students, health professionals, community service providers, community mental health organizations, community leaders, spiritual advisors, clergy, correctional facilities, school and district personnel, post-secondary staff and administrators, workplace staff and administrators, acute care staff and administrators, long term care staff and administrators, and youth workers</td>
</tr>
</tbody>
</table>
| Key Partnerships | - School personnel  
- School District Superintendent  
- Local and regional crisis centres  
- Local/community organizations providing mental health services and supports  
- Religious organizations  
- Community health organizations  
- Correctional facility staff and management  
- Workplace staff and management  
- Long-term care facility staff and management  
- Acute care facilities staff and management  
- Post-secondary institutions  
- Faith-based organizations  
- Researchers  
- Advocates  
- Child and Youth Mental Health  
- Regional Health Authorities  
- Crisis Line Association of BC  
- Local governments  
- BC Ministry of Education  
- BC Ministry of Advanced Education  
- BC Ministry for Children and Family Development  
- BC Ministry of Health Services  
- BC Ministry of Healthy Living and Sport  
- BC Ministry of Public Safety and Solicitor General  
- BC Mental Health and Addiction Services |
| Suggested Activities at the Systems- Level | - In organizational structures (e.g. workplaces, acute care facilities, post-secondary institutions, organizations of faith-based groups and long-term care facilities), identify potential gatekeepers or champions for suicide prevention and intervention (and more broadly, mental health and substance use prevention) (L, R, P)  
- Promote the use of gatekeeper training as a core component of mental health and substance use prevention programming efforts in the province (L, R, P)  
- Continue work to develop gatekeeper training programs as suggested by the BC Child Death Review Unit Report, *Looking for something to look forward to...* (2008) (L, R, P)  
- Establish methods to support and keep gatekeepers connected with communities (L, R, P) |

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*STRENGTHENING THE SAFETY NET A REPORT ON THE SUICIDE PREVENTION, INTERVENTION AND POSTVENTION INITIATIVE FOR BC (2009)*
<table>
<thead>
<tr>
<th>Suggested Activities at the Program-Level</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Local – L</strong></td>
</tr>
<tr>
<td><strong>Regional – R</strong></td>
</tr>
<tr>
<td><strong>Provincial – P</strong></td>
</tr>
<tr>
<td>- Determine the availability and accessibility of local community resources for mental health (L)</td>
</tr>
<tr>
<td>- Identify key individuals and organizations interested in providing gatekeeper training at local, regional and/or provincial levels (L, R, P)</td>
</tr>
<tr>
<td>- Identify specific potential gatekeepers in specific community settings (L, R)</td>
</tr>
<tr>
<td>- Consider community groups outside of the health care sectors that have broad membership and organizational structure to support program delivery (L)</td>
</tr>
<tr>
<td>- Support gatekeepers and keeping them connected with their community resources (L, R, P)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Development Opportunities</th>
</tr>
</thead>
<tbody>
<tr>
<td>A critical component of gatekeeper training is ensuring linkage to appropriate, evidence-informed training. It is imperative that the gatekeeper is provided training to promote their awareness of suicide risk and how to access community resources for an at risk person. Gatekeeper training can be implemented across a broad range of settings – virtually any setting in which a group/community structure and the potential exists to encounter a person who may be at risk of suicide.</td>
</tr>
</tbody>
</table>

Part of the process for gatekeeper training involves:  
- Understanding what aspects of mental health care and support exist within a given setting  
- Identifying and recruiting key participants for gatekeeper training  
- Training these key persons on how to identify someone who is suicidal or in distress including what questions to ask, and what resources they can then refer to within their communities  
- Consideration of persons who might access at risk populations but are not involved in the health care sector

<table>
<thead>
<tr>
<th>Signs of Success</th>
</tr>
</thead>
</table>
| - Reduced suicide ideation and behaviour  
- Increased access and connection to existing mental health services  
- Increased identification and referral of at-risk individuals  
- Increased awareness of risk factors and signs of suicidal behaviour  
- Increased feelings of community and connection  
- Increased use of community resources |

<table>
<thead>
<tr>
<th>Examples of Programs</th>
</tr>
</thead>
</table>
| - [http://www.livingworks.net/](http://www.livingworks.net/)  
- [http://www.qprinstitute.com/](http://www.qprinstitute.com/)  
- QPR UBC Program and SFU Counselling Programs  
- Many crisis centres throughout the province provide suicide gatekeeper training within communities  
- BC Ministry for Children and Family Development work to identify gatekeepers within school districts |
| Target Audiences | Peers, students, health professionals, community service providers, community mental health organizations, community leaders, spiritual advisors, clergy, correctional facilities, school and district personnel, college/university staff and administrators, workplace staff and administrators, acute care staff and administrators, long term care staff and administrators, and youth workers |
| Purpose of this template | To determine the stage of the current or potential program and which considerations might be required for developing, implementing, improving or evaluating a gatekeeper program. These questions are key considerations for the program to help plan and move to the next stage of the planning cycle. |
| Developing | **Currently providing programs:**
- What kinds of programs are currently being provided?
- Who are the recipients of current programs (e.g. students, peers, counsellors, teachers, administrators, parents, employees, coaches, management, etc)?
- Who are the target audiences of the programs?
- How are persons at risk of suicide currently being addressed?
- What are the community resources or supports available or currently being used?

**Considering potential programs:**
- What is the current dialogue about mental health and suicide among members of the group / organization / community?
- What other organizations might already provide gatekeeper training within the community?
- Do partnership opportunities exist with other organizations?
- Is the gatekeeper program under consideration known to lead to any positive changes at an individual, organizational, community or regional level?
- How have past programming efforts been received by community / management / administrators or those who would need to approve program implementation?
- How will it be determined that the training has been successful?
- What kind of baseline data could be collected and monitored?
- What changes are desired at the individual, organizational, community or regional level as a result of the gatekeeper training? |
| Implementing | • Who will be responsible for implementing and delivering the program (e.g. a program provider, counsellor, teacher, community member, a coach, a local government, a regional health authority)?
• Who will facilitate the training?
• Who determines the recipients of the gatekeeper training?
• Would training participants be self-selected, or invited to participate?
• Would participation be mandatory or optional; free or fee-based?
• Is there a particular time of day, week, or year for the group where participation is more likely (e.g. pre-existing conference or meeting or training program, school holidays, off/slow season)?
• Will training be offered in conjunction with other training or stand-alone? |
Evaluating

- How many workshops or classes will be required over what period of time?
- How many people can participate at one time?
- Will training be offered once or will it be ongoing to train more individuals?
- Will there be a contact for those that have completed training if they are looking for follow-up or support?
- What kind of resources would be required for training and delivery (e.g. staffing, materials, space, equipment, funding etc)? have a dialogue about mental health?
- What learnings do the students and school staff have about other programs that could be applied to this program?
- How many workshops or classes will be required?

<table>
<thead>
<tr>
<th>Improving</th>
</tr>
</thead>
<tbody>
<tr>
<td>- What positive changes have occurred in the group / organization / community as a result of the program?</td>
</tr>
<tr>
<td>- What negative changes have occurred in the group / organization / community as a result of the program?</td>
</tr>
<tr>
<td>- Where are ongoing opportunities to support gatekeepers?</td>
</tr>
<tr>
<td>- How are gatekeepers accessing community resources?</td>
</tr>
<tr>
<td>- What are strengths of the existing program?</td>
</tr>
<tr>
<td>- What are areas of opportunity for the existing program?</td>
</tr>
<tr>
<td>- Who would make the changes to an existing program?</td>
</tr>
<tr>
<td>- What would those changes look like?</td>
</tr>
<tr>
<td>- How will improvements be evaluated?</td>
</tr>
</tbody>
</table>

**Process considerations are:**

- Can all the details about the program be documented; who delivered it, who received it, when they received it, how it was administered?
- What were changes made to the program in other stages (developing, implementing and improving)?
- Are there any learnings that can be shared about the program?
- Are there opportunities to use research methods in the evaluation process?

**Outcomes considerations are:**

- What changes could be attributed to this program?
- Where did the changes occur (individual, organizational, community or regional level)?
- Did any of the following changes occur?
  - Reduced suicide ideation and behaviour
  - Increased access and connection to existing mental health services
  - Increased identification and referral of at-risk individuals
  - Increased awareness of risk factors and signs of suicidal behaviour
  - Increased feelings of community and connection
  - Increased use of community resources
PRIORITY AREA 3:

Physician and health professional education on early recognition, risk assessment, clinical assessment, mental health conditions and comorbidities and treatment of suicidal behaviour and/or ideation across the lifespan.

a) Education efforts would include addressing depression, other mental health conditions and concurrent disorders as well as the interpretation of policies around treatment provision (BC Mental Health Act, Infants Act, Freedom of Information and Protection of Privacy Act)
Understanding this statement:
This priority area considers how health professionals could proceed when encountering someone who is acutely or chronically suicidal. The purpose of providing physician and health professional education is to increase capacity and promote consistency in risk and clinical assessments during suicide intervention. Risk assessments and clinical assessments are driven by the goals of determining the intent behind suicidal ideation/behaviour and associated co-morbid mental health conditions. The assessment process also considers how to develop a dialogue on factors associated with suicidal behaviour and which factors are amenable to change. Part of the physician and health professional education process involves interpretation of privacy of information policies around treatment provision to be inclusive of families and concerned others during assessment and treatment.

Research Evidence
- According to clinical practice guidelines for self harm in the UK, clinical and non-clinical staff who have contact with people who self-harm in any setting should be provided with appropriate training for understanding and providing care (NICE, 2004).
- Research suggested that a comprehensive risk and clinical assessment should cover the following areas (Boyce et al., 2003; NICE, 2004; Anderson et al., 2006):
  - Risks – ideation and behaviour;
  - Psychosocial – social & motivational, family health, personal history; and
  - Psychiatric – including coping mechanisms, co-morbidities, substance use and social needs.
- Among general populations, Mann (2005) found that as a part of suicide prevention efforts, physician education in recognizing depression and treatment was a promising practice.
- Among children and youth, approaches to suicide risk assessment had included addressing and documenting in detail the following factors (MCFD, 2008):
  - Predisposing vulnerabilities (e.g. depression, substance use, previous history of suicidal behaviour);
  - Precipitating factors (e.g. conflict, break-up of relationship, health crisis);
  - Mental status including affective, cognitive, and behavioural states;
  - Current level of suicidal thinking; and
  - Planning and protective factors (or contraindications), (e.g. coping skills, hopeful attitude towards the future, strong social support).
- An example of professional training for depression was Changeways – evidence-based psychological services products and materials on depression and self care including training for professionals through a primary care manual on self care for depression.
- Among the elderly, it was also suggested that depression screening and seeking collateral sources of information was a promising practice for seniors (Canadian Coalition for Seniors Mental Health – CCSMH, 2006).
- The CCSMH Late Life Suicide Prevention Toolkit included National Guidelines for Seniors Mental Health: Assessment of Suicide Risk and Prevention of Suicide, risk assessment pamphlets, DVDs and facilitator guide (CCSMH, 2006).
A significant resource developed by the Ministry of Health and Centre for Applied Research in Mental Health and Addictions (CARMHA, 2007) was entitled “Working with the Client Who Is Suicidal.”


BC’s Freedom of Information and Protection of Privacy Act (BC FOIPPA) indicated that a clinician should inform the person that they may break confidentiality in the following scenarios:

- If the clinician has concern that the suicidal person, or another party, is at risk of causing harm or danger to self or others (including high/imminent suicide risk, and/or after a suicide attempt);
- If the clinician has concern of a child being at risk of abuse or neglect; or
- If a clinician’s records are subpoenaed by a court of law.

Key suggestions around informed consent, confidentiality and release of information were provided (CARMHA, 2007).

Some suggestions included having a dialogue with the person outlining that you are ethically and legally obligated to release information in situations where you are concerned about the suicidal person's imminent wellbeing, including contacting family members.

It was suggested that the person should be encouraged to engage a family member or a friend for involvement in their treatment process. It is stated that “above all, when a clinician's judgment suggests a suicidal person's safety or well-being is imminently at risk, the concerns about safety (and associated decisions to release information) override considerations about confidentiality” (CARMHA, 2007).

These comments were echoed in a recent document from the Office of the Information and Privacy Commissioner in BC entitled “A practice tool for exercising discretion: Emergency disclosure of personal information by universities, colleges and other educational institutions” which suggested that clear institutional policies and procedures regarding privacy and information was a promising practice (Loukedis & Cavoukian, 2008).

**Practice Evidence**

From the practice evidence, the types of existing training that services and program providers received for working in suicide, mental health and substance use was variable with the majority being at the Master's level of education (outside of and within multidisciplinary teams), followed by no specific training, Bachelor's level of education, followed by life experience.

Five respondents cited their training approach was one of their program's strengths, where communications, quality of training content and coordination within the community were all success factors.

Eight respondents cited lack of training as a barrier, where training of hospital staff, other staff or general practitioners received was not viewed as adequate to address suicide.

Services that were being planned by five respondents were to access more specialists and use more general practitioners or clinical tools for suicide intervention and possibly early screening.
### FRAMEWORK: Physician & Health Professional Education

<table>
<thead>
<tr>
<th>Goal</th>
<th>The purpose of providing physician and health professional education is to increase capacity and promote consistency in conducting risk and clinical assessments during suicide intervention. Risk and clinical assessments would be driven with the goals of determining the intent behind suicidal ideation/behaviour, and understanding associated co-morbid mental health conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target Audiences</td>
<td>Physicians, health professionals, nurses, mental health workers, community organizations, counsellors, alcohol and drug counsellors, community health workers, clinical educators, teachers, facilitators, and administrators</td>
</tr>
</tbody>
</table>
| Key Partnerships | • Local and regional crisis centres  
• Local/community organizations providing mental health services and supports  
• Community organizations  
• Local, regional and provincial organizations providing health professional education  
• Post-secondary institutions  
• Researchers  
• Advocates  
• Regional Health Authorities  
• Crisis Line Association of BC  
• Child and Youth Mental Health  
• BC Partners for Mental Health and Addictions Information  
• BC College of Physicians  
• BC College of Nurses  
• BC Medical Association  
• BC Ministry of Education  
• BC Ministry of Advanced Education  
• BC Ministry for Children and Family Development  
• BC Ministry of Health Services  
• BC Ministry of Healthy Living and Sport  
• BC Mental Health and Addiction Services |
| Suggested Activities at the Systems-level | • Develop or adapt a best or promising practice module for the assessment of depression and suicide risk for physicians and health professionals (L, R, P)  
• Collaborate with continuing medical education programs (possibly the Division of Health Care Communication, UBC; Inter-professional Network of BC, BC Medical Association; BC College of Physicians, BC College of Nurses, Postsecondary Institutions, Regional Health Authorities, BC Ministries to establish opportunities for suicide assessment training for health professionals (L, R, P)  
• Incorporate discussion of freedom of information and privacy policies in existing health professional training programs (L,R,P)  
• Review and modify current risk and clinical assessment tools to ensure consistency and comprehensiveness (L, R)  
• Consult and engage with families of suicidal persons regarding protection of privacy and freedom of information policies (L, R, P) |

**Local – L**

**Regional – R**

**Provincial – P**

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Chapter 6: The Suicide PIP Initiative Framework and Planning Template
### Development Opportunities

Health professionals are often called upon to address a person who is acutely or chronically at risk of suicide. To support their efforts in addressing suicide, education strategies on early recognition, risk assessment and clinical assessment may be beneficial. It has also been indicated that physicians require support and information on the interpretation of freedom of information and protection of privacy policies.

Part of the process would include:

- Understanding the existing risk and clinical assessment practices
- Identifying gaps in existing risk and clinical assessment practices to improve consistency and comprehensiveness
- Assessing comorbidities in mental health and substance use
- Involving the caregiver, family and/or concerned others in risk assessment, and treatment plans

### Signs of Success

- Reduced suicide ideation and behaviour
- Increased awareness among health professions regarding suicide risk factors and co-morbidities
- Increased use of comprehensive risk and clinical assessments
- Increased family engagement and involvement in care
- Increased understanding of protection of privacy and freedom of information policies
- Increased capacity for working with suicidal persons

### Examples of Programs

- CARMHA (2007). Working with the client who is suicidal document
- Registered Nurses in Ontario (2007). Best Practice Guideline for Suicidal Ideation and Behaviour
- BC Ministry for Children and Family Development: Child and Youth Mental Health working closely with schools for depression screening and suicide risk assessment
- Advanced skill development and competency based training provided for Ministry of Children and Family Development, Child and Youth Mental Health staff
- Government ministries enhancing knowledge and capacity of the health authority workforce to integrate mental health promotion and mental disorder prevention into multiple health programs as per the Core Functions
- BC Ministry of Health and BC Ministry of Health Services – Provision of physician education with ongoing booster sessions on mental health promotion and mental health disorders – particularly on recognition and treatment of depression and prevention of suicide
- Government partnership with primary care physicians to integrate the following into practice: mental health promotion, screening for mental health problems, early interventions, and screening to reduce risky alcohol and substance use
- Development of specialized mental health and addictions curriculum, training and education tools to support the dissemination and uptake of best practice information by clinicians and practitioners (BCMHAS; BC Ministry for Children and Family Development)
- A “Preventing Youth Suicide” website available on the Ministry for Children and Family Development that provides a compilation of best practice and research-informed approaches to youth suicide prevention, intervention and postvention with access to resources for practitioners (updated annually) at [http://www.mcf.gov.bc.ca/suicide_prevention/index.htm](http://www.mcf.gov.bc.ca/suicide_prevention/index.htm)
### Target Audiences
Physicians, health professionals, nurses, mental health workers, community organizations, counsellors, alcohol and drug counsellors, community health workers, clinical educators, teachers, facilitators, administrators

### Purpose of this template
To determine the stage of the current or potential program and the considerations that might be required for developing, implementing, improving or evaluating health professional education. These questions are key considerations for the program to help plan and move to the next stage of the planning cycle.

### Developing

**Currently providing programs:**
- What kinds of health professional programs are currently provided?
- Which health professionals currently receive programs?
- How are programs administered (e.g. online, webinar, workshop, conference)?
- How can existing curriculum incorporate discussion around freedom of information and protection of privacy policies?
- What is the content of current programs addressing suicide risk?
- Does the content include depression screening, comprehensive assessments, co-morbidities and substance use?
- How can existing programs incorporate a discussion on soliciting input from the family, and educating and supporting the family (e.g. where consent is not given)?

**Considering potential programs:**
- What partnership opportunities exist for health professional training?
- Which training environment is most suitable to reach a target audience?
- Is the program under consideration known to lead to any positive changes at an individual, clinic, hospital or department level?
- What is the current dialogue about suicide among health care professionals?
- What kind of baseline data should be collected and monitored?
- What is the content of the curriculum?
- What changes are desired at the individual, clinic, hospital, department or community level?
- What kind of resources would be required for training and delivery (e.g. staffing, materials, space, equipment, etc)?
- What is the knowledge base regarding depression, suicide, co-morbidities and privacy of information policies?

### Implementing
- Who will be responsible for implementing and delivering the program (e.g. administrators, clinical educator, physician, professional associations, post-secondary institutions)?
- Will the program be mandatory or optional?
- How will the program fit within other health professional curriculum?
- Is there a particular time of day, week, year where it would be most desirable to have a training about suicide (e.g. off season etc)?
- How many workshops or classes will be required?
- Where will the workshops be held?
- Who will be required to support or approve the implementation of a health professional education program?
- What kinds of dissemination opportunities exist on health professional education (e.g. clinic rounds, academic rounds, telehealth)?
- What kinds of incentives might be used to promote participation by health professionals?
- How could information about treatment outcomes or treatment satisfaction be obtained?
### Improving

- What kinds of risk or clinical assessments currently exist?
- Have the existing programs led to any positive changes in suicide?
- Are there gaps in clinical or risk assessments, early recognition education, co-morbidities and structures to address substance use or concurrent disorders?
- Have the existing programs led to any negative changes in suicide?
- What are the strengths of the existing program?
- What are the areas of opportunity for the existing program?
- Who would make the changes to an existing program?
- Are there clear processes regarding confidentiality/privacy and involving/supporting families?

### Evaluating

**Process considerations are:**

- Can all the details about the program be documented?; who delivered it, who received it, when they received it, how it was administered?
- What changes were made to the program in other stages (developing, implementing and improving)?
- Do opportunities exist for using research methods in the evaluation process?

**Outcomes considerations are:**

- What opportunities exist to measure outcomes among persons who have received services?
- What changes could be attributed to this program?
- Where did changes occur (e.g. individual, family, health professional, community)?
- Did any of the following changes occur among health professionals?
  - Increased awareness by health professions regarding suicide risk factors and co-morbidities
  - Increased use of comprehensive risk and clinical assessments
  - Increased family engagement and involvement in care
  - Increased understanding of protection of privacy and freedom of information policies
  - Increased capacity in working with suicidal persons
PRIORITY AREA 4:

Culturally appropriate services, cultural safety and diversity training for service providers regarding suicide prevention, intervention and postvention including:

a) Improved translation services, expanded language capacity, or improved awareness of existing services

b) Coping skills training and workshops for emotion regulation and coping

c) Providing stigma reduction, mental health education and awareness messages through TV, newspapers and radio

d) Gay, lesbian, bisexual and transgendered (GLBT) resiliency training administered by GLBT agencies and/or service providers
Understanding this Statement

It is known that suicide occurs across the lifespan and affects all cultures in some way. Not all persons and cultures respond to suicide risk and behaviour in the same way. Factors influencing responses to suicide risk can include culture, ethnicity, religion, language and sexual orientation. In addition, being of a non-dominant culture can make someone vulnerable through lack of accessibility of important services and resources. Providing culturally appropriate services involves consideration of who would potentially be accessing information/services regarding suicide risk and how information/services would be accessed. Culturally appropriate services can promote and enhance cultural safety. “Cultural safety aims to counter tendencies in health care that create cultural risk or those situations when people from one ethnocultural group believe that they are demeaned, diminished or disempowered by the actions or delivery systems of people from another culture” (Browne et al., 2009). In providing community or regional services within and outside of the realm of health care services, cultural safety is important to ensuring that diverse populations are respected and provided appropriate services to their needs.

Research Evidence

- Henere & Erhdhart (2004) examined the needs of Asian populations in Australia and suggested that culturally appropriate services would involve the following: culturally sensitive service provision in areas known to have culturally diverse populations, services that are linguistically appropriate (including pamphlets and help lines) and include family involvement where appropriate.

- Studies focusing on the health of refugees and asylum seekers in emergency mental health suggested that training of immigration and emergency department personnel was required (Proctor, 2005).

- In situations requiring intervention, features included the establishment and maintenance of contact, provision of information regarding immigration, visa and settlement processes (Proctor, 2005).

- In fact, one primary study, a cluster randomized control trial in low and middle income countries found that brief intervention and contact – similar to providing psychosocial counselling among suicide attempters, led to increased feelings of support, awareness of problem solving, and feelings of connectedness (Fleischmann et al., 2007).

- Stewart (2005) suggested that when working with different cultures, training targeting general practitioners and other health professionals for cultural competence including assessment for a history of interpersonal trauma or abuse; interdisciplinary collaborations, stigma reduction of regarding mental health and interpersonal trauma among families and friends are important considerations.

- Goldston et al. (2008) indicated that training for health professionals should involve discussion regarding collectivist cultures and acculturation challenges.

- Leitner et al. (2008) found promising evidence for suicide prevention and intervention regarding culturally tailored programs, video-based education and training interventions.
In postvention research, McDaid (2008) indicated that culturally specific bereavement practices need to be considered.

With the knowledge that different cultural populations may have different approaches to suicide, Goldston (2008) had specific recommendations for each ethnic population:

- Among African American populations – Teaching problem solving and gatekeeper training
- Asian American and Pacific Islander groups – Addressing ‘loss of face’ and stigma, including that of family members
- Latin American populations – Providing cognitive behavioural therapy, interpersonal therapy and stressing values of families

At the time of publication, an assessment tool known as the Cultural Assessment of Risk of Suicide Instrument (CARS) was under development by Drs. Joyce Chu, Bruce Bongar, and Peter Goldblum of the Pacific Graduate School of Psychology at Palo Alto University.

The Cultural Assessment of Risk for Suicide (CARS) instrument was an evidence-based tool for cross-cultural assessment of suicide risk detection of cross-cultural variations in idioms of suicide-related distress, meaning, risk and protective factors, intention and plan.

To date, CARS provided clinicians with a cultural assessment method that aimed to decrease misdetection of suicide risk in the context of a standard clinical interview.

CARS consisted of two parts: a) the CARS-Chart which outlines cross-cultural differences in suicide expression, meaning, risk and protective factors, intention, and plan among African American, Asian American, Latino, LGBTQ, and Caucasian individuals; and 2) the CARS-Questionnaire, a self-report questionnaire which included a set of universal and culturally-specific clinical questions that guide the clinician in the task of incorporating cultural differences in their risk assessment efforts.

At the time of publication, CARS was being validated in clinical and community samples.

**Practice Evidence**

- Approximately a third of the respondents \( n = 26 \) indicated that their organizations have access to translation services.
- Sixteen respondents also cited that their organization had staff speaking other languages or multiple language capacities.
- When asked about barriers to providing programs, five respondents cited lack of culturally appropriate services and eight respondents indicated their organizations wanted to improve their culturally appropriate services.
- For gay, lesbian, bisexual and transgendered populations, there were limited participants however, responses suggested that resiliency and protective factor training and youth social support (e.g. coming out groups) could be beneficial.
### FRAMEWORK: Culturally Appropriate Services

<table>
<thead>
<tr>
<th>Goal</th>
<th>To incorporate culturally appropriate services, promote cultural safety and encourage diversity training in the provision of mental health and substance use services across BC</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Target Audiences</strong></td>
<td>Culturally diverse groups, counsellors, health professionals, teachers, administrators, parents, employees, community service providers, clergy and religious leaders, community organizations, and other professional service providers (police, fire safety, corrections staff)</td>
</tr>
</tbody>
</table>
| **Key Partnerships** | **Local/community organizations providing mental health services and supports**
- Local/community organizations serving diverse populations within their mandate
- Culturally diverse groups
- Researchers
- Advocates
- Regional Health Authorities
- Child and Youth Mental Health
- Affiliation of Multicultural Societies and Service Agencies in BC
- Immigrant Services Society
- Crisis Line Association of BC
- BC Ministry of Education
- BC Ministry of Advanced Education
- BC Ministry for Children and Family Development
- BC Ministry of Health Services
- BC Ministry of Healthy Living and Sport
- BC Mental Health and Addiction Services
- BC Multicultural Advisory Council
- BC Ministry of the Attorney General (Settlement and Multiculturalism Division)
- Provincial Language Services (PHSA)
- BC Partners for Mental Health and Addictions Information
- Kelty Resource Centre |
| **Suggested Activities at the Systems-level** | **Local – L**
- Work with Affiliation of Multicultural Societies and Service Agencies BC, Immigrant Services Society, BCMHAS to promote cultural competency training and disseminate culturally informed tools more broadly (L, R, P)
- Explore opportunities to engage in a dialogue about mental health and substance use prevention through events such as the Cross Cultural Mental Health Symposium and Diversity Health Fairs (L, R, P)
- Explore opportunities to collaborate with community organizations and regional health authority diversity and/or cultural issues groups, including stigma reduction and anti-discrimination groups (L, R)
- Continue work by government and nongovernment organizations to produce mental health promotion, substance use prevention and suicide awareness materials in different languages (L, R, P) |
| **Regional – R** |  |
| **Provincial – P** |  |
| **Suggested Activities at the Program-level** | **Local – L**
- Provide opportunities for multiethnic/multilingual to be involved in programming efforts (L, R, P)
- Identify opportunities to engage with cultural media to provide messaging regarding mental health and suicide awareness (L, R, P)
- Develop or improve emotional health components of programs for multiethnic/multilingual populations (L, R)
- Promote self awareness regarding attitudes and perspectives that challenge cultural safety among service providers (L, R) |
| **Regional – R** |  |
| **Provincial – P** |  |
**Development Opportunities**

A number of strategies have been suggested to improve accessibility and the quality of services for local and regional service providers for ensuring culturally appropriate services and cultural safety.

Part of the process for providing culturally appropriate services and promoting cultural safety includes:

- Understanding what aspects of culturally appropriate mental health services and substance use prevention services and/or health services already exist within the organization and community
- Understanding the unique concerns of the culturally diverse population the program intends to serve or access
- Exploring the extent to which current services meet the needs of a culturally diverse population
- Identifying where gaps exist and what culturally appropriate programs or training could be implemented at the organizational and/or community level
- Identifying partnership opportunities locally, regionally and provincially with the goal of ensuring cultural safety
- Engaging with media to determine how to provide stigma reduction and mental health awareness messages

**Signs of Success**

- Reductions in suicide ideation and behaviour
- Reduction of stigma among culturally diverse groups with regard to mental health and substance use and suicide
- Increased access to services for culturally diverse groups
- Increased attention to the specific issues and risk factors among culturally diverse groups
- Increased language capacity for service providers and organizations
- Increased diversity training opportunities for care providers
- Increased experience of cultural safety among culturally diverse groups

**Examples of Programs**

- BC Mood Disorders Support Groups in Punjabi, Cantonese and Mandarin
- The Q’munity PRIDESPEAK Workshops, LGBT Awareness Workshops
- The Cross Cultural Mental Health Clinic, Vancouver Coastal Health
- BC Mental Health and Addiction Services – Provincial Health Literacy Strategy and Network
- Ministry of Health Services and Ministry of Healthy Living and Sport – Work to identify patterns of mental health inequities using gender and diversity lenses
- Provincial Language Service of the Provincial Health Services Authority – Cultural competency training
- Kelty Resource Centre resources and information in multiple languages
- Here to Help website (BC Partners) with resources and information in multiple languages
### Target Audiences
Culturally diverse groups, counsellors, health professionals, teachers, administrators, parents, employees, community service providers, clergy and religious leaders, community organizations, and other professional service providers (police, fire safety, corrections services)

### Purpose of this template
To determine the stage of the current or potential program and which considerations might be required for developing, implementing, improving or evaluating culturally appropriate services. These questions are key considerations for the program to help plan and move to the next stage of the planning cycle.

### Developing

#### Currently providing programs:
- To what extent are the group / organization / community currently practicing cultural diversity?
- What kinds of cultural diversity programs are currently provided?
- What cultural and age groups currently receive services?
- Are there any cultural groups whose needs are not being met by current services?
- Is there access to translation services or partnership opportunities for translation services?
- What are the current forms of communication that the programs use (e.g., radio, print, TV, community events/organizations, religious services)?
- How have past programming efforts been received by cultural groups, service providers and the community?
- What are the key issues within cultural groups (e.g., violence, abuse, sexual health, physical activity, physical safety, emotional well-being) that are being addressed by this or other programs?
- What elements of cultural safety could be incorporated into the program?

#### Currently providing programs:
- How does the organization foster an open environment for all cultures?
- What culturally diverse groups, languages, religions, genders and sexual orientations are represented within the group / organization / community?
- How will representatives from culturally diverse groups be involved in developing services?
- Is the program under consideration known to lead to any positive changes at an individual, family, organizational or community level?
- Do the culturally diverse groups targeted by the program have collectivist, individualistic, person-centred, family-centred or community-centred orientations?
- What is the current dialogue about mental health and suicide among the group / organization / community?
- How will it be determined that the program has been successful?
- What changes are desired at the individual, family, organizational, community level?
- What kind of resources would be required for training, delivery (e.g., staffing, materials, space, equipment, funding etc)?
- What are the cultural practices or cultural beliefs about mental health or suicide that need to be considered?
- What baseline data could be measured and monitored?
### Implementing

- Who will be responsible for implementing and delivering the program (e.g. a program provider, counsellor, teacher, community member, a co-worker, management, peer/student led models)?
- How will representatives from the cultural groups be involved in implementation of the programs?
- Will the program be free or will there be a fee attached?
- How will this program fit within existing training the organization already may be receiving?
- Will training be offered in conjunction with other programs or stand-alone?
- Is there a particular time of day, week, year for the group / organization / community where members would more likely engage in training opportunities (e.g. slow/off season, pre-existing meetings or workshops or holidays)?
- What learnings do the students / employees / members have from other programs that could be applied to this program?
- How many workshops or classes will be required?
- Will training happen once or will there be ongoing opportunities?
- Will there be a contact person for people for those who would like follow-up, support, supervision or consultation after their training?

### Improving

- Have existing programs led to any positive changes in the individual group / family / organization / community?
- Have existing programs led to any negative changes in the individual group / family / organization / community?
- What are strengths of the existing program?
- What are areas of opportunity for the existing program?
- How will representatives from the cultural groups be asked to provide feedback?
- How will feedback be gathered from service users and service providers about their experiences of the program?
- Who would make changes to an existing program?
- What will those changes look like?
- How are current tools (e.g. risk assessments) culturally appropriate to the service population?
- Where do possibilities exist to try non-traditional methods of promoting the program or service?
- How will changes be evaluated?
**Evaluating**

**Process considerations are:**
- Can all the details about the program be documented; who delivered it, who received it, when they received it, how it was administered?
- What were changes made to the program in other stages (developing, implementing and improving)?
- Are there opportunities to use research methods in the evaluation process?
- How will services user and service provider feedback be gathered?

**Outcomes considerations are:**
- What changes could be attributed to this program?
- Where did changes occur (e.g. individual, family, group, organization, community level)?
- Did any of the following changes occur?
  - Reduced suicide ideation and behaviour
  - Reduced stigma among culturally diverse groups around mental health concerns and suicide
  - Increased access to services for culturally diverse groups
  - Increased attention to specific issues and risk factors for culturally diverse groups
  - Increased language capacity for service providers and organizations
  - Increased access to resources and information in language of choice
  - Increased diversity training opportunities for care professionals and service providers
  - Increased experience of cultural safety among culturally diverse groups
PRIORITY AREA 5:

Coordination of services for suicide prevention, intervention and postvention in the mental health system, the health care system, school/post-secondary systems and the community including:

a) Interdisciplinary teams and case approaches such as active case management, integrated case management and assertive community treatment teams

b) Development of day programs to address suicidality and/or concurrent disorders and crisis stabilization teams/units to address people in acute suicidal states and provide ongoing support

c) Improved access to psychiatrists and psychiatric services

d) Promotion of a trauma informed response to suicidal people and their families
Understanding this statement:
Through research and practice evidence, it has become apparent that coordination of services is critically important for providing suicide prevention, intervention and postvention in a timely manner. For this project, coordination of services is defined as care coordinated among practitioners within and between organizations to provide the timely delivery of services. Some of the issues are centred on continuity of care for individuals receiving mental health services. The focus of this recommendation is largely on suicide intervention at the level of the mental health care system but has impacts on other systems (school, post-secondary, community and health care).

Based on the complexity of coordination of services issues, suggestions on how to address suicide intervention included the use of multidisciplinary teams and active case management (ACM), assertive community team (ACT) or integrated case management (ICM) approaches. These approaches would ensure that service could be tailored to individual needs. ACM, ACTs and ICM would ensure that individuals are consistently connected with their care providers. To address issues around acute care and waitlists, day programs and crisis stabilization teams and units could be developed for acute crisis situations. In addition, improving access to psychiatrists and psychiatric services (including mental health professionals providing psychological care, therapy and assistance) could make significant contributions to addressing gaps in the care of a suicidal person.

Lastly, to determine the right team and the right fit for an individual, any suicide response system needs to be trauma informed. A trauma informed system ensures that care providers are aware of the multifaceted and complex risk factors that can impact resiliency or propensity towards suicidal behaviour. Trauma informed practice also promotes collaborative relationships with other systems serving these persons and local networks of private practitioners with particular clinical expertise (Harris & Fallot, 2001).
Research Evidence

- Mann and colleagues (2005) suggested that collaboration between hospitals and follow-up teams may be a promising practice to promote comprehensive continuity of care (or chain of care).

- A clinical practice guideline from the UK (NICE, 2004) stated that Emergency Departments, Primary Care and local Mental Health Services should plan integrated mental health care services for people who self harm.

- White and Jodoin (2003) indicated that interagency coordination was a promising practice when providing treatment for Aboriginal youth.


- CARMHA (2007) suggested that collaborative and proactive relationships between service providers, organizations and families and linkages between emergency departments and mental health centres could lead to improvements in care.

- Other service providers such as hospital and community mental health providers, substance use services, physicians, police, child protection services can also be involved in the integration of services (CARMHA, 2007).

- Leitner and colleagues (2008) suggested that service delivery by specialist centres may be a promising practice.

Practice Evidence

- Some of the services cited by respondents included: Crisis stabilization \( (n = 9) \) and specific professional expertise and/or access to clinicians and specialists \( (n = 16) \).

- Some of the strengths cited by respondents were collaborations among organizations serving children and youth, adults and all populations \( (n = 37) \).

- Collaborative links in service coordination included mental health service providers, general practitioners, school personnel and workplace personnel.

- Some of the barriers cited by respondents included: inaccessibility \( (n = 26) \), lack of coordinated services \( (n = 30) \) and long wait times \( (n = 11) \).

- Some of the areas of planned expansion cited by respondents included providing assertive community teams \( (n = 8) \) and active case management \( (n = 4) \).
**FRAMEWORK: Coordination of Services**

<table>
<thead>
<tr>
<th>Goal</th>
<th>To increase coordination and collaboration among multiple sectors for the timely delivery of suicide prevention, intervention and postvention services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Target Audiences</strong></td>
<td>Families, physicians, health professionals, nurses, mental health workers, community organizations, counsellors, alcohol and drug counsellors, community health workers, clinical educators, teachers, facilitators, administrators, and policy makers</td>
</tr>
</tbody>
</table>
| **Key Partnerships** | - Local and regional crisis centres  
- Local/community organizations providing mental health services and supports  
- Community organizations  
- Post-secondary institutions  
- Researchers  
- Advocates  
- Regional Health Authorities  
- Crisis Line Association of BC  
- Child and Youth Mental Health  
- BC Partners for Mental Health and Addictions Information  
- BC Mental Health Information Line  
- BC Psychological Association  
- BC Association of Clinical Counsellors  
- BC Canadian Mental Health Association  
- BC College of Physicians  
- BC College of Nurses  
- BC Medical Association  
- BC Ministry for Children and Family Development  
- BC Ministry of Health Services  
- BC Ministry of Healthy Living and Sport  
- BC Mental Health and Addiction Services |
| **Suggested Activities at the Systems-level** | - Engage community and regional mental health services (including mental health organizations, health organizations and crisis centres) in a dialogue about opportunities for collaboration and partnership to support suicidal persons in acute crisis (L, R, P)  
- Map out available services through local and regional organizations and dissemination of information broadly (L, R)  
- In conjunction with risk and clinical assessments, identify other specialists and service providers, community supports and caregivers who could be involved in a multidisciplinary team (L, R)  
- Discuss service provision with existing assertive community treatment teams, crisis stabilization clinics/units to determine which lessons learned can be used to inform the coordination of services (L, R, P)  
- Develop suicide response plans for BC Hospital Emergency Rooms as suggested by the BC Child Death Review Unit Report, *Looking for something to look forward to...* (2008) (L, R, P) |
| **Suggested Activities at the Program-level** | - Work with communities and regional health authorities to determine the feasibility of expanded services (L, R, P)  
- Exploration of existing continuity of care opportunities among programs (L, R, P)  
- Consider incorporating or pilot testing of interdisciplinary teams or other service improvement through coordination initiatives (L, R)  
- Consider follow-up mechanisms and outreach that may or may not include ACT (L, R) |
Partnerships and collaborations are imperative among policy makers on the coordination of services to promote systems-level changes that would have local, regional and provincial impacts. As they exist currently, systems of care are fragmented and inconsistent, which ultimately impacts the person at risk of suicide seeking care. Case approaches that may improve support of a suicidal person include active case management, integrated case management and assertive community teams.

Part of the process involves ensuring that the suicidal person has seen the appropriate team of professionals and/or specialists to address suicidal behaviour and underlying health concerns in a holistic, trauma informed manner. Efforts also need to be made to ensure the person at risk of suicide is proactively provided with opportunities to access the needed care.

### Development Opportunities

- Reduced suicide ideation and behaviour
- Improved navigation of the mental health system among persons at risk of suicide and their supports
- Increased satisfaction with care
- Increased continuity of care
- Improved accessibility of services
- Decreased waitlists
- Increased mental health literacy

### Signs of Success

- Gateway Crisis Stabilization Program (Williams Lake)
- Regional Health Authorities, Assertive Community Teams
- Concurrent Disorders Clinic, UBC
- Youth Concurrent Disorders Teams, North Shore, Vancouver Coastal Health and BC Children's Hospital
- Assertive Community Team Bridging Program, Vancouver Coastal Health
- BC Ministry of Healthy Living and Sport and BC Ministry of Health Services - Consulting and collaborating with health authorities on the development of plans, policies, strategies and best practices for the prevention of mental health disorders and mental health promotion
- BC Mental Health and Addiction Services for system wide improvements – Linking providers across the province to improve quality, safety, consistency and accessibility of mental health and substance use services
- BC Mental Health and Addiction Services – Improving service coordination by reducing wait times through collaborative model of care
- BC Mental Health and Addiction Services for leadership in improving mental health literacy
- Some BC communities have developed inter-program, inter-ministerial protocols and agreements that ensure timely, effective and coordinated responses for children and youth at risk of suicide

### Examples of Programs
<table>
<thead>
<tr>
<th><strong>Target Audiences</strong></th>
<th>Families, physicians, health professionals, nurses, mental health workers, community organizations, counsellors, alcohol and drug counsellors, community health workers, clinical educators, teachers, facilitators, administrators, policy makers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Purpose of this template</strong></td>
<td>To determine the stage of the current or potential program and which considerations might be required to develop implement, improve or evaluate coordination of services. These questions are key considerations for the program to help plan and move to the next stage of the planning cycle.</td>
</tr>
</tbody>
</table>
| **Developing** | **Currently providing programs:**  
• What kinds of programs or services are currently provided?  
• Who receive current programs or services (e.g. general population, high risk populations, co-morbid mental health issues, substance users)?  
• What important exposures in the suicidal person’s life need to be considered (e.g. violence, abuse, trauma) and addressed in the treatment plan?  
• What are the current service provision issues in the community or region (e.g. waitlists, access to specialists)?  
• Which of the following are being provided (e.g. interdisciplinary teams, assertive community teams, active case management, crisis stabilization, psychiatrist care)?  
• What are the outcomes of current programs or services?  

**Considering potential programs:**  
• Is the program or service under consideration known to lead to any positive changes among suicidal persons?  
• How have programming efforts been received among suicidal persons, families, physicians?  
• Which of the following services are feasible (e.g. interdisciplinary teams, assertive community teams, active case management, crisis stabilization, psychiatrist care) and would make the most difference for among suicidal persons?  
• What kind of resources would be required for training, delivery (e.g. staffing, materials, space, equipment, etc)?  
• What partnerships are required to develop the following: (e.g. interdisciplinary teams, assertive community teams, active case management, crisis stabilization, psychiatrist care, other)?  
• What approvals are required to develop further services?  
• Are any certification or accreditation services required?  
What proportion of the existing caseload are presenting with suicidal ideation or behaviour? |
## Chapter 6: The Suicide PIP Initiative Framework and Planning Template

<table>
<thead>
<tr>
<th>Implementing</th>
<th>Improving</th>
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</thead>
<tbody>
<tr>
<td>• What would the composition of services look like?</td>
<td>• What elements of suicide prevention, intervention and postvention could be incorporated into existing programs?</td>
</tr>
<tr>
<td>• Who will be responsible for implementing and delivering services?</td>
<td>• Have existing programs led to any positive changes in mental health care?</td>
</tr>
<tr>
<td>• How will the services be delivered?</td>
<td>• Have the existing programs led to any negative changes in mental health care?</td>
</tr>
<tr>
<td>• What is a realistic timeline from the development of services to provision of services?</td>
<td>• What are strengths of the existing program?</td>
</tr>
<tr>
<td>• How will services target suicidal persons?</td>
<td>• What are areas of opportunity for the existing program?</td>
</tr>
<tr>
<td>• How do potential services fit within existing services already being provided?</td>
<td>• Who would make the changes to an existing program?</td>
</tr>
<tr>
<td>• Is there a particular time of day, week, year when it would be easier or more difficult to provide services?</td>
<td>• How would changes be evaluated?</td>
</tr>
<tr>
<td>• What learnings do service providers have about other programs that could be applied to this program?</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Evaluating</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process considerations are:</strong></td>
</tr>
<tr>
<td>• Can all the details about the program be documented?; who delivered it, who received it, when they received it, how it was administered</td>
</tr>
<tr>
<td>• What changes were made to the program in other stages (developing, implementing and improving)?</td>
</tr>
<tr>
<td>• Are there opportunities to use research methods in the evaluation process?</td>
</tr>
<tr>
<td><strong>Outcome considerations are:</strong></td>
</tr>
<tr>
<td>• What changes could be attributed to this program?</td>
</tr>
<tr>
<td>• Where did the changes occur (e.g. individual, family, group, organization, community level)?</td>
</tr>
<tr>
<td>• Did any of the following changes occur?</td>
</tr>
<tr>
<td>► Reduced suicide ideation and behaviour</td>
</tr>
<tr>
<td>► Improved navigation of the mental health system among persons at risk of suicide and their supports</td>
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<td>► Increased satisfaction with care</td>
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</tr>
<tr>
<td>► Increased mental health literacy</td>
</tr>
</tbody>
</table>
Development and enhancement of postvention bereavement programs, services and supports for persons touched by a suicide including:

a) Educational workshops, support groups, group therapy and survivor groups for those bereaved by a suicide-related death

b) Postvention response protocols involving referral practices, community response teams, critical incident management and treatment
Understanding this Statement
For the purposes of this report, postvention refers to strategies or approaches that are implemented after a death by suicide and intended to support those bereaved by suicide. Due to the elevated risk among persons bereaved by suicide, it is imperative that supports and services exist to address acute crisis and/or longer term bereavement and grief processes. Educational approaches include workshops, support groups, group therapy and peer- and health-professional-led survivor groups designed to enhance understanding of the grief process and make meaning of the loss. Educational efforts may target child, youth, adult and older adult survivors. Postvention response protocols can be designed to identify how a community, school, workplace or region may be supported by developing protocols and policies or planning and supporting postvention activities. Some of the key aspects of education effort could include understanding grief after suicide as a long term process which may take years and specific populations (e.g. children/youth) may need recurring support.

Postvention response protocols help determine how suicide survivors can return to school, the workplace and/or the community in a supported way. Elements of protocols need to be trauma informed and include information on the unique characteristics of bereavement after a suicide death. Some elements of postvention response protocols include having referral practices in place, community response teams, critical incident management approaches and treatment options.

Research Evidence
- Research literature on postvention and support for suicide survivors is limited at best.
- Among the existing literature, specific practice recommendations were found for specific populations.
- Among Aboriginal populations, routine follow-up for bereaved populations (ACSP, 2003) and developing a community healing plan (NAHO, 2005) were suggested as promising practices.
- Among cultural populations, addressing stigma (a barrier to getting help) to support surviving families and friends was also suggested as a promising practice (Stewart, 2005).
- Among children and youth within schools, it was recommended that a post suicide protocol involving a first talk through and psychoeducation approaches explaining coping, grief reactions and processes, and where to get further help.
- McDaid (2008) conducted a systematic review of bereavement intervention found the following promising practices:
  - Psychologist-led group therapy for children
  - Combined peer- and health-professional-led group therapy for adults
  - Nurse – or counsellor-led brief cognitive behavioural therapy family intervention
- In primary studies, one study found that an active postvention model may be beneficial where active postvention consists of immediate response to suicide survivors as close to the time of death by suicide as possible (Cerel & Campbell, 2008).
- In a cluster randomized controlled trial, De Groot and colleagues (2007) found that CBT for suicide survivors may assist in addressing maladaptive reactions and perceptions of blame.
Practice Evidence

- Some of the postvention services cited were support groups ($n = 8$), counselling services ($n = 8$), and critical incident management ($n = 8$).

- Twenty four respondents were providing referrals to community services ($n = 12$) or hospice ($n = 8$).

- Approximately 41 respondents did not have a formal postvention program in place or provided no program at all.

- Nine respondents indicated that their organizations needed bereavement and postvention services and 13 respondents were planning to offer postvention programs, services and supports.

- Survivor groups may help address the lack of awareness of other survivors and can provide support through the grief journey.
### FRAMEWORK: Postvention Programs and Resources

<table>
<thead>
<tr>
<th><strong>Goal</strong></th>
<th>To help implement or strengthen postvention efforts along a continuum of care for persons at risk of suicide, their families and their communities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Impacted Audiences</strong></td>
<td>Children, youth, parents, families, concerned others, school and district personnel, health professionals, grief counsellors, advocates, community organizations, survivors, clergy, police, coroners, Victim Services, workplace staff and administrators, community mental health service organizations, and funeral home staff</td>
</tr>
</tbody>
</table>
| **Key Partnerships** | • School and district personnel  
• Local and regional crisis centres  
• Local/community organizations providing mental health services and supports  
• Community organizations  
• Health professionals  
• Hospice  
• Funeral homes  
• Clergy and religious groups  
• Survivor groups  
• Researchers  
• Advocates including Survivors in Action groups  
• Regional Health Authorities  
• Child and Youth Mental Health  
• Crisis Line Association of BC  
• BC Ministry of Education  
• BC Ministry for Children and Family Development  
• BC Ministry of Health Services  
• BC Ministry of Healthy Living and Sport  
• BC Mental Health and Addiction Services  
• BC Ministry of Public Safety and Solicitor General |
| **Suggested Activities at the Systems-level** | • Continue work and collaboration with provincially focused organizations providing postvention or bereavement services (e.g. BC Council for Families, BC Bereavement Helpline and Living Through Loss, Griefworks BC) (L, R, P)  
• Dissemination of suicide survivor support group information such as Hope and Healing, A practical guide for survivors of suicide to widespread audiences as well as other local pamphlets and resources (L, R, P)  
• Continue work by ministries and provincial partners to establish a provincial task force on postvention efforts as suggested by the BC Child Death Review Unit Report, *Looking for something to look forward to…* (2008) (L, R, P)  
• Continue work by ministries to provide suicide survivors with existing postvention resources as suggested by the BC Child Death Review Unit Report, *Looking for something to look forward to…* (2008) |
| Suggested Activities at the Program-Level | • Disseminate suicide survivor support group information such as Hope and Healing, A practical guide for survivors of suicide to widespread audiences as well as other local pamphlets and resources (L, R, P)  
• Develop linkages with hospices and hospital based clergy & social workers throughout the province to provide them with information and referrals supports (L, R, P)  
• Support and educate Survivors in Action (or survivors who have become suicide awareness advocates) to help new survivors gain improved access to formal and community supports and educating both the helping agencies and the general public (L, R)  
• Develop return to school and work supports after a suicide has occurred (L, R) |
| Local – L | Postvention efforts are a necessary step in the continuum of care for suicidal individuals, their families and their communities. These efforts ensure that those affected by suicide are provided with appropriate support and care during the bereavement and grieving process. Implementing and strengthening postvention services can contribute to a reduction of future suicidal behaviours. Postvention efforts provide opportunities for engaging various agencies and organizations both locally and regionally, to work collaboratively to accommodate the needs of the individual, their family and their communities. Education efforts on grief and bereavement that integrate the opportunity for survivors to share their experiences can play a role in supporting survivors. Proactively developing protocols for postvention with community supports and resources is also an important component for supporting survivors. |
| Regional – R | |
| Provincial – P | |
| Development Opportunities | |
| Signs of Success | • Reduced suicide ideation and behaviour  
• Reduced stigma associated with suicide and mental health issues  
• Reduced suicide contagion  
• Improved help seeking skills and long term treatment of child/youth survivors  
• Increased use of and access to available postvention resources among survivors  
• Increased experience of connectedness, capacity with family, group, organization or community among survivors  
• Increased experience of emotional wellbeing among individuals, group, organization or community among survivors  
• Increased understanding of grief and bereavement  
• Increased collaboration with survivor groups including Survivors in Action |
| Examples of Programs | • BC Council for Families, Prevention is Postvention Workshops  
• Griefworks BC  
• Living Through Loss Society  
• Survivors groups established in collaboration with CMHA, crisis centres or funeral homes  
• Victim Services throughout BC  
• BC Bereavement Helpline |
## Target Audiences

Children, youth, parents, families, concerned others, school and district personnel, health professionals, grief counsellors, advocates, community organizations, clergy, Police, Coroner, Victim Services, Workplace staff and administrators, and community mental health service organizations

## Purpose of this template

To determine the stage of the current or potential program and which considerations might be required to develop implement improve or evaluate postvention services and supports. These questions are key considerations for the program to help plan and move to the next stage of the planning cycle.

## Developing

### Currently providing programs:
- What kinds of postvention programs are currently provided?
- Who receives current programs?
- What kinds of groups are provided by the program or within the community for postvention (e.g. survivor groups, bereavement groups, postvention groups, group therapy)?
- How and when are survivors accessed?
- Does a postvention protocol exist within the setting?

### Considering potential programs:
- Is the program or service under consideration known to lead to any positive changes among suicidal persons?
- How have programming efforts been received among suicidal persons, families, physicians?
- Are there any other individuals or organizations currently providing postvention services? (e.g. survivors groups, survivors in action groups, religious groups, hospice, mental health organizations, community services, etc)
- What are possible partnership opportunities with groups already providing services?
- What organizations or individuals need to be involved in a postvention response?
- Is the program that being considered known to lead to any positive changes at an individual, family, group, organizational or community level?
- How have past programming efforts been received by impacted groups?
- What is the current dialogue about mental health and suicide among the group, organization or community?
- How will it be determined that the program has been successful?
- What kind of resources would be required for training, delivery (e.g staffing, materials, space, equipment, funding, etc)?
- What cultural considerations around death and bereavement might need to be addressed?
- Does a postvention protocol exist within the setting?
- Who would be required to partner for developing a postvention protocol?
<table>
<thead>
<tr>
<th>Implementing</th>
<th>Improving</th>
<th>Evaluating</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Who will be responsible to implement and deliver the program (e.g. a program provider, counsellor, teacher, community member, peer/student led models)?</td>
<td>• What elements of a postvention program could be incorporated into already existing programs?</td>
<td>Process considerations are:</td>
</tr>
<tr>
<td>• Will the program be mandatory or optional?</td>
<td>• Have existing programs led to any positive changes in the group / organization / community?</td>
<td>• Can details about the program be documented?; Who received it, who delivered it, when they received it, how it was administered?</td>
</tr>
<tr>
<td>• Will the service be free of will there be a fee attached?</td>
<td>• Have existing programs led to any negative changes in the group / organization / community?</td>
<td>• What were changes made to the program in other stages (developing, implementing and improving)?</td>
</tr>
<tr>
<td>• Is there a particular time of day, week, year where individuals are more likely to attend or access services?</td>
<td>• What are strengths of the existing program?</td>
<td>• Are there opportunities to use research methods in the evaluation process?</td>
</tr>
<tr>
<td>• Who will be the target audience for services (e.g. age groups, families etc)?</td>
<td>• What are areas of opportunity for the existing program?</td>
<td>Outcomes considerations are:</td>
</tr>
<tr>
<td>• What kind of format will the program use (e.g. psycho-educational, therapeutic)?</td>
<td>• Who would make changes to an existing program?</td>
<td>• What changes could be attributed to this program?</td>
</tr>
<tr>
<td>• Will health professionals be required to provide the program or service?</td>
<td>• Which gaps might currently exist in postvention protocols in terms of referrals, critical incident management and community response?</td>
<td>• Where did the changes occur (e.g. individual, family, group, organization, community level)?</td>
</tr>
<tr>
<td>• What learnings do individuals, the group, organization, or community have about other programs that could be applied to this program?</td>
<td>• How can grief counsellors or bereavement workers be involved in the program?</td>
<td>• Did any of the following changes occur?</td>
</tr>
<tr>
<td>• How many workshops, classes or sessions will be required?</td>
<td>• Have existing programs led to any positive changes in the group / organization / community?</td>
<td>▶ Reductions in suicide ideation and behaviour</td>
</tr>
<tr>
<td>• Will there be a specific person or team involved coordinating services?</td>
<td>• Have existing programs led to any negative changes in the group / organization / community?</td>
<td>▶ Reduction of stigma associated with suicide and mental health issues</td>
</tr>
<tr>
<td>• How was input from survivors solicited for the program?</td>
<td>• What are strengths of the existing program?</td>
<td>▶ Reduction of suicide contagion</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▶ Increased use and access of available postvention resources among survivors</td>
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<tr>
<td></td>
<td></td>
<td>▶ Increased feelings of connectedness, capacity with family, group, organization or community among survivors</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▶ Increased understanding of grief and bereavement</td>
</tr>
</tbody>
</table>
References

Priority 1


Priority 2


**Priority 3**


Priority 4


Priority 5


**Priority 6**


CHAPTER 7:

OTHER RECOMMENDATIONS FOR SUICIDE PREVENTION, INTERVENTION AND POSTVENTION IN BC
Through an examination of the research evidence and practice evidence, 16 recommendations have been reviewed by the Suicide PIP Project stakeholders. Through the implementation of a stakeholder survey, six priority areas have formed the basis of the Suicide PIP Framework and Planning Template. While it is important to engage in strategic work on the priority areas, the remaining 10 recommendations for suicide prevention, intervention and postvention in BC also require further consideration. Due to the scope of the project, not all recommendations have been explored in the context of the Framework and Planning Template. It is acknowledged that individuals and organizations for different programs, services and supports might have an interest in exploring the 10 recommendations outside of the Framework and Planning Template. This section provides a discussion of these recommendations by explaining each statement, providing research evidence, practice evidence and some potential activities.

Mapping Out Each Recommendation

For each recommendation, information has been provided to assist in understanding fit within the Suicide PIP Initiative. An explanation regarding each heading has been provided:

- **Understanding this statement** provides an explanation for the recommendation statement and what is meant by specific concepts and terms

- **Research evidence** refers to findings from the evidence-informed practice review that support a given recommendation

- **Practice evidence** refers to findings from the snapshot survey that support a given recommendation

- **Suggested activities** refers to activities that could be undertaken, locally, regionally or provincially to support progress on a recommendation area
Cultural safety and community renewal approaches should be emphasized when engaging in suicide prevention, intervention and postvention with Aboriginal populations.

Understanding this Statement:
This recommendation recognizes the importance of culture, traditional practices and traditional knowledge as having a role in suicide prevention, intervention and postvention among Aboriginal populations. An understanding of the concept of community renewal requires acknowledgement that Aboriginal populations have experienced cultural stress, defined as a loss of confidence in understanding life and norms, values and beliefs that were taught in Aboriginal culture (Royal Commission of Aboriginal Peoples, 1995). In particular, empowerment, self determination and access to resources have been suggested as helping to revitalize collective and individual perceptions of culture and use of traditional strengths to solve public health issues (Olson & Wåhåb, 2006). Some aspects of cultural safety and community renewal that can be drawn from include traditional knowledge and wisdom from elders, promotion of community pride and control, promotion of self esteem and identity, and transmission of knowledge, languages and traditions (Report on the Advisory Group on Suicide Prevention, 2003).

Research Evidence:
- Nine studies were identified for the evidence-informed practice review and five additional studies were identified by stakeholders.
- Among strategies suggested to be examined for Aboriginal communities were strategies involving education on mental wellness, education on seeking help and community development.
- Among youth, connection to traditional culture was also identified as an important suicide prevention strategy (Elliot-Farrelly, 2004).
- In this document, community renewal strategies including cultural enhancement, traditional healing processes, community development and inter-agency community coordination may be potential areas/strategies that can be embraced.
- Detailed descriptions of the studies included in the evidence-informed practice review can be found in Chapter 8.
Practice Evidence:

- Seven respondents were identified in the snapshot survey that provided programs, services or supports for Aboriginal populations.

- Respondents represented the following geographic areas: Northern Health Authority (n = 2), Vancouver Island (n = 2), Vancouver Coastal (n = 1) and All of BC (n = 2).

- Four of the organizations focused specifically on Aboriginal youth aged 0 to 19 years, however all respondents indicated that the entire community was involved in their program, service or support.

- For suicide prevention and intervention, some of the programs, services and supports included community response teams (n = 2), gatekeeper training (n = 3), cultural camps (n = 2), education for students, peers and parents (n = 3) and providing access to clinicians (n = 2).

- Among postvention services, bereavement support groups (n = 1), community response teams (n = 1) and debrief and follow-up (n = 1) were cited.

- Some of the specific training that respondents received included cognitive behavioural therapy training, ASIST, cultural values training and specific workshops (e.g. Through the Pain, Canoe Journey).

- Strengths of programs, services and supports cited by respondents included approaches involving Aboriginal culture and values and community capacity building.

- Barriers to programs, services and supports cited by respondents included lack of mental health services (n = 3), isolated and remote communities being difficult to reach (n = 3) and lack of funding for further program development (n = 5).

- Some of the plans for expansion of services included offering more prevention resources and prevention targeted to specific populations (n = 4) and providing cultural awareness and values training (n = 2).

Suggested Activities are provided in Chapter 8.
Media education and guidelines for coverage and province-wide reporting on the issue of suicide prevention, intervention and postvention

Understanding this Statement:
This recommendation suggests that media should receive education and guidance on how to safely report on suicide and suicidal behaviour province wide. Education efforts would consist of providing local, regional and provincial newspapers with guidelines on how self harm, attempted suicides and death by suicide should be reported and how suicide prevention, intervention and postvention resources should be highlighted in each media story.

Research Evidence:
- Media guidelines currently exist developed by the World Health Organization (2000), Canadian Association for Suicide Prevention (2004), American Association for Suicidology (AAS, 2009), Canadian Psychiatry Association (Nepon et al., 2007) recommending specific reporting practices and providing information on how to present alternatives to suicide, warning signs and available resources.
- Crowley & Kilroe (2004) and White (2005) identified that a theoretical basis may exist for responsible media reporting playing a role in youth suicide prevention.
- The Living is for Everyone Framework (2007) also cited media guidelines as showing a promising link to decreased suicide rates.
- Neiderkrothaler & Sonneck (2007) found significant decreases in suicides in Vienna, Austria after conducting a nationwide evaluation of the reduction in the use of the words “suicide” and “self murder” in the media.

Practice Evidence:
- Respondents did not indicate a particular interest in media guidelines per se, but 16 respondents reported an interest in public education about suicide and stigma reduction which may involve the use of media to build awareness.
- Two programs cited use of the media to build awareness of World Suicide Prevention Day (September 10 yearly) and other suicide prevention related events.
- Among cultural populations, media was suggested to play an important role in providing messaging around health promotion and stigma reduction.
Suggested Activities (Locally, Regionally, Provincially):

- Engage with media to develop dialogue regarding reporting on suicide to understand the challenges that reporters are facing (L, R, P)
- Determine how existing guidelines can be disseminated and promoted to be utilized province wide (L, R, P)
- Examine newspaper and television reports on suicide in the province and determine common reporting concerns (L, R, P)
- Linkage with professional associations, journalism, broadcasting and related education/training programs and programs involving media to provide education around best practices on the reporting of suicide as recommended by the BC Child Death Review Unit Report, *Looking for something to look forward to...* (2008) (L, R, P)
Development of a clinician working group to assess the relevance of recommendations on therapies for suicide intervention

Therapies include:

a) Interpersonal therapy, cognitive behavioural therapy and problem solving therapy for intervention across the lifespan

b) Dialectical behaviour therapy for youth (and their families); adults; and older adults with borderline personality disorder

c) Selective serotonin reuptake inhibitors (SSRIs), clozapine and lithium for specific clinical populations

Understanding this Statement
The purpose of developing a clinician working group is to coallate expertise regarding clinical interventions and treatment for suicide and/or suicidal behaviour. The literature suggests a number of approaches as both best and promising practice applicable to specific populations that need to be examined for their relevance and applicability. The goal of this work would be to come to a consensus on therapeutic approaches for specific populations and to develop detailed practice guidelines for clinicians and health care providers in BC.

Research Evidence
Much of the evidence surrounding therapeutic intervention for suicide came from the clinical practice guideline literature. A summary is provided below:

- Cognitive Behavioural Therapy – CBT (Boyce et al., 2003; Links, 2005; Mann, 2005; Comtois and Linehan, 2006; Singer, 2006; Weishaar, 2006; Beautrais et al., 2007; Goldston, 2008; McDaid et al., 2008)

- Dialectical Behavioural Therapy – DBT (Boyce et al., 2003; RANZCP, 2004; Goldney, 2005; Links, 2005; Comtois & Linehan, 2006; Headley, 2006; Singer, 2006; Beautrais et al., 2007; Goldston, 2008)

- Interpersonal Therapy – IPT (Mann, 2005; RANZCP, 2004, Comtois & Linehan, 2006; Heisel, 2006; Singer, 2006; Beautrais et al., 2007; Heisel & Duberstein, 2007; Goldston, 2008)

- Problem Solving Therapy – PST (Boyce et al., 2003; Mann, 2005; Comtois and Linehan, 2006; Headley, 2006; Beautrais et al., 2007)

- Antidepressants (APA, 2003; RANZCP, 2004; Goldney, 2005; Heisel, 2006; Cardish, 2007)

- Lithium (APA, 2003; Cipriani, 2005; Goldney, 2005; Cardish, 2007)

- Clozapine (APA, 2003; Cipriani, 2005; Goldney, 2005; Anderson, 2006)
Practice Evidence

- Forty-seven respondents to the snapshot survey indicated that they were providing some form of counselling services.

- Of the populations being provided with counselling services, children and youth accounted for the highest proportion at 88% \((n = 21)\), followed by adults at 62% \((n = 13)\) followed by all age groups at 43% \((n = 13)\).

- Examples of counselling services included one on one counselling, DBT, group therapy, support groups (for parents, persons with depression, for families, ) CBT, IPT, telephone counselling and support.

- Strengths of counselling services included specific therapeutic approaches, responsiveness of services providers, communication and connection with communities.

- Barriers for counselling services included funding, staff retention, lack of safety planning and long waitlists.

- Lack of access to specialists or psychiatrists was also highlighted.

Suggested Activities (Locally, Regionally, Provincially):

- Collaborate with local, regional and provincial service providers to develop a clinician working group to assess research findings (L, R, P)

- Conduct an in-depth environmental scan on suicide related counselling services only, specifically to determine what types of medications and therapies are used when working with suicidal persons (L, R, P)

- Appoint a facilitator to work with clinicians on building consensus around clinical practice guidelines and best practices for suicide intervention (L, R, P)

- Continue leadership of the BC Mental Health and Addiction Services in promoting the dissemination and use of best practices in counselling services to service providers and clinicians (L, R, P)
Understanding this Statement

Family-centred approaches can be characterized by a collaborative approach to care giving and decision-making among the individual, family and health care provider (Institute for Family Centred Care, 2009). In general, families can play a very important role in supporting the treatment of a person at risk of suicide (CARMHA, 2007). To maximize the potential for families and concerned others a multi-layered approach needs to:

- Educate families regarding suicide warning signs and suicide risk
- Provide support groups for families and concerned others that are coping with suicidal persons
- Provide affordable options for family and/or individual counselling, possibly through professionally facilitated workshops to teach communication and coping skills
- Inform family members on how to act and react during an acute crisis and how they can be part of an individual's safety plan
- Provide outreach and follow-up with families to ensure that an individual is safe and stable

Research Evidence

- Much of the literature on family-centredness and involvement in suicide prevention, intervention and postvention was from work in Aboriginal Health and Wellness.
- Family skills education and providing family supports (ACSP, 2003; White & Jodoin, 2003) were both recommended for improving resilience and protective factors among children.
- Cultural research among Pacific, Maori and Asian populations in Australia strongly suggested that family focused services were a promising practice (Henere & Erhdhart, 2004).
- Other studies involving addressing suicide in different cultures suggested that collaboration and supports from the family and community were important aspects when addressing suicidal behaviour (Stewart, 2005; Proctor, 2005).
- White (2005) also found that family support and improvement of parental knowledge, behaviour and response around suicidal behaviour were a promising practice.
- Beautrais and colleagues (2007) highlighted the importance of family support, especially for families under stress.
Anderson and colleagues (2006) suggested that assessment of family health assisted in providing an understanding of suicidal behaviour.

It is suggested that the suicidal person and family should be involved in the development of treatment and safety plans (CARMHA, 2007).

Integrating family members into treatment plans can be supported by educating family members about suicide risk, looking to family members for monitoring and providing collateral information and incorporating family members feedback into treatment (CARMHA, 2007).

**Practice Evidence**

- Support for families and concerned others were cited as services provided by seven respondents working in areas of prevention, intervention and postvention.

- Examples of the work included family education and support groups \((n = 3)\), family outreach \((n = 2)\) family bereavement supports \((n = 2)\).

- Nine organizations planned to add services for family and concerned other supports and counselling to their existing programs and services.

- Three programs cited lack of family support and family therapy as barriers to providing their services.

**Suggested Activities** (Locally, Regionally, Provincially):

- Programs, services and supports should consider wherever possible to integrate and involve the family in service provision (L, R, P)

- Develop and/or implement family support groups and workshops to assist with understanding and coping with a suicidal family member (L, R, P)

- Proactively involve family members by service, program and support providers to support the safety of a suicidal person (L, R, P)

- Continue partnerships and collaborations among parent and family service providing agencies throughout the province with community level organizations (L, R, P)

- Continue work by the BC Ministry for Children and Family Development to support the integration of families and provide parental resources through Child and Youth Mental Health (L, R, P)

- Continue work by BC Mental Health and Addiction Services by providing family and parental support resources through the Kelty Resource Centre. The Kelty Resource Centre is a free, all-inclusive, virtual resource centre for BC children, youth and their families that provides information on mental health and addiction topics and on programs and services (L, R, P)

- Continue work by the BC Ministry for Healthy Living and Sport to develop and promote psychoeducational interventions for and provide outreach to adult family caregivers of chronically ill or older adults

- Continue work by the BC Ministry of Children and Family Development to develop a mental health literacy tool as recommended by the BC Child and Death Review Unit report, *Looking for something to look forward to…* (2008) (L, R, P)
RECOMMENDATION 5 OF 10

Education and awareness on means restriction approaches with needs and feasibility analyses including restrictions on firearms, bridge installations of barriers and/or fences, restrictions on drug package sizes, and restrictions on domestic toxic gases or provision of non-lethal substitutes

Understanding this Statement
Means restriction refers to techniques, policies, and procedures designed to reduce access or availability to means and methods of suicide and/or suicidal behaviours. It is important to think of means restriction as a potential population-level policy to implement however needs and feasibility analyses are necessary component.

Research Evidence
- Means restriction was suggested in the research evidence to be a best and most promising practice.
- Daigle (2005) examined suicide rates at the population level for substitution, that is, the study of whether when a specific means is restricted another means or method is substituted.
- No risks of substitutions were found for the restriction of domestic toxic gases, restriction of drugs and toxic substances and fences on bridges (Diagle, 2005).
- Other research suggested that educating families, especially the parents of adolescents on means restrictions were a promising practice for suicide prevention (Links, 2005; White, 2005, CARMHA, 2007).
- Specific means restriction measures with their research support are the following:
  - Gun control laws (White & Jodoin, 2003; Leenars, 2005; Goldney, 2005; Mann et al., 2005; Beautrais et al., 2007)
  - Reductions to access and toxicity of domestic gases (White & Jodoin, 2003; Goldney, 2005; Mann et al., 2005; Beautrais et al., 2007)
  - Restrictions on barbiturate prescriptions (Goldney, 2005; Mann et al., 2005)
  - Barriers on bridges (Goldney, 2005; Mann et al., 2005; Beautrais et al., 2007)
  - Restrictions to paracetamol (or acetaminophen) analgesic package sizes (Goldney, 2005; Mann et al., 2005; Beautrais et al., 2007)
  - Restrictions to pesticide use (Mann et al., 2005; Beautrais et al., 2007)
  - Reductions to toxicity of antidepressants (Mann et al., 2005)
  - Reducing carbon monoxide emissions (Beautrais et al., 2007)
Practice Evidence

- From the snapshot survey respondents, means restriction was not highlighted as a prevention measure per se.

- These findings were likely due to the fact that means restriction is typically viewed as a prevention effort for the general population that is implemented at a provincial or federal policy level rather than a community or regional level.

Suggested Activities (Locally, Regionally, Provincially):

- Identify needs by assessing data on deaths by suicide and suicidal behaviour by method used (R, P)

- Establish local, regional and provincial trends and patterns to determine which means are implicated in suicide related deaths, hospitalizations and other health services use (R, P)

- Examine suicide and suicidal behaviour data trends across the lifespan to determine which means are most amenable to restriction for policy development (L, R, P)

- Support advocacy efforts by the BC Ministry of Healthy Living and Sport for means restriction as a suicide prevention measure (L, R, P)
Outreach to promote access to suicide prevention, intervention and postvention services and resources with specific approaches targeting children & youth, young adults, adults and older adults including:

a) Building upon telehealth programs
b) Development of other services for rural and geographically isolated populations

Understanding this Statement
Outreach for suicide prevention, intervention and postvention refers to efforts initiated by an individual or organization to identify potential at risk and/or vulnerable populations (or their care givers) and encourage their use of existing services and resources. Outreach is designed to ensure that the people who need services most are aware of when and how to access them. Specific approaches are required to ensure that a targeted population is reached and awareness is built around the existing available supports. A parallel process of building on existing outreach services such as telehealth and developing other rural services (ie. mobile support teams, mobile crisis stabilization units) is also important.

Research Evidence
- Among Aboriginal populations, outreach was suggested for maintaining contact with suicidal people and outreach for high risk and socially, isolated populations (ACSP, 2003; Conwell & Yeates, 2008).
- Interventions designed to increase contact, such as a telephone outreach befriending program (Goldney, 2005) or sending caring letters (Comtois & Linehan, 2006) were promising practices for suicide prevention.
- A telephone outreach program for males in Australia involving calling the suicidal person twice weekly improved the person's sense of community connectedness (LIFE Framework, 2007).
- Community outreach and support that identified elders at-risk were also suggested (CCMSH, 2006).
- Only one literature review was found to address rural suicides (Hirsch, 2006) and suggested that telemental health and computer based communications were promising practices.
Practice Evidence

- From the snapshot survey, 22 organizations provided outreach services.
- Among the strengths of the services, respondents cited capacity building ($n = 7$), collaboration ($n = 14$) and providing culturally appropriate services ($n = 5$).
- Among the barriers to providing services, respondents reported inaccessibility ($n = 9$), lack of funding ($n = 11$), lack of coordination services ($n = 9$) and lack of public awareness of services ($n = 5$).
- Plans for expansion among respondents included expanding services populations ($n = 7$) and maintaining current service capacity ($n = 8$).

Suggested Activities (Locally, Regionally, Provincially):

- Collaborate with existing telehealth service providers (PHSA, BC Ministry for Health Services – e-health, BC Nurse Line, BC Telehealth Alliance on Research and Policy, BC Mental Health and Addiction Services, Kelty Resource Centre, Mental Health Information Line, Health Link BC, BC Provincial Health Literacy Network) to determine availability of suicide prevention, intervention and postvention education services and outreach to isolated populations (L, R, P).
- Continue partnerships to develop interjurisdictional policies around the provision of e-health or telehealth services (L, R, P).
- Build or enhance partnerships and collaborations between local and regional organizations to promote accessibility of services (L, R, P).
- Working with crisis centres to support expansion of telephone support and distress line counselling (L, R, P).
- Expand the use of safe web-based outreach services to maximize accessibility (L, R).
Safety planning tools, follow-up and outreach for suicidal individuals and for those who are in contact with suicidal individuals including family members, concerned others and health care providers

Understanding this Statement
Safety planning refers to a collaborative harm-reduction strategy where a suicidal person and/or others concerned engage in making specific plans to reduce risk of harm, increase protective factors and delineate concrete actions for safety. With the understanding that each individual is unique, safety planning tools work to ensure those in the position to discuss safety planning are aware of the safety planning tools that are available. Those involved in safety planning can then able to make informed choices about which tools to use when tailoring a safety plan with a suicidal person. Potential safety planning tools include: Emergency contact cards, coping cards, family involvement, outreach and follow-up by telephone or mail. Follow-up and outreach should occur within 48 hours of the suicide attempt.

Research Evidence
- Mann (2005) found that intensive care and outreach exemplified by contact mailings (also found by RANZCP, 2004), emergency contact cards (also found by Crowley et al., 2004; Guo & Harstall, 2004), and counsellors to coordinate treatment demonstrated mixed results but fewer suicides.
- Hirsch (2006) suggested that telephone follow-up, crisis lines and travelling counsellors were practices warranting further consideration.
- Telephone support through crisis lines was suggested (Beautrais et al., 2007; Goldney 2005; Hirsch, 2006), especially for older adults (Dombrovski et al., 2007, Conwell & Thompson, 2008).
- Other mechanisms indicated that were promising practices were follow-up within 7 days and providing no more than 2 weeks of medications at discharge (Links, 2005).
- Weishaar (2006) suggested that safety kits and coping cards were promising practices.
- CARMHA (2007) indicated that for coping and safety planning, a self report tool was recommended that guided people through the creation of a written safety plan to deal with any future feelings of suicidality by accessing internal resources, informal supports or the formal system. The tool included:
  - Doing activities to calm and comfort oneself
  - Remind self of reasons for living
  - Call a friend or family member
  - Call a back-up person
  - Call a therapist or care providers
Other suggestions for a comprehensive safety plan included an approach of the risk profile where level of risk dictated whether a suicidal person should receive more frequent appointments, telephone contacts, concurrent individual and group treatment, when a person is treated on an outpatient basis (CARMHA, 2007).

Practice Evidence

- From the snapshot survey, eight respondents reported providing safety planning as apart of their programs, services or supports.
- In addition, 16 respondents working with crisis lines participated in the survey.
- Among the strengths cited by these programs were collaborations ($n = 4$) and access to specialists and clinicians ($n = 4$).
- Among the barriers reported by these programs were funding ($n = 6$), lack of accessibility ($n = 3$), lack of coordinated services ($n = 3$) and staff workload ($n = 6$).
- Among the plans for expansion, respondents cited maintaining current service capacity ($n = 5$) and expanding service populations ($n = 5$) and provide more follow-up services ($n = 3$).

Suggested Activities (Locally, Regionally, Provincially):

- Collaborate with different organizations providing safety planning services including discharge planning with crisis centres, emergency departments, hospitals, general practitioners, counselling services and community mental health services (L, R, P)
- Use of multiple forms of safety planning including emergency contact cards, coping cards, outreach phone calls, outreach letters, emergency contact cards, coping cards, family involvement, outreach and follow-up within a minimum of 48 hours (possibly meeting within care setting) and maximum of 7 days of discharge/treatment for suicide attempt (L, R, P)
- Map out of potential resources available to a suicidal person including local community resources for use during distress including crisis centres, emergency departments, hospitals, general practitioners, counselling services and community mental health services (L, R, P)
- Collaborate with family members and concerned others to both provide support as a resource for a suicidal person and ensure their own safety as a care provider (L, R, P)
- Collaborate with schools and workplaces to ensure support and reintegration to school and work after a suicide attempt has occurred (L, R, P)
- Develop suicide response planning for BC Hospital Emergency Rooms including safety planning, community mental health team notification and discharge summary distribution with follow-up as suggested by the BC Child Death Review Unit Report, *Looking for something to look forward to*… (2008) (L, R, P)
Support for care providers working in the suicide and mental health field including safety planning for their health and wellness

Understanding this Statement
Care providers in the suicide and mental health field are challenged with providing acute and/or ongoing support to individuals and families who are in distress. To ensure that their health is not at risk or compromised in their care providing roles, it is important for the workplace to consider developing safety plans with each of their workers. Safety plans for care providers are geared towards having care providers conduct self assessments, develop coping tools and determine which resources, both personal and professional are available for support.

Research Evidence
- Most of the evidence around support for care providers was found in the BC Ministry of Health and CARMHA (2007) document, “Working With the Client Who is Suicidal.”
- Some of the key suggestions were encouragement for clinicians to recognize the stressors associated with working with suicidal persons, awareness about transference and countertransference, to seek clinical consultation/supervision and awareness of potential occupational hazards of burnout and secondary traumatic stress (CARMHA, 2007).
- Within the practice of dialectical behavioural therapy, one component involved consultation with other clinicians for a supportive therapeutic environment (DBT research studies included: Boyce et al., 2003; RANZCP, 2004; Goldney, 2005; Links, 2005; Comtois & Linehan, 2006; Headley, 2006; Singer, 2006; Beautrais et al., 2007; Goldston, 2008)
- Guidelines existed for the development of workplace policies around mental health and included the following components (CARMHA, 2007):
  > Organizing training to recognize mental health problems;
  > Supporting employees who are experiencing stress and depression;
  > Ensuring employee awareness of workplace health and counselling benefits;
  > Creating a safety protocol for employee mental health crises; and
  > Developing and implementing reintegration and return to work programs
Practice Evidence
- Data collected from the snapshot survey suggested that some underlying issues may exist around staff providing programs, services and supports.
- Among the barriers, six respondents reported staff turnover as a significant issue.
- Other staffing issues were cited as barriers among 15 respondents, as were lack of volunteers ($n = 6$).
- Heavy workloads were cited as barriers by 10 respondents.
- Only six respondents cited service specific training to be a strength of their programs, services and supports.
- Among planned expansion, seven respondents indicated that their program, service or support were planning on increasing the number of staff.

Suggested Activities (Locally, Regionally, Provincially):
- Develop safety protocols and support groups for persons working in the mental health field (L, R)
- Continue work by the BC Ministry for Children and Family Development by providing supervision courses available to all frontline workers to help deal with job stress (L, R, P)
- Continue collaboration among government and nongovernment organizations to develop tools and programs to support mental health in the workplace (Workers Compensation Board, Occupational Health and Safety Agency for Health Care in BC, BC Healthcare Collaboration Group, Canadian Mental Health Association, CARMHA, BC Mental Health and Addiction Services, Provincial Health Services Authority) (L, R, P)
- Consider implementation of programs such as Guarding Minds at Work and/or Antidepressant Skills at Work (L, R, P)
- Consider de-stigmatization of suicidal behaviour at the organization level by having protocols, policies and guidelines around what to do about a colleague who is possibility suicidal or how to get help if you are suicidal (L, R, P)
Improved accessibility to local detoxification, substance use treatment and withdrawal management especially for those with concurrent disorders/dual diagnosis disorders

Understanding this statement
A concurrent disorder or dual diagnosis disorder refers to the experience of having a psychiatric disorder and either a substance abuse disorder and/or gambling disorder at the same time. From the research literature, it is evident that both mental health and substance use issues may increase vulnerability and/or increase risk of suicidal behaviour. To address issues around substance use, improving accessibility to local detoxification, substance use treatment and withdrawal management are recommended. These potential methods would ensure that those with concurrent disorders and persons with substance use disorders are able to access timely treatment and care.

Research Evidence
- In a clinical practice guideline for Australia and New Zealand, Boyce (2003) recommended that comprehensive treatment of comorbidities, especially substance use should be initiated when working with suicidal persons.

- In a review study, Cornelius (2004) suggested the following promising practices when intervening with suicidal persons with alcohol problems:
  - Screening and assessment for suicidal ideation
  - If hospitalization is required, utilizing the dual diagnosis unit
  - Engaging with the family and
  - Considering the possible use of antidepressants and/or psychotherapies such as interpersonal therapy or cognitive behavioural therapy.

- Illgen and colleagues (2004, 2007) suggested that substance use treatment settings were helpful in addressing suicidal behaviour.

Practice Evidence

■ Of snapshot survey findings, while three respondents indicated that they would provide specific services for substance use issues, six respondents indicated that they would have to exclude substance users from their program, service or support and provide a referral.

■ Two respondents cited that a focus on substance use treatment was a strength of their programs.

■ Four respondents cited a lack of substance use treatment services.

■ Two respondents reported an interest in providing more substance use treatment services including local detoxification treatment.

Suggested Activities (Locally, Regionally, Provincially):

■ Collaborate with government and nongovernment organizations (e.g. Alcohol and Drug Information Referral – United Way, Centre for Addictions Research BC, BC Mental Health and Addiction Services, CARMHA, BC Provincial Youth Concurrent Disorders, Centre for Mental Health and Addictions, Centre for Concurrent Disorders) to develop and promote services for substance use (L, R, P)

■ Continue work by BC Mental Health and Addiction Services to address concurrent disorders and develop capacity to address problematic substance abuse (L, R, P)

■ Continue work by BC Ministry for Children and Family Development in providing concurrent disorders and/or dual diagnosis training for child and youth mental health (L, R, P)
Public-Private Partnerships are a cooperative venture between the public and private sectors, building on expertise of each partner to best meet public needs through the appropriate allocation of resources (including funding), risks and rewards. Organizations with public mandates, providing public services (non-profits, non-governmental or government organizations) could consider linking with private, for-profit organizations to fund work that has local, regional or provincial impacts. In terms of relevance to suicide prevention, intervention and postvention, public private partnerships would allow organizations to seek support from for profit companies (or groups of companies) to fund programs and services. The vision for the public-private partnership for suicide prevention intervention and postvention programs, services and supports is more of a sponsorship arrangement where both parties benefit from the positive impacts of the agreement.

Research Evidence

- Only one evidence-based strategy suggested that public and private partnerships may be a promising practice within the National Suicide Prevention Strategy from the US (SAMHSA, 2004).

- Public-private partnerships were suggested that incorporated collaboration, blending resources and building on each groups’ strengths.

- While not formally included in the literature review, a study of suicide risk factors by Beautrais and colleagues (2003) suggested that there is a need to develop public/private partnerships to address youth suicide prevention, with this partnership coordinated across government agencies and integrated across public and private sectors.

Practice Evidence

- From the snapshot survey, 40 organizations cited funding issues as a significant barrier for their program, service or support.

- Two respondents indicated that they would be engaging in a program evaluation in the future however, funding was a key issue in further program development.

- Twenty-five respondents indicated that their future plans were to maintain their current service capacity which suggested that further program development was impacted by fiscal constraints.
Suggested Activities (Locally, Regionally, Provincially):

- Assess local, regional and provincial potential for establishing relationships with the following forms of private funders (L, R, P):
  - **Foundations** (e.g. private, independent, family, community)
  - **Corporate** (e.g. foundations, corporate giving, community involvement, marketing sponsorships, research and development)
  - **Granting charities**
  - **Trades associations** or **unions**
  - **Entrepreneurial** (e.g. entrepreneurial activities, fee for services)
  - **Individuals** (e.g. philanthropists, direct mail memberships, memorial contributions, fundraising events)

- Establish a relationship with a potential private funding source by providing a business plan, project charter or operational plan and report on the proposed program, service or support outcomes (L, R, P)

- Select a part of the Suicide PIP Framework and Planning Template that has salience, relevance and potential impacts for the private funder for implementation (L, R, P)
References


Background Information

Aboriginal communities have varying suicide rates; however, a disproportionate rate of suicides exist within some Aboriginal communities when compared with non-Aboriginal communities. There are multi-faceted, multi-generational factors that are considered to be root causes of Aboriginal suicide (First Nations and Inuit Health – FNIH, 2008). The National Aboriginal Youth Suicide Prevention Strategy (NAYSPS) has indicated some of the root causes of suicide (relevant to all age groups, especially youth) are based on social conditions or the consequences of social conditions that have historically undermined security of identity among Aboriginal people. Some root causes include colonization, rapid cultural change, trans-generational grief associated with Residential Schools, the child welfare system and being a member of a marginalized and economically disadvantaged group (FNIH, 2008).

In addition to the root causes, risk factors for suicide that are prominent among some Aboriginal communities include (Royal Commission on Aboriginal Peoples, 2005):

- **Psychobiological factors**: Pre-existing mental illness, cognitive style, anxiety disorders;
- **Life history of situational factors**: Early childhood trauma, current dysfunctional family situations, child abuse, conflict with authority, absence of spiritual connection;
- **Socio-economic factors**: Unemployment, poverty; and
- **Culture stress**: Loss of confidence in understanding norms, values, and beliefs that were taught within the original cultures.

Based on consideration of root causes and risk factors, it is evident that suicide prevention, intervention and postvention among Aboriginal populations require a different strategy when compared to non-Aboriginal populations.

Definitions

For this document, term Aboriginal refers to status and non-status First Nations, Metis and Inuit peoples (Alberta Health Services – AHS, 2009). It is acknowledged that within Aboriginal populations some distinct vulnerable and/or high risk groups exist including children in care and on-reserve populations. The socio-economic environment is uniquely different for those who reside on-reserve and off-reserve. In addition, access to services is based upon federal and provincial service delivery formulas, and equitable access to services is an ongoing issue for Aboriginal people living on-reserve when compared to the other populations.

For this document, the term community refers to the traditional components that make up the fabric of an Aboriginal community including the Band, Tribal Council, Elders, children, youth, adults, agencies, and organizations.
Suicide PIP Initiative Approach
For the Suicide PIP Framework and Planning Template, an evidence-informed practice review has provided literature on suicide prevention, intervention and postvention. From the literature review, nine research studies have focused specifically on Aboriginal populations. Six additional studies have been recommended by project members and stakeholders.

A number of strategies exist in the research literature on Aboriginal populations addressing suicide however, most studies advocate for cultural safety and community renewal approaches. From the snapshot survey, seven respondents working specifically with Aboriginal populations have been interviewed.

From the results of the evidence-informed practice review and snapshot survey, one recommendation has been developed for Aboriginal populations. The recommendation was:

Cultural safety and community renewal approaches should be emphasized when engaging in suicide prevention, intervention and postvention with Aboriginal populations.

While this recommendation highlights the importance of cultural safety and community renewal, it did not sufficiently explore how Aboriginal communities could address suicide. To fill the gap in our understanding of Aboriginal health and wellness issues, all 16 recommendations from the Suicide PIP Initiative have been reviewed by a small Aboriginal Health working group and an Aboriginal Health and Wellness Facilitator. The recommendations have also been examined for relevance and applicability to Aboriginal communities.

Some of the underlying principles that have emerged from this work are the following:

- Appropriate practices for Aboriginal populations in suicide prevention, intervention and postvention involve a mix of western and traditional practices
- Best practices should be developed by a community
- Suicide prevention, intervention and postvention among Aboriginal populations should have an across the lifespan approach
- Communities would benefit most by being presented with a compilation of strategies that they can choose from to implement given the diversity that exists across communities

It has been recommended that any strategy or framework designed to decrease suicide and suicidal behaviour at the community level should be LEFT OPEN, FLEXIBLE AND NON-PRESCRIPTIVE.  

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4. This statement is applied here in the context of Aboriginal populations; however, it is also relevant for other communities.
Given that suicide prevention, intervention and postvention among communities requires an open, flexible and non-prescriptive approach, the Suicide PIP Initiative proposes some potential tools for consideration by Aboriginal communities engaging in suicide prevention, intervention and postvention. A range of options are presented in this chapter for Aboriginal communities to tailor and adapt according to community needs.

1) Building consensus around suicide prevention, intervention and postvention

It may be a worthwhile process for communities to come together to review and consider the relevance of the Suicide PIP Framework and Planning Template for adaptation to community needs. Building consensus would provide the opportunity for communities to decide on which priority areas exist for suicide prevention, intervention and postvention. By determining priorities, the community could focus on developing potential strategies to address suicide.

Some of representatives who could be involved in such a community process include:

- Youth groups/councils
- Community individuals and caregivers
- Band and tribal councils
- Tribal administrators
- Elders
- Agencies and organizations serving youth and families
- Mental health workers
- Substance use counsellors
- Health nurses
- Social workers
- Government decision-makers
- School administrators and teachers
- Community organizations and agencies
- Justice system
- Police members
- Mental health system users

Some literature has suggested that community consultations may be one way to establish a dialogue regarding suicide (Eliot-Farrelly, 2004; National Aboriginal Health Organization, 2005). Consultation processes should consider varying levels of community readiness and should be community defined. Some possible procedures for community consultations are provided below:

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### Table 8.1: Consultation Processes for Building Consensus in Aboriginal Communities

<table>
<thead>
<tr>
<th>CONSULTATION TYPE</th>
<th>PROCEDURES</th>
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| Formal Structured | • Inviting key stakeholders  
                 | • Implementing a survey similar to the Suicide PIP Recommendations Survey  
                 | • Encouraging use of traditional knowledge and tools |
| Formal Semi-Structured | • Inviting key stakeholders  
                          | • Promoting a discussion about suggested recommendations regarding community issues and needs through the use of a facilitator  
                          | • Encouraging use of traditional knowledge and tools |
| Informal Semi-structured | • Inviting key stakeholders  
                             | • Providing opportunities to share community stories  
                             | • Encouraging use of traditional knowledge and tools |

As an example of a formal, semi-structured consultation process, all recommendations for the Suicide PIP Initiative have been reviewed by a small Aboriginal health working group. The Aboriginal health working group was comprised of 5 total members representing the following organizations:

- First Nations and Inuit Health, Health Canada
- First Nations Health Society
- First Nations Summit
- Ts’ewulhtun Health Centre

The working group was provided with the goals and purpose of the Suicide PIP Initiative, the recommendations and summaries of the research. Each participant met with the Aboriginal Health and Wellness Facilitator individually to provide their feedback. All of the input was very valuable and supported by their experiences as health care professionals, Aboriginal people, service providers and community members. The resulting table provides discussion of each recommendation and their ranking by the working group. The feedback considers the relevance of the recommendation to Aboriginal populations and different components that should be included in Aboriginal populations. These findings also illustrate how a community consultation process could lead to program development.
<table>
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<tr>
<th>RECOMMENDATION</th>
<th>PRIORITY RANKING</th>
<th>POTENTIAL COMPONENTS TO INCLUDE FOR ABORIGINAL COMMUNITIES</th>
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</table>
| Education and awareness on means restriction       | Very High       | • Incorporate adults and Elders into means restriction efforts  
• Provide information on use and misuse of medications, firearms and other lethal means |
| Developing public and private partnerships         | Very High       | • Include public and private, on-reserve and off-reserve services and supports  
• Partnerships should exist to provide resources for education and support, between health care workers, community members, government and funding agencies  
• Partnerships should build on common denominators of safety; honesty; respect; communication; Elder inclusion and families |
| School-based programs on mental health promotion   | High            | • Develop programs to help children and youth understand death early in their life and in their own language  
• Focus on cultural teachings  
• Demonstrate awareness and respect for others, signs symptoms and beliefs around suicide |
| Postvention bereavement program enhancement and development | High | • Provide counselling services, support groups, group therapy, short term treatment and community response teams |
| Media education                                    | High            | • Develop community protocols and community guidelines for suicide stories |
| Gatekeeper training                                | High            | • Implement training among leaders, schools, youth and peers, helpers, spiritual advisors |
| Outreach to promote access                         | High            | • Employ multiple methods to reach people at risk especially those who have a history of stigma, institutional abuse, isolation and barriers  
• Seeing persons in their own environment |
| Local detoxification, substance use treatment and withdrawal management | High | • Start cultural teachings at an early age and continue throughout life  
• Improve accessibility treatment centres and programs  
• Increase the amount of youth detoxification and substance use treatment centres |
| Physician and health professional education        | Medium          | • Cultural safety training for clinicians to not make assumptions about Aboriginal culture  
• Educate youth, adults and Elders on health resources available both within and outside of the community  
• Early recognition of suicidal behaviour for physicians |
2) Community Asset Mapping

Community asset mapping involves conducting an assessment of community issues, strengths and needs. Asset mapping highlights an appreciative inquiry approach that builds on positive strengths that exist within the community. Community assets can include all potential resources in the community, including (FNIH, 2007):

- Talents and skills of community members;
- Values, support systems and relationships;
- Available buildings and facilities;
- Natural resources and the environment;
- Professional expertise; and
- Community leadership.

The National Aboriginal Health Organization (2005) suggests that effective community healing and effective suicide prevention plans are more likely if a community has its own information including demographics, infrastructure, community health and social programs and services, education programs, community views and attitudes about suicide, community review regarding suicide, community responses to suicide, community risk factors, community factors, cultural continuity factors, and community strengths. Consultation should incorporate community-initiated strategies and culturally appropriate methods of addressing social problems (Report of the Advisory Group on Suicide Prevention, 2003).
For asset mapping, data collection is required. It may be helpful to conduct community asset mapping and collect data by considering assets in groups:

- Natural Assets (e.g. environment, water, land, crops)
- Built Assets (e.g. physical structures, roads, buildings, housing)
- Social Assets (e.g. community connections, community strengths)
- Economic Assets (e.g. employment, labour, economy)
- Service Assets (e.g. health services, educational services, community services)

Some of the questions in asset mapping can include:

- What resources exist in the community?
- What resources are needed in the community?
- What are some of the issues?
- What are some of the characteristics of the community?
- What are some strategies to address the issues?
- Who needs to be involved?
- What kinds of partnership and collaboration opportunities exist?

Other helpful resources for community asset mapping include the report entitled “Strengths First: An Asset Mapping Guide for First Nations and Inuit Communities” developed by First Nations and Inuit Health, Health Canada (2007).

3) Examining Research Findings for Relevance

Within the existing research, there may be potential to consider the relevance of research studies to communities. To support communities in considering the research when developing community based strategies, an annotated bibliography of included studies has been developed. Use of the research findings will largely depend on the capacity of the community and its members to review research however, within the literature summaries, there may be useful content.

Conclusions

All these strategies are meant to support communities for engaging in dialogue about which issues are most important to address suicide prevention, intervention and postvention.

The purpose of this chapter was to provide a broad range of suggestions on how Aboriginal communities could build on what currently exists and how communities can use the findings from the Suicide PIP Initiative. It is acknowledged that each community has its own unique customs, tradition and land. Approaches to suicide prevention, intervention and postvention in Aboriginal communities need to be adapted to each community’s traditional activities and healing practices as well as its social and cultural contexts and needs. All activities should demonstrate cultural safety as well as a strong appreciation for the history of the culture.
Annotated Bibliography (in alphabetical order)


Formerly known as the Aboriginal Youth Suicide Prevention Strategy, the strategy focuses on resiliency, empowerment and holistic wellness approaches in providing a culturally appropriate response when addressing risk factors in Aboriginal youth. This strengths based approach provides insight around and supports for protective factors and encourages community capacity building for issues that face Aboriginal youth. The Strategy has three main goals:

- Support communities, identify strengths and build capacity to contribute to well being and resiliency of Aboriginal youth and communities
- Establish partnerships to support awareness, education and training in the areas of well-being and resiliency for Aboriginal youth and communities
- Establish partnerships to support research and evaluation to inform future planning

The report also provides two recommendations for policy direction. The first policy recommendation is shifting to a holistic wellness where a focus on community protective factors and individual and community well-being can form the foundation of intersectoral work in preventing Aboriginal youth suicide. The second policy recommendation is a shared vision with long time commitment among provincial and federal counterparts and Aboriginal community representatives to jointly address youth suicide.

**Child and Youth Officer for British Columbia.** (2006). *Sayt K’üülm Goot – Of One Heart – Preventing Aboriginal Youth Suicide Through Youth and Community Engagement*. Victoria: Child and Youth Officer for British Columbia.

Seven recommendations from the Child and Youth Officer for BC have been developed to advise the provincial government on Aboriginal youth suicide prevention. Practices that are highlighted by the report are youth involvement, community engagement and addressing longstanding jurisdictional and funding barriers.

The recommendations (based on Aboriginal youth input) include:

- Honouring youth who participated in the inter-nation forum in Prince Rupert on May 5, 2005 by acting on their recommendations and taking them into account in planning, policy and funding decisions within all relevant ministries and at whatever level is appropriate.
- In the Ministries of Health and Children and Family Development, focusing energy and resources on supporting communities in developing local strategies to prevent Aboriginal youth suicide, including sharing of ideas by Aboriginal communities that are not experiencing youth suicide.
Engaging, in a meaningful way, Aboriginal communities and youth in the Ministry of Children and Family Development planning process for the provincial Child and Youth Mental Health Plan, and incorporating in community plans a holistic approach to the delivery of services.

Expecting provincially-funded mental health service providers, as part of their job, to develop community-based alliances with mental health workers funded by federal departments, and making community and youth engagement key principles in the work done through these alliances.

Ensuring Aboriginal youth are fully involved in all discussions about suicide prevention policies and programs, and that all programs developed include training, development, compensation and leadership roles for youth.

Policy, funding and practice decisions related to preventing Aboriginal youth suicide and promoting healthy youth and communities should recognize the uniqueness of Aboriginal communities, the diversity of their need, the significance of their gatherings and cultural activities, and for youth, the importance of relationships with adults and connecting with traditional values.

Taking leadership at the premier’s level, as well as at the level of the ministers of Health and Children and Family Development, in developing and implementing a strategy to break down the barriers created by jurisdictional issues. In particular, pressure the federal government for more flexible funding to support Aboriginal child and family service agencies so that they can fully participate in community-based youth suicide and mental health promotion strategies.


This report provides a narrative review of suicide patterns, intervention approaches and issues. The authors argue that Aboriginal-specific suicide prevention initiatives based on Aboriginal understanding of suicide and self-harm behaviour are needed; rather than approaches based on non-Aboriginal models. Issues include general approaches to intervention; however, effectiveness of specific types of suicide prevention programs in Aboriginal communities is not addressed. Three areas of promising practice are identified including:

- Community involvement in program development and implementation
- Community ownership
- Connecting youth with traditional culture and spirituality

Greater long-term successes are reported for Aboriginal suicide prevention or interventions that include programs developed and implemented by and for communities that foster empowerment. Involving Aboriginal communities in programming and delivering services increases personal/community awareness, increases self-respect and dignity. Authors state that involvement, consultation and control increase commitment to achieving desired outcomes.

The strategy is a response by the federal government to address the unique determinants and high rates of Aboriginal youth suicide. The strategy is evidence-based, recognizes cultural and traditional knowledge, is built on existing structures and processes, and respects federal, provincial and territorial mandates. It contains four main elements including:

- **Primary prevention**: Focusing on public education to raise awareness and decrease stigma related to talking about suicide and mental health promotion to increase resiliency and reduce risk
- **Secondary prevention**: Focusing on supporting collaborative, community-based approaches to preventing suicide
- **Tertiary prevention**: Focusing on increasing the effectiveness of responding to and stabilizing crisis, and of after-care for survivors; and
- **Developing Knowledge**: Focusing on improving what we know about what works in preventing suicide among First Nations youth.


The goal of this strategy was to develop an evidence-based strategy with components required for Aboriginal and Inuit communities. The strategy used an approach of reducing suicide and promoting healthy living and provides a series of recommendations centered on building strength in working relationships and organizations to increase cooperation and service delivery, and tailoring services to meet local needs. As well, there are recommendations for respecting traditional wisdom, respecting community decisions and emphasizing Inuit societal values. The strategy identifies four promising practices:

- Culturally relevant programs and services
- Promotion of healthy lifestyles
- Community awareness
- Centralized data and information


This report examines issues around suicide among Maori populations. Utilizing a Prevention, Intervention and Postvention approach, this report focuses on reducing suicide attempts and providing support after an attempt. Accessibility and diversity are all important considerations in service provision. When working with Maori populations, approaches should recognize the Pacific Model of Health which represents Maori traditional ways that are characterized by balance in relation to humanity, ongoing relationships and interconnectedness with the land. The model encapsulates the physical, mental, emotional and spiritual relations of an individual. For the Maori, choice of services should consider both cultural needs and diversity, and be developed in areas with a significant Maori populations.

This review focuses on developing and individualizing prevention and intervention to the needs of specific communities. Authors state that developing mental health promotion curricula should be a priority and programs should be assessed according to acceptability, sustainability and capacity to integrate into existing organizational and community structures. The review identifies promising practices in five key areas:

- Community wellness strategies to improve suicide awareness
- Mental health promotion curriculum
- School-based programs including health promotion, recreation, sports, cultural and family
- Gatekeeper training
- Culturally sensitive adaptation of dialectical behaviour therapy


This document is a comprehensive resource addressing suicide among Aboriginal people. Theoretical models are presented for individual and community level approaches for addressing suicide, with an emphasis on improving social conditions. Some strategic efforts with the best chance of making a difference is better conceptualized as a “mental health” or “community wellness” promotion strategy.

Kirmayer et al (2007) found evidence of benefits from programs or interventions that:

- Restrict access to the means of suicide
- Provide school-based education to teach coping skills, how to recognize and identify individuals at risk, and how to refer them to counselling or mental health services
- Train youth as peer counsellors or “natural helpers;” and other individuals with whom youth come into regular contact (teachers, nurses, primary care providers, clergy, parents) to recognize and refer youth at risk
- Mobilize the community to develop suicide prevention programs, a crisis intervention team, family support, and activities that bring together youth and Elders to transmit cultural knowledge and values
- Ensure that mass media portray suicide and other community problems in appropriate ways

Primary suicide prevention strategies for Aboriginal communities could include the activities listed below:

- Peer counselling by youth
- A school curriculum that incorporates learning about positive mental health, the recognition of suicide, substance use, and other problems as serious mental health issues, as well as cultural heritage as a source of ways of healthy coping
- Recreational and sports programs for children and young people to combat boredom and alienation and to foster peer support and a sense of belonging
Workshops on life skills, problem solving, and communication for children and young people
Family life education and parenting skills workshops for new parents and adults.
Support groups for individuals and families at risk
Cultural programs and activities for the community at large
Collaboration between community workers in health, social services, and education to promote integration of services
Training in mental health promotion and suicide risk factor awareness for lay and professional helpers
Opening lines of communication by creating opportunities for community members to express their concerns and interests (e.g. town council or community meetings and gatherings)

Secondary suicide intervention Aboriginal communities to address the needs for intervention with individuals at high risk for suicide that could form part of a comprehensive prevention strategy include:

- Training of primary care providers (e.g. nurses, physicians, social workers, etc.) in suicide detection and crisis intervention, as well as in treatment of depression, anxiety disorders, substance use, and other psychiatric disorders
- Development of a regional crisis hotline based outside the community to provide some confidentiality; but workers should have knowledge of the community
- Development of a crisis centre based in the community or in an adjoining community to provide a safe place, “time out,” and an opportunity for intensive intervention
- Immediate availability of crisis intervention for those at acute risk
- Family therapy and social network interventions fit the family- and community-centred values of many Aboriginal people
- Development of assessment and intervention services for parents of youth at risk

Tertiary prevention efforts (or postvention efforts) could include:

- Community review to develop a plan before the onset of a suicide cluster
- Response to the crisis should involve all concerned sectors of the community
- First step in crisis response is to contact and prepare all groups involved
- Avoid glorifying suicide victims and minimize sensationalism.
- High-risk persons should be identified and have at least one screening interview with a trained counsellor, and then be referred for further counselling as needed
- Means restriction
- Long-term issues suggested by the nature of the suicide cluster should be addressed

This assessment and planning toolkit for communities utilizes an approach of prevention and postvention, and outlines 3 keys phases for programs: Pre-assessment, Community Assessment, and Developing a Community Healing Plan followed by evaluation and resources.

**Phase 1** focuses on risk factor assessments for communities. The toolkit acknowledges the work of Chandler & Lalonde (1998) and their recommendations for cultural continuity as protective against suicide. Factors such as community control over its own affairs, strong connections to traditional values and culture, and the manner of healthy recognition and support given to youth as they become adults, act as protective factors to decrease suicide rates. Examples can be found in steps taken by bands to secure Aboriginal title to traditional lands, rights to self-government taken back from government agencies, degrees of community control over education, police, fire and health services, and cultural facilities. Factors that strengthen the healing process include the role of Elders and youth in decision-making, the presence of adult role models, and the use of traditional healing practices.

**Phase 2** indicates that more effective community healing occurs and development of effective suicide prevention plan can happen if communities have information of their own. Information to collect and assess include: demographics, infrastructure, community health and social programs and services, education programs, community views and attitudes about suicide, community review regarding suicide, community responses to suicide, community risk factors, community factors, cultural continuity factors, and community strengths.

**Phase 3** provides steps communities can take once the current state of risk factors and of the community has been established. Authors recommend analysing the information discovered in the community assessment, considering what information/services are missing and how to go about getting that information. Through community consultation, communities can evaluate efforts in primary prevention, secondary prevention (intervention programs), postvention programs and community strengths, and see where more attention needs to be placed. The toolkit provides a framework for community healing and suicide prevention which gives questions to use for each project/program plan to assist programs to be evaluated in a holistic way using the medicine wheel. In addition, the toolkit provides 5 evaluation steps for communities as guidance through the process.

This article focuses on risks and behaviours, and provides information for research design and evaluation outcome measures. Support is given to factors of empowerment and access to resources by tribal groups, which are thought to help revitalize collective and individual perceptions of culture and use of traditional strengths to solve public health issues. The article identifies promising practices:

- Self esteem building for youth
- Culturally relevant programming
- Broad public health based interventions,
- Targeting high risk populations
- Community involvement


This report focuses on the role of mental health nurses and provides an overview of self-harm and suicide in First Nations communities. Suggestions are provided on principles that should be used in community prevention efforts. Prevention efforts could reflect local interests and culture, as well as take into account kin & family ties. Authors recommend taking a lifespan approach incorporating practical problem-solving and utilizing community led responses and qualitative exploration to generate local programmes. Community intervention responses should be coordinated and help to develop cultural safety. Promising prevention practices include:

- Community education for resource gatekeepers
- Practical problem solving approaches
- Approaches emphasizing cultural safety


This document provides a narrative review of Aboriginal suicide prevention, intervention and postvention. The review provides guidance on which areas and approaches can be used for youth suicide prevention among Aboriginal populations. There are suggestions that gaps in understanding risk and protective factors, and evaluation are major issues in conducting research on suicide prevention. There are also suggestions that we need to increase what we know about suicide prevention in Aboriginal Populations. Possible ways to achieve this include developing effective, integrated holistic health care at the national, regional and local levels that integrates Aboriginal culture and traditional healing in suicide programs. Thirty recommendations for short term, medium term and long term for holistic and collaborative prevention of youth suicide in Aboriginal populations are identified.
Promising practices identified in the report include:

- Peer counselling and support for youth
- School curriculum on positive mental, emotional and spiritual health, and cultural heritage
- Recreational and sports programs for children and youth
- Workshops on life skills, problem solving and communications (specifically around anger and conflict)
- Family life education and parenting skills workshops based on culturally sensitive models of roles and responsibilities
- Support groups for individuals and families at risk
- Community based cultural programs and activities
- Integration of community services and cultural traditional helpers
- Training on physical, mental, emotional and spiritual risk factors
- Laypersons and primary care providers for risk detection, crisis intervention and treatment of mental health conditions
- Development of a regional crisis hotline and community crisis centers
- Assessment and intervention services for parents of youth at risk
- Routine follow-up for bereaved populations


The report outlines important data on Aboriginal suicide and the root causes that are crucial to understand in order to decrease incidence of Aboriginal suicide. It describes the unique risk factors Aboriginal youth experience, including psychobiological factors, life history of situational factors, socioeconomic factors and culture stress.


This discussion paper was developed by a working group on Aboriginal Mental Health “Best Practices” in British Columbia. The working group identified a list of challenges and recommendations to improve mental health of Aboriginal people in BC. The paper examined current practices for Aboriginal suicide in Aboriginal communities and developed several recommendations of best practices involving:

- Taking a strength-based approach for individuals, families and communities supported in Aboriginal traditions
- Integrating mental health services across the hospital and community from both administrative and clinical perspectives to create a complete circle of care
- Strong support for community-based initiatives
- Culturally relevant/safety and education/training as a high priority to equip practitioners of First Nations and Aboriginal backgrounds to promote holistic wellness within their families and communities
- More research to be done in the area of Aboriginal mental health

This manual provides a model for understanding suicide and related factors for Aboriginal youth and their entire communities. In addition, an outline of strategies for prevention, general summaries of evidence and examples of current programs underway for each strategy are provided. A model was created with understanding that suicide and suicidal behaviour among Aboriginal youth can only be understood through a historical and cultural lens. The role of cultural oppression, racism and dominant culture practices and policies of colonization are recognized and strengths of Aboriginal communities themselves are recommended for suicide prevention models and strategies for Aboriginal people.

A list of 17 “before the fact” promising strategies are listed below broken down into Community Renewal Strategies, Community Education Strategies, School Strategies, and Youth/Family Strategies. Specific examples are provided under key headings where available.

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<th>Community Renewal Strategies</th>
<th>Community Education Strategies</th>
<th>School Strategies</th>
<th>Youth and Family Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Cultural Enhancement</td>
<td>• Peer Helping</td>
<td>• School Gatekeeper Training</td>
<td>• Self-Esteem Building Programs</td>
</tr>
<tr>
<td>• Traditional Healing Practices</td>
<td>• Youth Leadership</td>
<td>• School Policy and Procedures for intervention and postvention</td>
<td>• Life Skills Training Programs</td>
</tr>
<tr>
<td>• Community Development</td>
<td>• Community Gatekeeper Training</td>
<td>• School Climate Improvement</td>
<td>• Suicide Awareness Education</td>
</tr>
<tr>
<td>• Interagency Community &amp; Coordination</td>
<td>• Public communication &amp; reporting guidelines</td>
<td></td>
<td>• Family Support</td>
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<tr>
<td></td>
<td>• Means Restriction</td>
<td></td>
<td>• Support Groups for Youth</td>
</tr>
</tbody>
</table>


Many non-Aboriginal practitioners are interested in working effectively with Aboriginal youth, families, and communities. Honouring Indigenous ways of knowing and being informed by a critical consciousness regarding the influence of history, politics, and social forces in the emergence of suicidal behaviour among Aboriginal youth are central to this work. By uncovering assumptions and locating suicide prevention practice within specific discourses, this article demonstrates the relevance and value of critical reflection. Qualities of curiosity, collaborative meaning-making, joint knowledge construction, and ethical engagement are valuable resources for counsellors practicing at the clinical or community level. (Content from Abstract)
CHAPTER 9:

KNOWLEDGE EXCHANGE FOR THE SUICIDE PREVENTION INTERVENTION AND POSTVENTION INITIATIVE FOR BC
For any strategic initiative, it is important that end results reach the appropriate audiences. The Suicide PIP Initiative for BC has been created within a community development model where the power and authority for the uptake of the Framework and Planning Template is meant to exist at any local, regional and provincial level. To ensure the Suicide PIP Framework and Planning Template reaches the intended audience, implementing a knowledge exchange strategy is a critical next step.

Community Development
The Suicide PIP Initiative has involved more than 40 stakeholders across BC who consulted on the development of the Suicide PIP Framework and Planning Template over a 20 month period. The BC Mental Health and Addiction Services, the BC Ministry for Children and Family Development and the Fraser Health Authority have funded the initiative and provided guidance on strategic and policy direction. The BC Ministry of Health Services, BC Ministry of Education and BC Ministry of Healthy Living and Sport have supported the initiative in an advisory capacity. These collaborative partners suggest that there is significant momentum around suicide prevention, intervention and postvention. With a well established group of stakeholders involved in the project, significant interest in use of the Framework and Planning Template it is critical for knowledge exchange processes to help catalyze action around suicide prevention, intervention and postvention in BC.

Knowledge Exchange
The Canadian Health Services Research Foundation defines knowledge exchange as collaborative problem solving between researchers and decision-makers that happens through linkage and exchange. Effective knowledge exchange involves interaction between decision-makers and researchers that results in mutual learning through planning, producing, disseminating, and applying existing or new research in decision-making (CHSRF, 2008). Knowledge exchange models emphasize interactive, mutually respectful, collaborative approaches driven jointly by researchers, practitioners, policy-makers and consumers using evidence-based information (or promising practice) and skills in a manner that facilitates successful adoption and application by individuals, organizations and systems (BCMHAS, 2007).

For the knowledge exchange activities, the model from the BC Mental Health and Addiction Services will be used. The BCMHAS model considers that knowledge exchange should involve working with knowledge through a continuous feedback loop at stages of knowledge creation, knowledge translation, diffusion & dissemination, adoption/uptake, and evaluation.

FIGURE 9.1:
BC Mental Health and Addiction Services Knowledge Exchange Model (2007)
Knowledge exchange has been cited as a potential means to address the “system knowledge–practice gap” which is possibly the result of the following aspects of the Canadian mental health and substance use treatment system (BCMHAS, 2007):

- Multiple sectors providing services and support
- Limitations to infrastructure, leadership and resources
- Overemphasis on didactic strategies with limited use of more effective tools
- Professional development common but impact not being maximized

While it is difficult to address all the systems-level issues within the mental health and substance use treatment field, it is possible to engage in knowledge exchange efforts that consider potential obstacles to achieving success. Research suggests that planned knowledge exchange is more likely to be successful if the choice of strategy is informed by an assessment of the likely barriers and facilitators (Grol, 2003; Graham, 2006). Barriers and facilitators of knowledge exchange are well recognized in dozens of studies at the individual level, organizational level, communications level and timing. A summary of barriers and facilitators are presented in Table 9.1.

**TABLE 9.1:**
Barriers and Facilitators of Knowledge Exchange

<table>
<thead>
<tr>
<th>BARRIERS</th>
<th>FACILITATORS</th>
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<tbody>
<tr>
<td><strong>INDIVIDUAL LEVEL</strong></td>
<td><strong>ORGANIZATIONAL LEVEL</strong></td>
</tr>
<tr>
<td>Lack of experience and capacity</td>
<td>Ongoing collaboration</td>
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<tr>
<td>for assessing evidence</td>
<td>Values research</td>
</tr>
<tr>
<td>Mutual mistrust</td>
<td>Networks</td>
</tr>
<tr>
<td>Negative attitude toward change</td>
<td>Building of trust</td>
</tr>
<tr>
<td>Concern for job security</td>
<td>Clear roles and responsibilities</td>
</tr>
<tr>
<td>Lack of knowledge/understanding of broader issues &amp; impacts</td>
<td></td>
</tr>
<tr>
<td><strong>COMMUNICATION LEVEL</strong></td>
<td><strong>TIMING</strong></td>
</tr>
<tr>
<td>Unsupportive culture</td>
<td>Face-to-face exchanges</td>
</tr>
<tr>
<td>Competing interests</td>
<td>Involvement of decision-makers</td>
</tr>
<tr>
<td>Researcher incentive system</td>
<td>Planning and design</td>
</tr>
<tr>
<td>Frequent staff turnover</td>
<td>Clear summaries with policy recommendations</td>
</tr>
<tr>
<td>Lack of knowledge/understanding of broader issues &amp; impacts</td>
<td>Tailored to specific audience</td>
</tr>
<tr>
<td>Negative attitude toward change</td>
<td>Relevance of research</td>
</tr>
<tr>
<td>Poor choice of messenger</td>
<td>Knowledge brokers</td>
</tr>
<tr>
<td>Information overload</td>
<td>Opinion leader or champion</td>
</tr>
<tr>
<td>Traditional, academic language</td>
<td>Sufficient time to make decisions</td>
</tr>
<tr>
<td>No actionable messages (information on what needs to be done and the implications)</td>
<td>Inclusion of short-term objectives</td>
</tr>
<tr>
<td>Lack of common language</td>
<td>to satisfy decision-makers</td>
</tr>
<tr>
<td>Differences in decision-maker and researcher timeframes</td>
<td></td>
</tr>
<tr>
<td>Limited time to make decisions</td>
<td></td>
</tr>
</tbody>
</table>
Knowledge Exchange and the Suicide PIP Initiative for BC

Knowledge exchange has been ongoing in different elements of the Suicide PIP Initiative for BC to provide the basis for continued and more effective networking and collaboration among those involved in suicide prevention, intervention and postvention at local, regional and provincial levels. For example, in the knowledge creation phase, an evidence-informed practice review and snapshot survey formed the foundation for the next phase. In the knowledge translation phase, evidence from multiple inputs was synthesized for stakeholder appraisal and consultation. In the diffusion & dissemination phase, stakeholders were engaged in the development and dissemination of Suicide PIP Initiative processes and documents.

Supporting Suicide PIP Knowledge Exchange Activities

The focus of future knowledge exchange activities are identifying local and regional organizations to participate in Suicide PIP Framework and Planning Template Workshops. The goals of the workshops are engaging with local, regional and provincial stakeholders to support adoption and uptake of the Suicide PIP Framework and Planning Template.

The workshops have the dual purpose of presenting the Framework and Planning Template (diffusing and disseminating) and promoting its use with regionally relevant examples as well as promoting collaboration. The adoption and uptake stage would also examine change management including facilitators and barriers to change and how policy and procedure changes could be made to support the implementation of the Framework and Planning Template. A community of practice would be developed as an accessible comprehensive system for posting web-based resources to support connection and coordination of researchers, practitioners, policymakers and consumers throughout the province.

Current Situation

At the time of publication, the Suicide PIP Initiative was seeking funding opportunities to support the implementation and uptake of the Suicide PIP Framework and Planning Template. The goals of the next phase of funding would be to provide support in the implementation of the Suicide PIP Framework and Planning Template. While funds are currently not available to implement the knowledge exchange strategy in its entirety, opportunities to conduct pilot tests in communities and regions are being explored.

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6. Change management refers to the theory and application of organizational and leadership practices that foster and minimize barriers to change.
References


The process of developing the Suicide PIP Framework and Planning Template for BC has been complex and challenging, yet inspiring and revitalizing.

It is very important that the momentum around suicide prevention, intervention and postvention in BC continues to move forward.

The Suicide PIP Framework and Planning Template are designed so that groups at any level – local, regional and provincial – can approach a priority area and use materials to support positive progress.

Collaboration and partnerships should be recognized as the cornerstone of all efforts to move forward.

Together, we can impact lives and make a difference by supporting each other in addressing suicide in BC.
Aboriginal: In section 35 of the Constitution Act, 1982, Aboriginal Peoples of Canada are identified as the “Indian, Inuit and Métis peoples of Canada”

Accessibility: The ability to obtain care and services from the right place, at the right time based on their respective needs. Include things such as waiting times, physician availability, geographical proximity, extended service hours, etc.

Active Case Management: The assessment and coordination of services that facilitate independence and optimum health for individuals with chronic conditions and/or who are regular users of primary and secondary health care services

Adult: Persons 20 to 64 years of age and conditions common in this population

Advocacy: Efforts on behalf underserved individuals and/or populations for improved services, supports or access

Assertive Community Teams: Teams that provide comprehensive, community-based psychiatric treatment, rehabilitation, and support to persons with mental health conditions

Best Practices: The provision of care and service utilizing evidence-based decision-making and a continuous quality improvement approach focused on best outcome within the context of available resources.

Clinician Working Group: A working group comprised of clinicians to provide their expertise regarding clinical intervention and treatment for suicide and/or suicidal behaviour

Community of Practice: Refers to the process of social learning that occurs, and shared sociocultural practices that emerge and evolve, when people who have common goals interact as they strive towards these goals

Co-Morbid (comorbidity): The co-occurrence of any two illnesses, where one illness coexists or with an unrelated pathological or disease process

Concurrent Disorder: Where an individual experiences a psychiatric disorder and either a substance abuse disorder and/or gambling disorder at one time

Counselling: Providing either short term or ongoing therapy

Crisis: An upset in an individual’s baseline level of functioning that is generally thought to last no more than four to six weeks

Crisis Stabilization: Providing opportunity for individuals in crisis to receive support and observation until acute crisis has passed
**Critical Incident**: A traumatic event, or the threat of such which has the potential to harm life or well-being and causes extreme stress, fear or injury to the individual experiencing or witnessing the event

**Culturally Appropriate Services**: A set of values, behaviours, attitudes, and practices reflected by an organization or program that enables it to be effective across cultures; includes the ability of the program to honour and respect the beliefs, language, interpersonal styles, and behaviours of individuals and families receiving services

**Cultural Awareness**: An understanding of how a person's culture may inform their values, behaviour, beliefs and assumptions

**Delphi Survey**: A group facilitation technique involving an iterative multistage process, designed to transform group opinion into consensus

**Detoxification**: Treatment provided in a residential facility with withdrawal management

**Dialectical Behaviour Therapy (DBT)**: A psychological approach primarily utilized to treat persons with borderline personality disorder (BPD). It includes the following key elements: behaviourist theory, dialectics, cognitive therapy, and its central component, mindfulness. Its application is effective in treating persons who represent varied symptoms and behaviours associated with spectrum mood disorders, including self-injury

**Early Screening**: Identifying vulnerable individuals / populations and provide supports and resources such as to reduce their potential risk for future harm

**Emotion Regulation**: An individual's ability to understand and accept his or her emotional experience, to engage in healthy strategies to manage uncomfortable emotions when necessary, and to engage in appropriate behaviour when distressed

**Evaluation**: The systematic investigation of the value and impact of an intervention or program

**Evidence-based Practice**: The provision of care and service utilizing evidence-based decision making and continuous quality improvement approach focused on best outcome within the context of available resources

**Evidence-informed Practice**: Approaches that have been shown among some populations to lead to direct or indirect change in suicide risk and behaviours

**Experimental study designs**: Consist of quasi-experimental studies, randomized controlled trials and controlled clinical trials

**Family and Concerned Others Support**: Support and services offered for family and concerned others of those who are currently suicidal, or have made a suicide attempt

**Family-centred**: Approaches characterized by a collaborative approach to care giving and decision-making among the individual, family and health care provider

**Follow-up**: Ability to provide services after suicidal behaviour at some level

**Framework**: A basic conceptual structure used to solve or address a complex issue
Gatekeepers: Individuals who have face-to-face contact with large numbers of community members as part of their usual routine; they may be trained to identify persons at risk of suicide and refer them to treatment or supporting services as appropriate

Gatekeeper Training: Training that provides the knowledge, skills and attitudes necessary for individuals to become gatekeepers

Hierarchy of Evidence: Used for assessing the relative contributions of the quality of evidence, where a research question has been studied using a variety of methodologies and approaches; Considers quantitative research and pre-processed evidence

Holistic Approach: Addressing the relationships between all aspects of a person’s life when providing services (e.g. mental, emotional, physical, spiritual)

Intermediate Outcomes: Outcomes indirectly associated with change in suicide risk and behaviour

Knowledge Exchange: A collaborative problem solving between researchers and decision-makers that happens through linkage and exchange; it results in mutual learning through the process of planning, producing, disseminating, and applying existing or new research in decision-making

Means Restriction: Techniques, policies, and procedures designed to reduce access or availability to means (firearms, drugs, poisons, access to heights) and methods of deliberate self-harm

Mental Disorder: A diagnosable illness characterized by alterations in thinking, mood, or behaviour (or some combination thereof) associated with distress that significantly interferes with an individual’s cognitive, emotional or social abilities

Mental Health Literacy: Knowledge and beliefs which assist in the recognition, management or prevention of mental health or substance use issues or disorders

Mental Illness: Conditions characterized by impairment of an individual’s normal cognitive, emotional, or behavioural functioning, and caused by social, psychological, biochemical, genetic, or other factors, such as infection or head trauma

Observational studies: Consist of cohort, case control, cross sectional, pre and post, controlled before and after, and case series studies

Outreach: Efforts initiated by an individual or organization to identify potential at-risk and/or vulnerable populations (or their care givers) and encourage their use of existing services and resources

Partnerships: Ability to partner with other organizations providing care in the community

Peer-Led Support Groups: Lay-people offering opportunities to gather and share stories to gather support

Peer Support: Connecting individuals with similar circumstances or challenges to gather ideas and support

Phone Support: Provides over the phone support to individuals in crisis
**Planning Template**: An action oriented document or tool that provides a detailed description of how objectives will be achieved.

**Pre-processed evidence**: Consists of practice guidelines, evidence-based strategies, and narrative reviews.

**Primary Care**: Considered to be the first-contact in the provision of continuing medical care through a broad scope of health services including diagnostics, treatment and management of health problems, promotion and prevention activities and ongoing support from professionals, family and community.

**Promising Practice** is a process of continual quality improvement that

- Accumulates the applies knowledge about what is working and not working in different situations and contexts; Continually incorporates lessons learned, feedback, and analysis to lead toward improvement/positive outcomes; and,
- Allows for a incorporates expert review, feedback, and consensus from the public health field
- Has an evaluation component/plan in place to move towards demonstration of effectiveness, however, it does not yet have evaluation data available to demonstrate positive outcomes.

**Protective Factors**: Factors that make it less likely that individuals will develop a disorder or engage in suicidal behaviours and may encompass biological, psychological or social factors in the individual, family and environment.

**Public – Private Partnerships**: A cooperative venture between the public and private sectors, built on the expertise of each partner, that best meets clearly defined public needs through the appropriate allocation of resources, risks and rewards.

**Quality Assessment**: Use of a tool to assess the quality and methodology of research literature.

**Quantitative Research**: Consists of systematic reviews, experimental and observational studies.

**Resiliency**: Capacities within a person that promote positive outcomes, such as mental health and well-being, and provide protection from factors that might otherwise place that person at risk for adverse health outcomes.

**Refugees**: Persons who have fled to a foreign country or power to escape danger or persecution.

**Risk**: Any factor (or threat) that may adversely affect the patient population, the organization and its personnel, and/or the initiative itself.

**Risk Factors/indicators**: Factors that make it more likely that individuals will develop a disorder; risk factors and may encompass biological, psychological or social factors in the individual, family and environment.

**Rural and Remote**: Geographically isolated, non-urban areas or small towns.
Safety Planning: A collaborative harm-reduction strategy whereby a suicidal individual and/or others concerned for their wellbeing is engaged in making specific plans for reducing risk of harm, increasing protective factors and delineating concrete actions for safety

Service Specific Training: Volunteer or professional education specific to providing services for suicide prevention, intervention and postvention

Specialized Clinicians: Access to clinicians who can provide specialized mental health or suicide services

Stakeholders: A representative working group of academics, decision-makers, practitioners, and users; entities, including organizations, groups and individuals, which are affected by and contribute to decisions, consultations and policies

Stigma: An object, idea, or label associated with disgrace or reproach

Substance Use: Refers to the ingestion or administration of any substance that is psychoactive (e.g. alters consciousness).

Suicide Attempt: A potentially self-injurious behaviour with a nonfatal outcome, for which there is evidence (either explicit or implicit) that the person intended at some level to kill himself or herself; may or may not result in injuries

Suicidal Behaviour: A spectrum of activities related to thoughts and behaviours that include suicidal thinking, suicide attempts, and completed suicide

Suicidal Ideation: Self-reported thoughts of engaging in suicide-related behaviour

Suicide Intervention: Identification, treatment and care of a suicidal individual, with the goal of reducing the likelihood that the individual will die of a suicide

Suicide Postvention: A strategy or approach that is implemented after a death by suicide has occurred aimed at supporting those bereaved by suicide

Suicide Prevention: Strengthening resilience, reducing risk factors, and improving protective factors on both the individual and community levels

Suicide Prevention, Intervention and Postvention: A part of a continuum of services whose ultimate aim is to prevent death and risk of death by suicide while raising awareness about reducing stigma about suicide

Suicide Survivors (bereaved): Family members, significant others, or acquaintances who have experienced the loss of a loved one due to suicide

Support Groups: Groups run by professionals or lay-people offering opportunities for affected individuals to gather and share stories to gather support

Synthesis Literature: Consists of systematic reviews, narrative reviews, meta-analysis, evidence-based guidelines, and evidence-based strategies
**Systems-level Approach**: Seeks to understand and measure the impact of interventions on multiple programs or total populations, not merely the outcome of a single program.

**Systematic Literature Search**: Identify key literature discussing various approaches in a certain period of time and countries.

**Telehealth**: Use of communications and information technology to deliver users cannot access services.

**Therapeutic Approaches**: Application of specific psychological techniques designed to increase understanding of problems, with the goal being relief of symptoms and changes in behavior leading to improved functioning.

**Transgendered**: A person whose gender identity, outward appearance, expression and/or anatomy do not fit into conventional expectations of male or female. Often used as an umbrella term to represent a wide range of non-conforming gender identities and behaviours.

**Trauma Informed Response**: Taking knowledge about the impact, dynamics and paths to recovery of trauma and incorporating this knowledge into service delivery.

**Volunteer Support**: Effectively providing support to front-line volunteers to allow them to be effective in their work.

**Vulnerable and/or High Risk Populations**: Individuals made vulnerable by a variety of circumstances such as: health status, chronic illness, terminal illness, disability, age, functional status, developmental status, financial circumstances, personal characteristics and/or being part of a group that experiences stigma or discrimination.

**Wait times**: Inability to provide timely services in house or through referrals due to long waitlists for available resources.

**Web Support**: Providing online support through email or messaging systems for individuals in crisis.

**Withdrawal Management**: A group of treatment interventions with the primary purpose of supporting a person in overcoming physical and/or psychological dependence on a substance.

**Youth**: Persons aged 15-24 years (Note: Definition overlaps with youth and adult populations, as well as vulnerable populations).