Hope, Help, and Healing

A Planning Toolkit for First Nations and Aboriginal Communities to Prevent and Respond to Suicide

First Nations Health Authority
Health through wellness

In Partnership With

BRITISH COLUMBIA | Ministry of Health

First Nations Health Authority
Health through wellness

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In partnership with:

BRITISH COLUMBIA | Ministry of Health

Tripartite First Nations Health Plan

Our Vision:

Healthy, Self-Determining and Vibrant BC First Nations
Children, Families and Communities.

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Acknowledgements

Emergency Resources

• 1-800-SUICIDE
If you are in distress or are worried about someone in distress who may hurt themselves, call 1-800-SUICIDE (1-800-784-2433) 24 hours a day to connect to a BC crisis line, without a wait or busy signal.

• KUU-US Crisis Line Society
First Nations and Aboriginal specific 24/7 crisis line based in Port Alberni and serving the entire province. Toll-free: 1-800-588-8717 - Youth Line: 250-723-2040 - Adult Line: 250-723-4050.

• Native Youth Crisis Hotline - 1-877-209-1266
Answered by staff 24/7. Available throughout Canada and US.

• Youth in BC
Visit www.youthinbc.com for youth resources or chat with a counselor online.
You can also call 1-866-661-3311 (toll-free in BC) 24 hours a day.

• 310-6789 (no area code needed) Mental Health Information Line
Answered 24/7/365 it provides empowering emotional support, information on appropriate referral options and a wide range of support relating to mental health concerns.
See the Here to Help website for more information: www.heretohelp.bc.ca/

Celebrating Wellness

The artwork and drawings in this document were developed by First Nations youth in BC to express their concepts of wellness. They were initially developed for the First Nations Education Steering Committee Seventh Generation Club Art Contest and were kindly shared for the use of this document. We raise our hands to the Youth artists for sharing their wellness vision.
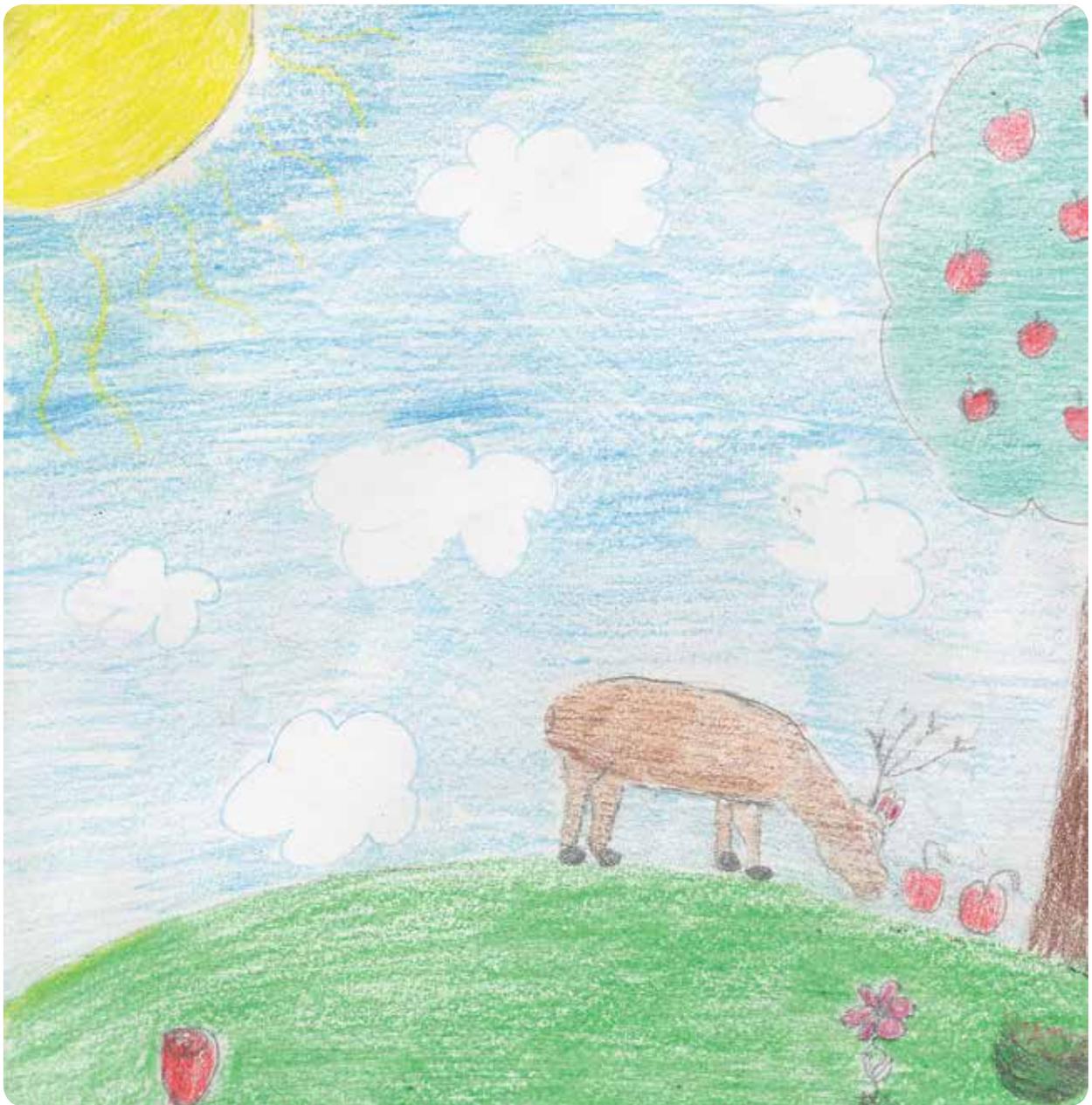
Leah
Jaffray Elementary School

HOPE   HELP   HEALING

The Path to the "Hope, Help, and Healing" Toolkit
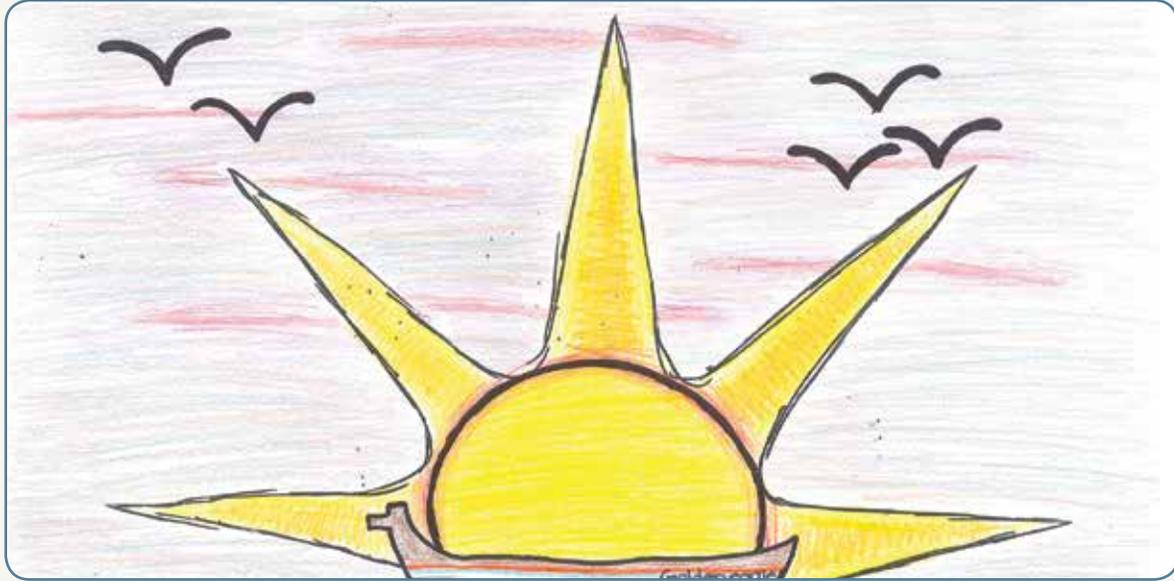
Tyresse
Sts'ailes Community School

Tripartite Partners Shared Vision - from the 2012 Health Partnership Accord

Our shared vision is a future where BC First Nations people and communities are among the healthiest in the world. We envision healthy and vibrant BC First Nations children, families, and communities playing an active role in decision-making regarding their personal and collective wellness. We see healthy First Nations people living in healthy communities, drawing upon the richness of their traditions of health and wellbeing. In this vision, First Nations people and communities have access to high quality health services that are responsive to their needs, and address their realities. These services are part of a broader wellness system – a system that does not treat illness in isolation. These services are delivered in a manner that respects the diversity, cultures, languages, and contributions of BC First Nations.

The Transformative Change Accord: First Nations Heath Plan (2006) outlines a health action to:

"Improve collaboration and partnership between agencies, organizations, authorities, and governments with First Nations and Aboriginal people to prevent and respond in a timely manner to young adult suicide through a range of supports and services."

"A Path Forward: BC First Nations and Aboriginal People's 10 Year Mental Wellness and Substance Use Plan" (2013). Within "A Path Forward", Strategic Direction H relates directly to suicide response and prevention:

Strategic Direction H: *First Nations and Aboriginal communities have the capacity to support and deliver mental health promotion, suicide prevention, intervention, and postvention initiatives that build resiliency and promote wellness.*

The Tripartite Working Group on Suicide Prevention, Intervention, Postvention (PIP) was contacted by a Health Director who was grappling with a number of recent suicides in their community. The Health Director was aware of supports available to draw on for immediate support and stabilization but identified a lack of resources in the areas of suicide prevention and postvention - or as the Health Director asked, "what supports are available to stop this from happening again?" The Tripartite Working Group Suicide PIP began work on developing a resource for communities to assist in suicide response and prevention.

A literature review of suicide prevention, intervention, and postvention was completed, as well as feedback gathered through a focus group discussion. Planning tools were added, and a community engagement process was done to gather input, feedback, and direction from five First Nations communities:

1. Cowichan Tribes at Duncan in the Vancouver Island Region
2. Three Corners Health Society at Williams Lake in the Interior Region
3. Skidegate Health Centre at Haida Gwaii in the Northern Region
4. Southern Stl'atl'imx at Pemberton in the Vancouver Coastal Region
5. Sts'Ailes First Nation near Mission in the Fraser Region

Collaboration with the FNHDA through a UBC Learning Circle and online input demonstrated a clear need for a resource such as this. As you will read within this document, suicides disproportionately impact First Nations communities in BC over other British Columbians. It is also noted that suicide is not an issue within each and every community, but can impact some more often than others.

Regional and Nation-based forums discussing implementation of *"A Path Forward: BC First Nations and Aboriginal People's Mental Wellness and Substance Use 10 Year Plan"* took place throughout 2014 and at these forums, FNHA representatives heard the need for clear and concise crisis response and intervention tools at the community level.

"Hope, Help, and Healing" intends to support planning efforts at the community, tribal council, Nation-based, and sub-regional levels. The document you see before you is the combination of significant collaborative work, engagement, and commitment to better supporting communities in responding to and preventing suicide.

About the Approach

"Hope, Help and Healing: A Planning Toolkit for First Nations and Aboriginal Communities to Prevent and Respond to Suicide"

1. The Hope, Help and Healing approach adopted in this toolkit is based on *The Suicide Prevention, Intervention and Postvention Initiative for BC* which combines published research findings, the experiences of other provinces, and plans developed in BC.

2. Prevention, Intervention and Postvention (PIP)[1] has been adopted as a best practice for use in BC.

3. Think about the three elements of the framework in this way:

- **Prevention** works to promote protective factors (strengthening community resilience) and reduce risk factors that could lead to suicide ideation....**HOPE**
- **Intervention** works to address suicidal thoughts and behaviours. It focuses on how best to respond to someone feeling suicidal or attempting suicide....**HELP**
- **Postvention** refers to the community response after a death by suicide has occurred, and is intended to support people affected by suicide, as well as providing follow-up education / prevention to reduce the risk of future crises....**HEALING**

Based on feedback from communities the PIP approach has been adapted to use strengths-based language and ideas to express the continuum of work done to prevent and respond to suicide in communities.

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1 Joshi, P., Damstrom-Albach, D., Ross, I., Hummel, C. (2009). Strengthening the Safety Net: A Report on the Suicide Prevention, Intervention and Postvention Initiative for BC. Retrieved July 20, 2013:
http://suicidepipinitiative.files.wordpress.com/2009/05/suicide-pip-initiative-full-report.pdf

HOPE
(PREVENTION)
How to reduce the likelihood of suicide in our community

HELP
(INTERVENTION)
How to support the person and their close family members and friends at the time of suicidal feelings or attempts

HEALING
(POSTVENTION)
How to support close family members and friends, and the entire community after a death by suicide
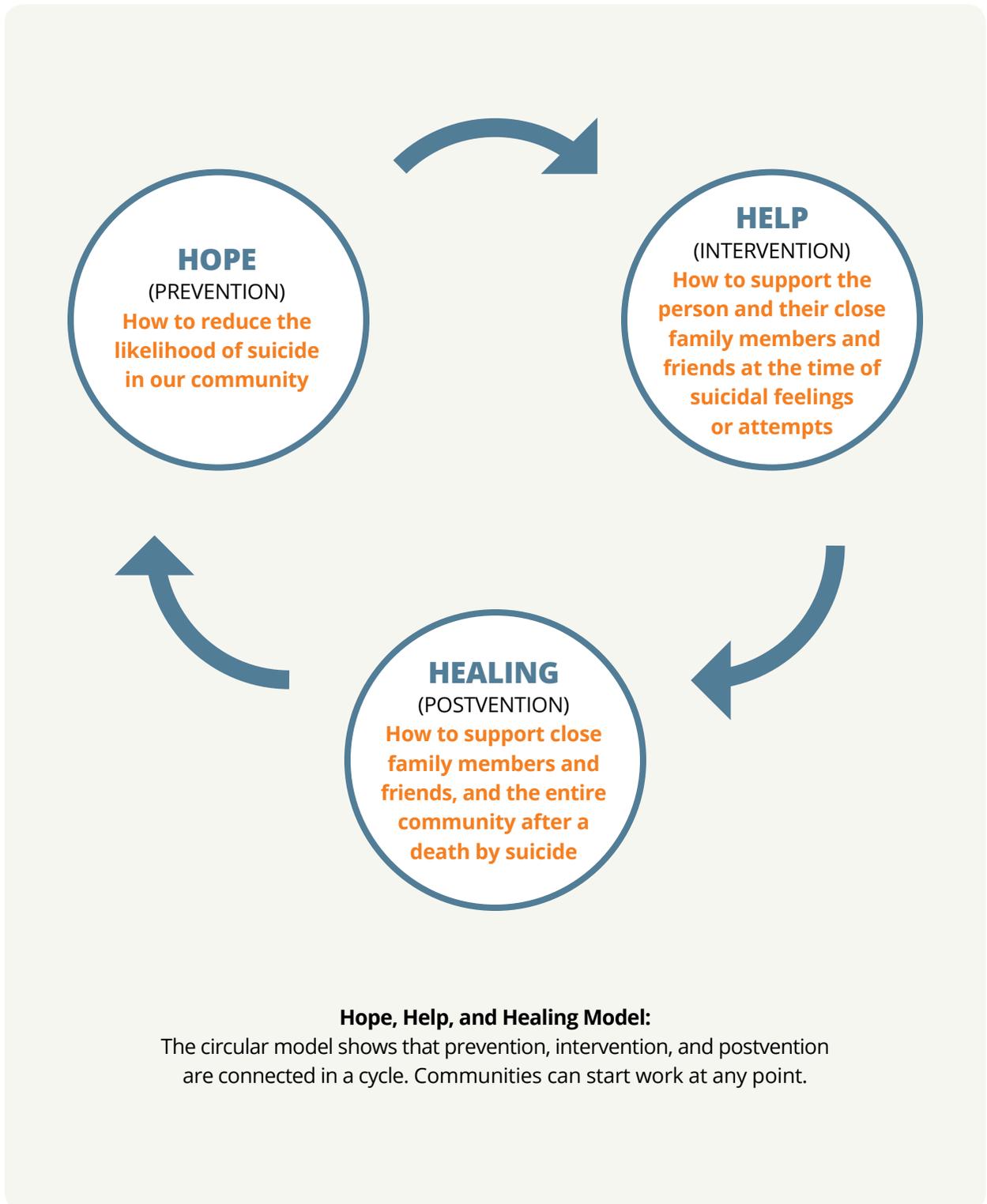
HOPE HELP HEALING

Hope, Help, and Healing Model:
The circular model shows that prevention, intervention, and postvention are connected in a cycle. Communities can start work at any point.

About the Toolkit

Who is this toolkit for?

This toolkit was developed for community health leads (e.g. Health Directors, Band Managers or equivalent), and community health workers in First Nations and Aboriginal communities and others working in an area that touches on preventing and responding to suicide in their community.

What is the toolkit's purpose?

To support community workers in planning and developing a community suicide prevention, intervention and postvention plan that can be used in their community.

How can I use this toolkit?

• The toolkit is organized around four sections, with the work for each section broken down into smaller steps. There are several appendices at the back.

• The four sections can be used together in order OR they can be used separately depending on the work being done in the community already.

• Additionally, your community may want to focus its planning efforts on suicide prevention (Hope), or if you determine that there are already good suicide prevention resources in place, you may want to spend more time planning for intervention (Help) or postvention (Healing) resources.

• Also, this toolkit can be used as a "checklist" for you to see if your community has some of the promising practices in place already.

Dustin
Grade 5, John Field Elementary School

What does each section include?

Section 1: Preparing for the Planning Journey.

This section is for the community worker or other people who will be coordinating this planning for the community. It provides guidance on preparing yourself to do this work (which can often be quite sensitive or emotional).
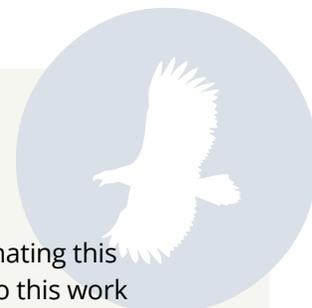
Section 2: Learning Important Facts about Suicide.

This section provides a snapshot of information that is helpful to know, such as suicide data (numbers) and trends in Canada and BC, historical and cultural information, and circle work and its link with mental wellness and substance use. It also contains information on risk and protective factors.
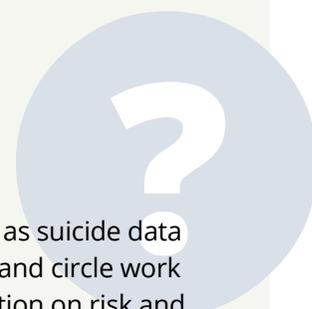
Section 3: Gathering People and Information

This section supports you to bring together a Coordinating Committee, gather information about suicide in your community and identify any strengths and/or gaps in suicide-related programs and resources in your community.

Section 4: Sharing, Writing and Evaluating

This section provides tips and tools for engaging your community in the planning process, writing up your plan and evaluating your efforts.

Appendices
The appendices attached to this toolkit provide essential contacts and resources, blank templates, practical tools, and a glossary of terms used in this toolkit.

Developing Your PIP Plan - The Planning Roadmap

This toolkit has been organized around four sections. As you move through each section you will see one of the icons below on the first page of each section. Additionally, you will find suggested learning checklist at each section and some tools/resources to help you plan.

Section 1 – Preparing

Begin preparing for the planning journey.

Actions:

1. Review the First Nations Perspective on Wellness.

2. Review information about your role.

3. Review what you and your planning team can do to stay well.

Section 2 - Learning

Become familiar with important information about suicide.

Actions:

1. Learn about suicide, the determinants of health, risk factors, and protective factors and the importance of culture.

2. Learn about promising practices related to suicide prevention, intervention and postvention.

Section 3 - Gathering

Bring together the people and information you need to make a plan (includes processes and tools to guide you)
Actions:

1. Form a Coordinating Committee or use one that already exists in your community.

2. Seek and gain political support.

3. Compile information about suicide in your community.

4. Identify any strengths and/or gaps in the existing suicide-related programs and resources in your community.

Plan

Act & Reflect

Community Planning (change) Process

Assess

Write

Share

Section 4 – Sharing

Engage the broader community in the development of your plan, write up your plan and evaluate your efforts.
Actions:

1. Bring together the broader community to discuss your proposed plan.

2. Write up your plan.

3. Evaluate your efforts.

HOPE HELP HEALING

Preparing for the Planning Journey

S.
Jaffray Elementary School
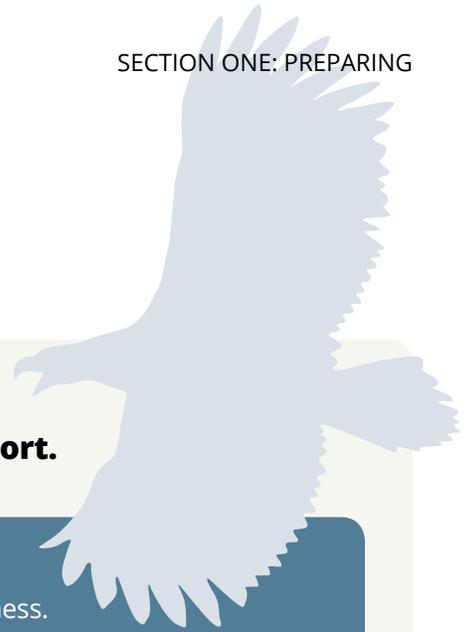
Section 1 - Begin preparing for the journey:
Preparing a self-care approach and seeking support.

Learning Checklist

❑ Become familiar with the First Nations Perspective on Wellness.

❑ Learn about your role in the planning journey.

❑ Learn about ways you can help yourself and the team in the planning journey.

Resources (Tools)

• First Nations Perspective on Wellness.

• Tool 1.1: Comprehensive Self-Care Reminders (pg. 20).

HOPE HELP HEALING

First Nations Perspective on Wellness
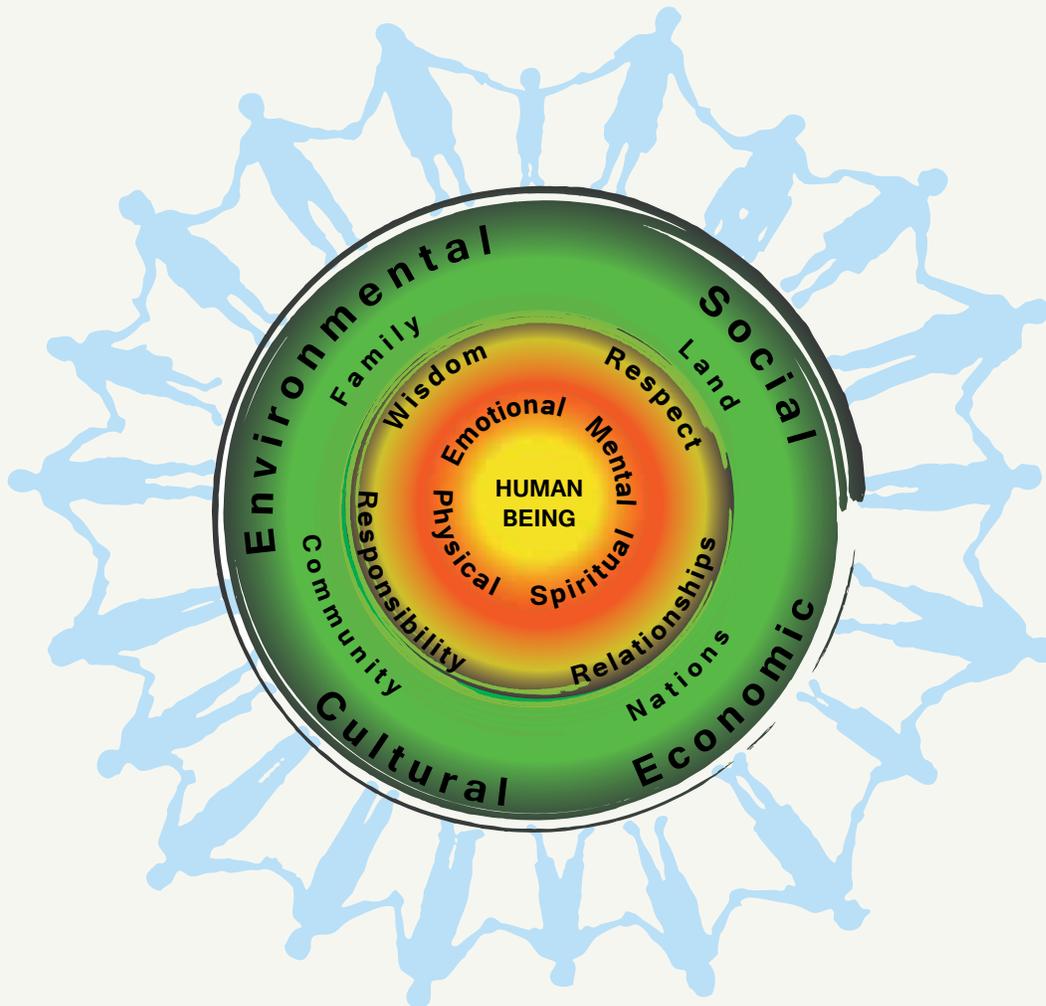
Figure 1: **First Nations Perspective on Wellness**

The First Nations Perspective on Wellness is a shared understanding of the holistic vision of wellness shared by BC First Nations. The basis of this perspective is to achieve health and wellness by taking a look at and nurturing the internal and external factors that affect wellbeing. Many of these concepts are based on traditional knowledge.

Although the First Nations Perspective on Wellness appears in layers, it is important to acknowledge that all the words in each circle are interconnected with each other, and with the components of other circles. In addition, all the circles themselves are connected and responsible for each other. Ultimately, all of these factors are important and need balance to achieve wellness.

Centre Circle (Core of Wellness)

The Centre Circle represents the human being taking responsibility for their own health and wellness with a strong sense of self-identity and self-esteem. Everything originates at the centre, and it is with one's self, that the journey of wellness begins. The broader context that an individual lives in (e.g. one's community and larger society) also effects decisions, actions, and choices.

Second Circle (Aspects of Wellness)

This circle illustrates the Mental, Emotional, Spiritual and Physical dimensions that are necessary for a healthy, well, and balanced life. It is critically important that there is balance between these dimensions of wellness and that they are all nurtured in tandem to create a holistic level of well-being, one in which all four areas are strong and healthy.

Examples of wellbeing: When looking at mental wellbeing, consider looking at career satisfaction and stress management. When looking at emotional wellbeing, it is important to nurture relationships and identify support networks. When looking at spiritual wellbeing it is important to nurture the spirit, whether it is through culture, language, ceremonies, religion or the creative arts, such as writing, drumming, dancing or drawing. When looking at physical wellbeing, consider nutrition, physical activity, and weight management.

Third Circle (Values of Wellness)

The third circle represents the overarching values that support and uphold wellness: Respect, Wisdom, Responsibility, and Relationships. These four values need to be acknowledged when honouring yourself and others.

Respect: Respect is honouring where you come from, your culture, your traditions, yourself. It is intergenerational, and is passed on through ones community and family. It is the driving force of the community because it impacts all of our life experiences, including our relationships, our health, and our work. It is defined as consideration of, and appreciation for, others, but there is recognition that respect is so much more in First Nations communities – it entails a much higher standard of care, consideration, appreciation and honour and is fundamental to the health and wellbeing of our people. There is an intuitive aspect to respect, because it involves knowing how to be with oneself and with others.

Wisdom: Wisdom includes knowledge of language, traditions, teachings, culture, and medicine. Like respect, wisdom is passed on by our ancestors from generation to generation. It is sacred in nature and includes honouring your spirit and sharing your knowledge with others.

HOPE HELP HEALING

Responsibility: Every person has responsibility to self, families, communities, and the land. Responsibility extends not just to those that we come into contact with or relate to - but also to the roles we play within our families, our work, and our experiences in the world. There is also a mutual accountability and reciprocity aspect to responsibility. Responsibility intersects with so many areas of our lives, and involves maintaining a healthy and balanced life and leadership through modelling healthy behaviour and wellness.

Relationships: Relationships are what sustain us. Relationships and responsibility go hand in hand. Like responsibility, relationships involve mutual accountability and reciprocity. Relationships are about togetherness, team-building, partnerships, capacity building, nurturing, sharing, strength, and love. It is recognized that relationships need to be maintained strongly within oneself as well as with those around you.

Fourth Circle (Relationships for Wellness)

The fourth circle depicts the people that surround us and the places where we come from: Nations, Family, Community, and Land. You, the individual, need to build healthy relationships and responsibilities within these areas, which will provide the foundation for health and wellness.

Land: The land is what sustains us physically, emotionally, spiritually and mentally. We use the land for hunting, fishing, and gathering. The land is about where you come from, including your territory and is the basis of our identity. It is more than just the earth. It includes all living and non-living things such as: water, air, fire, food, medicines, animals, all plants and trees, the mountains, and our ancestors. We have a responsibility to care for the land and to share that knowledge with our people. Land and health are closely intertwined because land is the ultimate nurturer of people. It provides physical sustenance but also provides emotional and spiritual sustenance because it inspires you and provides beauty; it nurtures your soul.

Community: Community represents the people where we live, where we come from, and where we work. There are many different ways to view community: community of place, community of knowledge, interest, experience, values, and it important to recognize that these all have a role in our health.

Family: Our family is our support base, is where we come from, and includes our languages and culture. There are many different kinds of families that surround us, including our immediate and extended families, our ancestors, those who we care for and who care for us, our support system, or traditional systems in addition to or instead of simply blood lines. It is important to recognize the diversity that exists across BC, that there are many different family systems that exist, e.g. matrilineal.

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Nations: This Nation includes the broader community outside the immediate and extended family and community. In essence, Nation is an inclusive term representing the various Nations that comprise one's world.

Fifth Circle (Determinants of Wellness)

The fifth circle depicts the Social, Cultural, Economic and Environmental determinants of our health and well-being. These determinants affect our health and wellbeing and it is our responsibility as an individual and as a collective to ensure these determinants are available and protected.

Social: Social determinants, such as security, housing, food, prevention, promotion, education, health awareness, outreach supports, are all critical aspects of our health and well-being.

Environmental: The environment, including the land, air, water, food, housing, and other resources, need to be taken care of and considered in order to sustain healthy children, families and communities. Safety and emergency preparedness are critical components.

Cultural: Culture is different for every individual, community and Nation. It can mean language, spirituality, ceremonies, traditional foods and medicines, teachings, and a sense of belonging.

Economic: Economic means resources, which we have a responsibility to manage, share, and sustain for future generations. There is a need to create balance in how we use our resources and good leadership to help us create this balance. Economic can include our employment and our workplace health.

Outer Circle

The people in the outer circle represent the vision of strong children, families, Elders, and people in communities. The people are holding hands to demonstrate togetherness, respect and relationships, which in the words of a respected Elder can be stated as "one heart, one mind." Children are included in the drawing because they are the heart of our communities and they connect us to who we are and to our health.

Colours

The colors of the sunset were chosen specifically to reflect the whole spectrum of sunlight, as well as to depict the earth's rotation around the sun, which governs the cycles of life in all BC First Nations communities.

HOPE HELP HEALING

Closing the Circle

The resilience of First Nations and Aboriginal peoples has been demonstrated by the incredible ability of individuals, families and communities to withstand the harmful effects of colonization and other inequities in the social determinants of health. It is through partnerships and collaborations among all groups, authorities, and agencies that we can improve the mental wellness outcomes for and with First Nations and Aboriginal people.

Circles remind us of our accountability to each other in this work and how respectful interactions are key in addressing suicide, mental wellness and substance use among First Nations and Aboriginal People in BC.

How the First Nations Perspective on Wellness was Created

The First Nations Perspective on Wellness was developed using feedback and ideas gathered from BC First Nations over the past several years and from traditional teachings and approaches shared by First Nations healers and Elders at gatherings convened by the FNHA and its predecessor - the First Nations Health Society.

Brandy
Grade 2, Sts'ailes Community School

HOPE HELP HEALING

What is your role as the Community Worker / Coordinator?

You may be a Community Health Representative, Health Director, mental health clinician, health promoter or other worker assigned by Chief and Council or your health service to carry out this planning for your community, or you may be doing it for other reasons. When you are organizing the community suicide prevention and response planning process, take some time at the start and throughout to consider your own self-care.

Things to consider at the start of the planning journey:

1. **THE BEST TIME TO SEEK POLITICAL SUPPORT** - Depending on your community, gaining the support of your Chief and Council may be a task that needs to happen before you bring a committee together or it might be one that can wait until a committee has been formed. You will know best when this should happen in your process. See Tool 3.6 (pg. 71) in Section 3 for you to adapt and use to gain support from your Chief and/or Band Council.

2. **EDUCATE YOURSELF** - About suicide prevention, intervention and postvention and other related information (see Sections 1 and 2).

3. **TAKE CARE OF YOURSELF BY PREPARING FOR THE PLANNING JOURNEY** - Make sure you and the team are in a good place to start this planning journey and to stay healthy along the way. Talking about suicide can be an emotional experience and may trigger some strong reactions in people and the community. Taking care of yourself, physically, emotionally and spiritually, can help ensure that you maintain your own health and well-being as you move through the Hope, Help and Healing process.

Tips for Looking after yourself during the journey

- **Ask for help.** Find people who can help you at the start of the journey. This is a sensitive issue and you may hear some upsetting stories. Look after yourself with prayers, consulting Elders and trusted advisors.

- **Seek peace and support** within your traditional teachings, culture and spiritual beliefs, and/or religous connectedness to help you.

- **Work on building team unity** with those working alongside you as it removes the sense of isolation.

- **Make a list of actions you can take** to help the team as they journey together. (see Tool 1.1: Comprehensive Self-Care Reminder pg. 20)

- Check in at the start of every meeting to **see how everyone on the team is feeling.**

- One of the only things we have control over when we're grieving is our own bodies. **Eat healthy food** as often as you can during the journey to keep your body replenished, healthy and focused.

- **Take a break if you need to** - especially if other difficult or stressful events are happening in your life. The development of the plan needs to be a good process – not a speedy one that places too much pressure on those involved.

- **Develop a Safety Plan.** Beyond it being good practice to create your own, it is helpful to have first-hand experience when you support others in developing their Safety Plan.

- **Accept** that despite doing all that you can do some people will make the choice to suicide.

- Working and living in a close knit community can be difficult when responding to suicide. Develop a mind-set that says, **"I will do what I can to help people struggling with suicide; and I recognize that ultimately the choice to live or die is theirs"**; as opposed to "I can and must save this person. If they die by suicide then I am a failure."

- When there is a suicide attempt or death, **helpers can experience feelings similar to those of close family members and friends**, including shock, grief, guilt and/or anger. Helpers' confidence in their ability to intervene may be impacted. Often, helpers fear losing the respect of their peers; however, this fear is largely self-imposed.[2]

- **Give yourself permission to feel joy and laughter;** include fun activities in your daily events and meetings.

2 Henden, H., Pollinger Haas, A., Maltsberger, J.T., Szanto, K., & Rabinowicz, H. (2004). Factors contributing to a therapists' distress after the suicide of a patient. American Journal of Psychiatry, 161 (8), 1442-1446.

Tool 1.1 Comprehensive Self-Care Reminders

The following reminders for areas of self-care is only a starting point. You can add areas of self-care that are helpful for you and then create a care plan to find ways to keep yourself well and safe.

Workplace or Professional Self-Care

❑ Take a break during the workday
❑ Take time to chat with co-workers
❑ Make time to complete tasks
❑ Identify projects or tasks that are exciting and rewarding
❑ Set limits with clients and colleagues
❑ Balance your workload so that no one day or part of a day is "too much"
❑ Arrange work space so it is comfortable and comforting
❑ Attend staff meetings
❑ Seek regular supervision or consultation
❑ Have a peer support group
❑ Have regular debriefing sessions either as teams or one-on-one
❑ Seek out additional training and educational opportunities

Spiritual Self-Care

❑ Spend time in nature
❑ Find a spiritual connection or community
❑ Be open to inspiration
❑ Cherish your optimism and hope
❑ Identify what is meaningful to you and notice its place in your life
❑ Meditate
❑ Pray
❑ Drum
❑ Sing
❑ Find things that make you laugh
❑ Spend time with Elders
❑ Participate in ceremony

Physical Self-Care

❑ Eat regularly (e.g. breakfast, lunch, and dinner)
❑ Eat healthy foods
❑ Exercise
❑ Get medical care when needed
❑ Take time off when sick
❑ Dance, swim, walk, run, play sports, sing, or do some other fun physical activity
❑ Get enough sleep

Psychological and Emotional Self-Care

❑ Take time to do something you truly enjoy
❑ Make time away from telephones, email, and the Internet
❑ Make time for self-reflection
❑ Notice your inner experience - listen to your thoughts, beliefs, and feelings
❑ Write in a journal
❑ Try to minimize stress in your life
❑ Say no to extra responsibilities sometimes
❑ Spend time with others whose company you enjoy
❑ Stay in contact with important people in your life
❑ Give yourself affirmations, praise yourself
❑ Love yourself
❑ Identify comforting activities, objects, people, places and seek them out
❑ Allow yourself to cry

HOPE HELP HEALING

Learning

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Toree
Grade 2, John Field Elementary School

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Section 2 - Learning important facts about suicide:
Gaining the knowledge you'll need to help in your planning journey

Learning Checklist

❑ Learn about suicide in BC and why we need to address suicide.

❑ Learn about First Nations history and what contributed to suicide taking hold in some communities.

❑ Learn about culture and how it can strengthen First Nations communities.

❑ Learn about risk and protective factors.

❑ Learn about best practice examples for PIP programs and strategies.

Resources (Tools)

• Links to additional resources found throughout this document (each topic).

What are we talking about?

A few common terms related to suicide and self-injury [3/4]:

Non-suicidal self-injury - the deliberate harm of someone's own body but without the intention to die. This does not include behaviours such as tattooing and piercing which are typically approved of by society.

Suicidal ideation – thoughts of harming or killing oneself (the person tells you this).

Suicide behaviour- gathering the means to make a suicide attempt; writing suicide notes; talking, writing or drawing about suicide.

Suicidal crisis – a serious increase in suicidal behaviour, which may involve thinking about, planning, intending, or attempting suicide.

Suicide attempt – any self-inflicted action (with or without sign of injury) taken where the person is trying to kill him/herself.

Suicide – intentional, self-inflicted death - died by suicide.

Suicide survivor - close family members or friends of someone who has died by suicide. An individual who has attempted suicide has sometimes been called a "suicide survivor". This makes things confusing. It is better to identify this individual as "someone who attempted suicide". A person can self-identify by stating, "I attempted suicide".

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Setting the Context

Why is this issue important to First Nations and Aboriginal communities?

Although many communities have low rates of suicide or have not experienced suicide in many years, a loss by suicide has a significant impact on many First Nations and Aboriginal communities. This impact can be especially experienced by smaller, tight-knit First Nations and Aboriginal communities.[5]

The significant rate of suicide on First Nations and Aboriginal communities is associated with ongoing intergenerational impacts of colonization, Indian residential schools, the 60's scoop, child apprehension, land dispossession, racism, and attempted physical/cultural genocide.

Healing from the impacts of historical trauma, building on community strengths and supporting resiliency are all key to promoting hope and healing in communities. Culture is healing. Suicide prevention is grounded in cultural continuity, self-determination, stewardship of ancestral lands, and control of education, emergency response and health services.[6]

Why does suicide happen?

Suicide isn't usually caused by a single issue or event. It is usually the result of many combined issues that a person or his/her community faces. Many factors influence physical and mental health and wellness. Suicides are most often the result of emotional pain, hopelessness and despair. They are almost always preventable through caring, compassion, commitment and community.[7] But to understand more about the deeper reasons why suicide happens among First Nations and Aboriginal peoples, we have to understand more about what are referred to as the "determinants of health."

3 Ministry of Children and Family Development (2013). Preventing Youth Suicides: A Guide for Practitioners. Retrieved from:
  www.mcf.gov.bc.ca/suicide_prevention/pdf/pys_practitioners_guide.pdf
4 Centre for Research in Mental Health and Addictions (CARMHA) (2007). Working With the Client Who is Suicidal: A Tool for Adult Mental Health
  and Addiction Services. BC Ministry of Health. Retrieved March 28, 2014 from:
  www.health.gov.bc.ca/library/publications/year/2007/MHA_WorkingWithSuicidalClient.pdf
5 British Columbia. Provincial Health Officer (2009). Pathways to Health and Healing- 2nd Report on the Health and Well-being of Aboriginal People
  in British Columbia. Provincial Health Officer's Annual Report 2007. Victoria BC: Ministry of Healthy Living and Sport.
6 Chandler, M.J. & Lalonde, C. (1998). Cultural Continuity as a Hedge Against Suicide in Canada's First Nations. Transcultural Psychiatry, 35,191-219
7 Canadian Association for Suicide Prevention (2009) The CASP National Suicide Prevention Strategy. Winnipeg: Canadian Association for Suicide
  Prevention.

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The Determinants of First Nations/Aboriginal Health[8]

Many factors influence health and mental wellness for both individuals and communities. Some of these factors are personal, and some of them relate to our circumstances and environment. For First Nations and Aboriginal people in Canada, these factors include the impacts of colonization, the current living conditions in your community (e.g. access to food that culturally is appropriate, suitable housing, jobs and schools,) and personal factors such whether or not you have a job, your level of education and the health of your relationships with family and friends. For instance, supportive relationships with family and friends can make you feel cared for, loved, esteemed and valued, and as a result they have a protective effect on your health.

These many factors are called "determinants of health." Some of the most important social factors included in the First Nations/Aboriginal determinants of health are:

• **Historical, social, political, and economic contexts. Examples include:**
     o Self-determination
     o Colonialism, racism and social exclusion

• **Community infrastructure, resources, and capacity. Examples include:**
     o Social support networks
     o Healthy child development
     o Health services
     o Cultural continuity (passing on cultural teachings)
     o Environmental stewardship
     o Educational systems

• **Physical and social environments. Examples include:**
     o Housing, access to food, remoteness of a community
     o Income and social status
     o Employment and working conditions
     o Education and literacy

• **Health behaviours, personal health practices, coping skills and healthy relationships. Examples include:**
     o Getting enough exercise and sleep
     o Eating healthy food
     o Minimizing or reducing the use of alcohol and other substances
     o Receiving prenatal care when pregnant

8 Reading, C.L. & Wien, F. (2009). Health Inequalities and Social Determinants of Aboriginal Peoples' Health. Prince George, BC: National Collaborating Centre for Aboriginal Health. www.nccah-ccnsa.ca/docs/social%20determinates/nccah-loppie-wien_report.pdf

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Determinants of health affect individuals, families, and whole communities. They can impact health in the immediate, or later on in the future. Some of the determinants of health include historical events and complicated structures and institutions in society, like the examples listed above. All of these determinants of health affect mental well-being and suicide in First Nations and Aboriginal communities. For example, we know poverty, crowded living conditions, and poor access to food can increase the risk of suicide.

The root causes of increased rates of suicide among First Nations and Aboriginal peoples are complex and stretch across generations. Some of the determinants of health that affect suicide are based on the consequences of social and political conditions that have historically harmed First Nations and Aboriginal peoples. These include colonization, rapid cultural change, forced assimilation, grief associated with Residential Schools, the child welfare system and being a member of a marginalized and economically disadvantaged group.[9] These effects can be passed on from one generation to the next. This is called "intergenerational trauma."[10] These broader factors have affected all of the determinants of health and have increased the risk of suicide for some people.

Links to additional resources

If you are interested in further information or training opportunities about the cultural and historical context for First Nations and Aboriginal people, here are some helpful resources:

• **Cultural Competency and Safety: A Guide for Health Care Administrators, Providers and Educators (National Aboriginal Health Organization, 2008)**
(www.naho.ca/documents/naho/publications/culturalCompetency.pdf)

• **Cultural Safety: Peoples' Experiences with Colonization (Module 1) (University of Victoria)**
(http://web2.uvcs.uvic.ca/courses/csafety/mod1/notes.htm)

• **Cultural Safety: Peoples' Experiences with Oppression (Module 2) (University of Victoria)**
(http://web2.uvcs.uvic.ca/courses/csafety/mod2/notes.htm)

• **Cultural Safety: Peoples' Experiences of Colonization in Relation to Health Care (Module 3) (University of Victoria)**
(http://web2.uvcs.uvic.ca/courses/csafety/mod3/notes.htm)

9 Joshi, P., Damstrom-Albach, D., Ross, I., Hummel, C. (2009). Strengthening the Safety Net: A Report on the Suicide Prevention, Intervention and Postvention Initiative for BC. Retrieved July 20, 2013: http://suicidepipinitiative.files.wordpress.com/2009/05/suicide-pip-initiative-full-report.pdf
10 Centre for Suicide Prevention (2013). Suicide Prevention Resource Toolkit. Retrieved Aug 20, 2013 from:
http://suicideinfo.ca/LinkClick.aspx?fileticket=MVIyGo2V4YY%3D&tabid=563

- **Health Inequalities and Social Determinants of Aboriginal Peoples**
  (National Collaborating Centre for Aboriginal Health)
  (www.nccah-ccnsa.ca/en/publications.aspx?sortcode=2.8.10&publication=46)

- **Health Professionals Working With First Nations, Inuit, and Metis, Consensus Guideline**
  (Society of Obstetricians and Gynecologists)
  (http://sogc.org/wp-content/uploads/2013/06/June-JOGC-2013-CPG293_Supplement_Eng_On-line-Final_NO-cropmarks_REV-F.pdf)

- **Indigenous Cultural Competency Training Programs**
  (Provincial Health Services Authority in BC)
  (www.culturalcompetency.ca)

Risk and Protective Factors Related to Suicide

In 1995, the Royal Commission on Aboriginal People released a special report on suicide which identified four groups of factors often associated with suicide in First Nations and Aboriginal populations. These factors include: psycho-biological factors, situational factors, socio-economic factors and culture factors.[11] Like the determinants of health, these factors (discussed below) can have either 'protective' or 'risk' qualities to them and can occur at both the individual and community-levels.

In the context of suicide, risk factors are events or characteristics that give someone a higher chance of considering suicide. Some risk factors such as family history and genetics cannot be changed. Others, such as exposure to violence, or lack of social support can be changed with intervention. Some risk factors are the result of early experiences in life. For example, children deprived of affectionate, attentive and stable care and children who experience abuse, neglect or violence are more likely to develop mental and behavioural problems, either during childhood or later in life. Risk factors such as the ones listed above can be strongly influenced by the presence or absence of other risk and protective factors.

Factors or strategies that can support resilience and protect against risk factors are called 'protective factors'. Protective Factors 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 - lowering the chance of negative outcomes such as suicide.[12] Like risk factors, protective factors can be found in individuals, families and communities. They help people cope with challenges and difficult events, and help people deal with the demands and stresses of life. Protective factors can act as a buffer to reduce the risk of mental health issues. Research shows that childhood is an ideal time to develop the protective factors that influence social and emotional well-being.[13]

11 Chemier, N.M. (1995). Suicide Among Aboriginal People: Royal Commission Report. Retrieved March 10, 2014 from:
    www.parl.gc.ca/Content/LOP/researchpublications/mr131-e.htm
12 BC Ministry of Healthy Living and Sport (2009). Model Core Program Paper: Mental Health Promotion and Mental Disorders Prevention.
    www.health.gov.bc.ca/public-health/pdf/Mental_Health_Promotion_and_Mental_Disorders_Prevention-Model_Core_Program_Paper.pdf
13 Ibid.

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Two-Spirited
– Did You Know

Two-spirited is a term that has been chosen by First Nations peoples to reflect traditional sexual and gender diversity. Colonization brought Western social norms that have led two-spirited, lesbian, gay, bisexual, transgender, queer, questioning, intersex, and asexual people to experience stigma, discrimination, racism, sexism, cissexism (see Glossary), heterosexism, and homophobia, which all contribute to an increased risk of suicide for two-spirited and LGBTQIA First Nations and Aboriginal people. Two-spirited and LGBTQIA people are anywhere from two to fourteen times more likely to attempt suicide than people who do not identify as two-spirited or LGBTQIA.

Here are some strategies to promote social inclusion and reduce risk of suicide among two-spirited and LGBTQIA Aboriginal people:

As an organization and community

- Get involved in creating an organizational culture and advocate for institutional policies that facilitate a positive and safe culture for two-spirited and LGBTQIA people.
- Be assertive about the standards you expect for workplace relationships. Take anti-bullying training, provide training opportunities for others, and support the implementation of progressive policies in our workplaces
- Become familiar with the Canadian Human Rights Act. It has been in effect in First Nations communities (on-reserve) since June 2008, and it prohibits

As Individuals

- Learn about the contributions of LGBTQIA and/or two-spirited individuals in the community.
- Educate others about the history, role and traditions of LGBTQIA and/or two-spirited people.
- Create positive, affirming resources or safe spaces in the community for LBGTQIA and/or two-spirited people. These help young people to develop a positive self-concept and have positive impacts on the health of LGBTQIA and/or two-spirited people of all ages.
- Break the silence - talking about suicide and gender identity / sexual orientation to family members, friends, leaders, Elders and service providers to help overcome stigma.
- Develop supportive resources and help clients to access LGBTQIA and two-spirit organizations and inclusive spaces.
- Identify and provide access to positive LGBTQIA and/or two-spirited role models specific to the individual's culture and traditions.
- Provide queer competency training and implement anti-bullying policies in workplaces and school settings.

discrimination based on sexual orientation.
- Avoid assumptions – when inviting "spouses" to social activities, use the term "partners" instead - a more specific, and gender-inclusive term, which includes same gender couples.
- Include gender and sexual orientation topics in health, education, and employment meetings, workshops, and conferences.
- Recognize that diversity can only strengthen our communities and that it takes many voices to build a successful organization.

Resources:

- [Best Practices in Creating and Delivering LGBTQ Cultural Competency Training for Health and Social Service Agencies](#)
  (www.cancer-network.org/downloads/best_practices.pdf)
- [Qmunity Queer Competency Quick Information Sheet](#)
  (www.phabc.org/files/agm_2013/Queer_Competency_in_Health_Service_Provision.pdf)
- [Qmunity Queer Competency Training](#)
  (www.phabc.org/files/summer_school/2013/Presentations/Queer_Competency_Training.pdf)
- [Gay and Suicidal: Sexual and Gender Minorities and Suicide](#)
  (https://suicideinfo.ca/LinkClick.aspx?fileticket=88I4gNh0i5c%3D&tabid=563)

Suicide-related risk and protective factors for First Nations and Aboriginal people typically fall into four broad categories[14]:

Individual factors (also called psycho-biological factors) occur at the personal level and include family genetics, diagnosed or undiagnosed mental health problems (including depression, anxiety, and post-traumatic stress disorder), unresolved grief, substance use, low self-esteem, gender, and sexual orientation. In the First Nations Perspective on Wellness model on page 13, this would include "Core of Wellness" (the human being) as well as the emotional, mental, spiritual, and physical "Aspects of Wellness".

Situational factors are those related to the unique circumstances of an individual or a community (see below for examples of community-level situational factors). In the First Nations Perspective on Wellness model, situational factors would include both the "Values of Wellness" and "Relationships of Wellness" levels in the circle.

Socio-economic factors pertain to the social and financial resources available to an individual or a community. In the First Nations Perspective on Wellness model, this includes the social, economic and environmental aspects of the "Determinants of Wellness"- the fifth circle in the model.

Cultural factors pertain to the ways in which traditional practices and traditional knowledge influence or shape a person or community. This is the last "Determinant of Wellness" identified in the fifth circle of the First Nations Perspective on Wellness model.

What are community-level risk and protective factors for suicide?

Historically, suicide was rare amongst First Nations and Inuit. Today, not every community is affected by suicide in the same way. For example, between 1987 and 1992 more than half of the bands located in BC did not report any youth suicides. During that same time, 90% of youth suicides happened in less than 10% of the bands[15], suggesting that 90% of the communities had strong protective factors in place.

Just as there are risk and protective factors that can increase or decrease an individual's risk of suicide (discussed below), there are risk and protective factors at the community level as well. Communities have different histories, environments and current circumstances (situational, socio-economic and cultural factors), and this may change how they are impacted by suicide.

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14 Chemier, N.M. (1995). Suicide Among Aboriginal People: Royal Commission Report. Retrieved March 10, 2014 from: www.parl.gc.ca/Content/LOP/researchpublications/mr131-e.htm
15 Chandler, M.J. & Lalonde, C. (1998). Cultural Continuity as a Hedge Against Suicide in Canada's First Nations. Transcultural Psychiatry, 35,191-219

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Situational factors for First Nations and Aboriginal communities are often related to self-determination, which has been cited as the most important determinant of health among First Nations and Aboriginal people.[16]

> **Community-level situational factors related to reduced levels of suicide include:**
> • Bands taking steps to secure First Nations/Aboriginal title or their traditional lands;
> • Securing certain rights of self-government and some degree of community control;
> • Having some community-level control over educational services;
> • Having some community-level control over police and fire protection;
> • Having some community-level control over health service delivery;
> • Establishing officially recognized cultural facilities to preserve and enrich people's cultural lives;
> • Elected band councils composed of more than 50% women; and
> • Having a degree of community-level control over child and family services.[17/18]

Other community-level situational factors related to the determinants of health include access to health care (including fly-out hospitalizations), the degree of stability or number of disruptions faced by the community (such as "the 60's scoop" and residential schooling) and/or the availability of alcohol and other drugs in the community.[19]

Socio-economic factors for First Nations and Aboriginal communities are also closely related to the level of self-determination experienced by the community and the determinants of health. Self-determination has been shown to be a key element in improving community-level socio-economic conditions.[20] Socio-economic factors affect development across the life course: the circumstances in which infants are born, children develop and grow, youth learn to make healthy life choices, and adults foster their physical and mental health.[21] Improved community-level socio-economic factors can contribute to decreased levels of poverty, improved employment and educational opportunities, adequate housing and improved public health infrastructures (e.g. improved water quality and sanitation systems) all of which have been linked with improved health outcomes.[22]

16 Reading, C.L. & Wien, F. (2009). Health Inequalities and Social Determinants of Aboriginal Peoples' Health. Prince George, BC: National Collaborating Centre for Aboriginal Health.

17 Chandler, M.J. & LaLonde, C. (1998). Cultural Continuity as a Hedge Against Suicide in Canada's First Nations. Transcultural Psychiatry, 35, 191-219.

18 Chandler, M.J. & LaLonde, C.E. (2009). Cultural continuity as a moderator of suicide risk among Canada's First Nations. In L.J. Kirmayer and G.G. Valaskakis (Eds.) Healing Tradition: The Mental Health of Aboriginal Peoples in Canada. pp. 221-248. Vancouver BC: UBC Press

19 Chemier, N.M. (1995). Suicide Among Aboriginal People: Royal Commission Report. Retrieved March 10, 2014 from: www.parl.gc.ca/Content/LOP/researchpublications/mr131-e.htm

20 Cornell, S. (2006). Indigenous peoples, poverty and self-determination in Australia, New Zealand, Canada and the United States. Joint Occasional Papers on Native Affairs (JOPNA) No. 2006-02. Retrieved March 10, 2014 from: http://nnidatabase.org/db/attachments/text/JOPNAs/2006_CORNELL_JOPNA_indigenouspeoples.pdf

21 Reading J., & Halseth, R. (2013). Pathways to Improving Well-Being for Indigenous Peoples: How Living Conditions Decide Health. Prince George, BC: National Collaborating Centre for Aboriginal Health.

22 Reading, C.L. & Wien, F. (2009). Health Inequalities and Social Determinants of Aboriginal Peoples' Health. Prince George, BC: National Collaborating Centre for Aboriginal Health

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Cultural factors at the community level are also very important. When certain protective factors exist within a community, the risk of suicide appears to decrease.[23] Examples include:

- How much connection there is to traditional values and culture;
- The way recognition and support are given to youth as they become adults (e.g. coming of age ceremonies);
- Officially-recognized cultural facilities established within their communities to help preserve and enrich their cultural lives; and
- The role of Elders and Youth in decision-making.

Culture, traditional practices and traditional knowledge are important for suicide prevention, intervention and postvention among First Nations and Aboriginal people and communities. This includes wisdom from Elders, community pride, promotion of self-esteem and identity, and knowledge, languages and traditions.[24] Activities targeting multiple risk and protective factors working in multiple settings (home, school, workplace, and community) are likely to be more effective than activities based on a single approach.[25]

Cultural safety and community renewal approaches should also be emphasized when engaging in suicide prevention, intervention and postvention with First Nations and Aboriginal peoples.[26/27] In communities where there is a strong sense of culture, community ownership, and other protective factors, there can be much lower rates of suicide, and sometimes none at all.

LATERAL VIOLENCE:

Lateral Violence occurs within marginalized groups where members strike out at each other as a result of being oppressed. The oppressed become the oppressors of themselves and each other. Common behaviours that prevent positive change from occurring include gossiping, bullying, finger-pointing, backstabbing and shunning. (Kweykway Consulting - www.kweykway.ca/lateral-violence-in-first-nations-communities)

The intergeneratinal trauma, or the trauma of colonization that is passed down from generation to generation, is kept in place and perpetuated by lateral violence. Addressing lateral violence supports people in healing from intergenerational trauma and determining their own paths to wellness.

23 National Aboriginal Health Organization. (2005). Assessment and planning Toolkit for suicide prevention in First Nations communities. Retrieved from: www.naho.ca/documents/fnc/english/FNC_SuicidePreventionToolkit.pdf

24 Health Canada First Nations and Inuit Health Branch (n.d.) Acting on What We Know: Preventing Youth Suicide in First Nations. Retrieved April 2, 2014 from: www.hc-sc.gc.ca/fniah-spnia/alt_formats/fnihb-dgspni/pdf/pubs/suicide/prev_youth-jeunes-eng.pdf

25 BC Ministry of Healthy Living and Sport (2009). Core Public Health Functions for BC: Model Core Program Paper: Mental Health Promotion and Mental Disorders Prevention. www.health.gov.bc.ca/public-health/pdf/Mental_Health_Promotion_and_Mental_Disorders_Prevention-Model_Core_Program_Paper.pdf

26 Joshi, P., Damstrom-Albach, D., Ross, I., Hummel, C. (2009). Strengthening the Safety Net: A Report on the Suicide Prevention, Intervention and Postvention Initiative for BC. Retrieved July 20, 2013: http://suicidepipinitiative.files.wordpress.com/2009/05/suicide-pip-initiative-full-report.pdf

27 Chandler, M.J. & LaLonde, C.E. (2009). Cultural continuity as a moderator of suicide risk among Canada's First Nations. In L.J. Kirmayer and G.G. Valaskakis (Eds.) Healing Tradition: The Mental Health of Aboriginal Peoples in Canada. pp. 221-248. Vancouver BC: UBC Press

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What are individual-level risk and protective factors for suicide?

As mentioned above, "protective factors" can counter the influence of risk factors and support resilience. Overall emotional wellbeing and mental wellness is strongly connected with resilience. Resilience means being able to cope and adapt to life situations despite setbacks and disappointments and is a key factor in determining a person's ability to move past hardship. Individual-level protective factors include:

- positive self-esteem;
- strong cultural identity and affiliation;
- strong connection to the community, a sense of belonging;
- family harmony, strong family cohesiveness and involvement in family activities;
- good lines of communication within families so that all members feel understood and respected;
- a healthy lifestyle that includes eating healthy food, exercising and getting enough sleep;
- good relationships with friends and peers;
- success in school or work; and,
- opportunities to use skills and talents.

There are also factors at the level of the individual that are known to increase the likelihood of suicidal behaviour in some people. Individual-level risk factors include:

- negative physical and social environments – at home, school or in the community;
- negative developmental experiences in childhood and across the lifespan;
- a lack of positive relationships with parents, family members, friends and partners;
- problems with alcohol and/or other substances;
- a challenging chronic health condition such as Fetal Alcohol Spectrum Disorder;[28]
- a history of emotional, physical or sexual abuse;
- a friend/family member who attempted suicide and/or died by suicide;
- negative attitudes towards someone's gender or sexual orientation (e.g. Two-spirited people);
- poor school attendance or performance;
- previous suicide attempts;
- low self-esteem;
- insomnia;
- mental health problems, including depression, anxiety and post-traumatic stress disorder.

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28 Streissguth, A.P.,; Barr, H.M.,; Kogan, J. 7 Bookstein, F. (1996). Understanding the Occurrence of Secondary Disabilities in Clients With Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Effects (FAE). Final Report to the Centers for Disease Control and Prevention. Tech. Rep. No. 96-06. Seattle: University of Washington, Fetal Alcohol and Drug Unit.

How can I tell if someone is thinking about suicide?

There are warning signals that may appear in someone who is thinking about suicide. These signals can include:

- Talks about or threatens to hurt or kill themselves, or looks for ways to do it
- Says things like, "I wish that I were dead" or "Life is hopeless"
- Increases their use of alcohol or other drugs
- Mentions having no reason to live or no purpose in life
- Shows increased anxiety and changes in sleep patterns
- Demonstrates drastic changes in behaviour like giving away cherished or all personal possessions or excessive changes in spending habits
- Talks about feeling trapped - like there's no way out
- Expresses hopelessness about the future
- Withdraws from friends, family members or activities they enjoy
- Has experienced sudden losses (e.g. financial, relationship break-up, death of a loved one)
- Shows uncontrolled anger or suggests they want to seek revenge
- Engages in risky activities, seemingly without thinking about consequences
- Experiences dramatic changes in mood
- Has close family members or friends who have died by suicide

If you see several of these behaviours, especially the first one, it is important to take them seriously and try to get them help right away.

If you are in distress or are worried about someone in distress who may hurt themselves, call SUICIDE (1-800-784-2433) 24 hours a day to connect to a BC crisis line, without a wait or busy signal.

HOPE   HELP   HEALING

Survey and focus group respondents shared ways to strengthen cultural connections:

- Encourage participation in cultural practices relevant to your customs, values and beliefs (e.g. smudges, sweats, coming of age ceremonies, etc.)
- Promote the learning of traditional languages and names
- Organize community groups for practicing culture (e.g. dancing, singing, drumming)
- Involve Elders and promote their connections with youth and other community members

"Strengthening self-identity and pride: getting to know our collective history"

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How do these factors change throughout life?

A healthy start in early childhood is important for good mental wellness later in life. Other time periods in people's lives also can be very important to their mental health, especially times where there are major decisions to be made. Looking at how these decisions and time periods affect mental health is called the life-course approach.

Each stage in someone's life has points where they are more at risk. People can also be vulnerable when moving between stages (e.g., during the transition to school, the transition to adolescence, etc.). Each stage is also different for each person depending on the determinants of health that most affect them (e.g., gender, education and income).

Key stages include:

- Prenatal period (pregnancy)
- Infancy
- Early childhood
- Middle to late childhood
- Adolescence and young adulthood
- Middle adulthood
- Older adulthood

Having a new baby can be an exciting time for some women and a challenging time for others. Some women may experience post-partum depression following the birth of a new baby - a type of depression that is specific to women who have recently given birth. Although it doesn't happen often, there can be an increased risk of suicide for women who are experiencing a more severe form of post-partum depression known as post-partum psychosis. *Celebrating the Circle of Life, Coming back to Balance and Harmony: A guide to emotional health in pregnancy and early motherhood for Aboriginal women and their families* (www.perinatalservicesbc.ca/FamilyResources/CelebratingCircleLife/default.htm) may be a useful resource for helping women (and their families) adjust to the changes that pregnancy and having a baby can bring.

The life-course approach helps us to remember to look at the protective and risk factors that occur at every stage of life and at transition points. It also helps us to think about how people might experience their lives differently, because of the determinants of health that affect them.

Programs that support and maintain protective factors against suicide should be ongoing in order to positively reinforce wellness.

Now that you have learned about the determinants of health, risk factors and protective factors, and how these relate to suicide, we will talk about promising practices for how we can prevent and respond to suicide.

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By understanding the presence of risk factors in your community – and the types of individuals who may be in need of more support - you will be able to tailor your activities to try to reach these groups. Although everyone in your community should be engaged in your prevention activities as much as possible – it is important to try to reach those most at risk.

Stephen
Grade 1, Sts'ailes Community School

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Promising Practices for HOPE, HELP AND HEALING

You may prefer to describe your suicide prevention strategy as a "mental health" or "community wellness" promotion strategy.[29] This shift in focus frames your strategy as one that aims to improve individual and community wellbeing, as opposed to one that exclusively seeks to prevent or stop a behaviour from happening. The following guiding principles have been identified as important considerations when developing suicide prevention programs for First Nations and Aboriginal people:

- The program is community-based;

- There is a focus on children and youth;

- Suicide PIP may include emotional, mental, physical, spiritual and cultural dimensions of health and well-being;

- Programs that are long-term in focus are developed along with "crisis" responses. These programs are integrated within larger programs of health promotion, family and parenting supports, community and cultural development;

- Political suuport and empowerment. Many of the protective community and cultural factors rely on political support to enable and prioritize;

- Evaluations of programs are done; and

- Programs are locally-initiated, owned, and accountable, embodying the norms and values of First Nations/Aboriginal culture. However, useful participation with external partners should not be rejected if it can be helpful.[30]

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29 Kirmayer, L.J., Boothroyd, L.J., Laliberté, A., Laronde Simpson, B. (1999). Suicide Prevention and Mental Health Promotion in First Nations and Inuit Communities. Culture and Mental Health Research Unit Report No. 9. Montreal QC: Institute of Community and Family Psychiatry, Sir Mortimer B. Davis- Jewish General Hospital
30 Ibid.

Hope

Promising Practices for HOPE (Prevention)[31/32/33]

In prevention and healing, we look at increasing individual, family and community supports (protective factors) to reduce the risk of suicide. The more individuals and communities learn about these factors, the better able they will be to develop and start a suicide prevention and healing plan. Promising practices for suicide PIP can also occur at the individual, situational, socio-economic and cultural levels, although there is significant cross-over between these categories. Promising practices for suicide prevention may include:

PREVENTION: Enhancing Knowledge and Skills

Individual

- Building personal skills to learn about ways to promote positive mental, emotional and spiritual health; for example health literacy, nutrition, physical activity, healthy coping skills, positive relationship and parenting skills, budgeting and financial management training, among others

- Utilizing cultural practices and teachings as a source of healthy ways of coping and building on strengths

- Learning how to recognize the signs of mental distress or suicidal behaviour

Cultural

- Providing educational and training opportunities to increase personal skills, knowledge and awareness of mental wellness issues

- Family life education and parenting skills workshops for new parents and adults based on culturally sensitive models of roles and responsibilities

- Encouraging the development of recreation/sports programs to promote a sense of belonging and social support as well as physical and mental health

- Implementing school, workplace and community peer-helping programs, that include training regarding when and where to refer peers for additional support

- Implementing school-based health education curriculum to enhance students' ability to cope with stress or distressing emotions (especially anger and depression), problem solving, interpersonal communication, healthy relationships and conflict resolution – all measures that help to build self-esteem and deal with emotional conflict and crisis

- Promoting community and school-based anti-bullying programs; including cyber-bullying prevention

31 Fraser Region Collaborative Partnership Response to Youth Suicide (2012). Fraser Region Aboriginal Youth Suicide Prevention Collaborative: Suicide Prevention, Intervention and Postvention Initiative. Retrieved from: www.fraserhealth.ca/media/AH_suicide-prevention.pdf
32 National Aboriginal Health Organization (2005). Assessment and Planning Tool Kit for Suicide Prevention in First Nations Communities. Retrieved from: www.naho.ca/documents/fnc/english/FNC_SuicidePreventionToolkit.pdf
33 Health Canada First Nations and Inuit Health Branch (n.d.) Acting on What We Know: Preventing Youth Suicide in First Nations. Retrieved April 2, 2014 from: www.hc-sc.gc.ca/fniah-spnia/alt_formats/fnihb-dgspni/pdf/pubs/suicide/prev_youth-jeunes-eng.pdf

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PREVENTION: Strengthening Social and Health Supports

Individual/Cultural

- Counselling or psychotherapy that focuses on holistic wellness, including community protective factors; community/individual well-being; and renewing the person's sense of power, self-worth and self-confidence

- Creating opportunities for community members to express their concerns and interests and discuss issues of mental well-being and suicide openly (e.g. Council or community meetings and gatherings)

- Providing community level adult suicide awareness programs, including education and basic training to: **ASK** directly; **LISTEN** attentively, be curious, don't judge; and **GET HELP**, involve others – Elders/spiritual leaders, cultural supports, community services, counselors.

- Support groups for families/people at-risk for poor mental health and suicide (e.g. young mothers and fathers, people recovering from chronic substance use problems, ex-offenders)

- Providing community-based opportunities for cultural ceremonies and gatherings, as well as access to traditional healing and cultural interventions such as talking circles to address inter-generational trauma and its effects

Situational/Socioeconomic

- Addressing the determinants of health and well-being, including access to safe and affordable housing, sufficient income and educational opportunities, availability of nutritious, affordable food sources including access to traditional foods

- Collaborating with other groups for service integration and resource sharing (health, education, etc.) by building on common themes of honesty, safety, respect and communication. Invite Elders, families, and if possible, suicide survivors to provide input

- Addressing longstanding jurisdictional and funding barriers[34]

- Expanding opportunities for social enterprise and employment in community

- Providing opportunities for education and employment skills training

- Increase access to a range of mental health and social services

- Increasing availability and accessibility of substance use treatment programs

- Increasing screening and early identification programs for mental health problems

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34 Child and Youth Officers for British Columbia. (2006). Sayt K'uulm Goot – Of One Heart – Preventing Aboriginal Youth Suicide through Youth and Community Engagement. Victoria: Child and Youth Officer for British Columbia

<div style="text-align:right"></div>

System

- Enabling counselling services that are available in youth friendly places (youth clubs/drop in centers) to allow for easy access without stigma of having to attend formal sites

- Training lay and professional helpers in mental health promotion

- Increasing access to training for primary care providers (nurses, physicians, social workers, etc.) in the early detection and treatment of depression, anxiety disorders, substance use, and psychiatric disorders

- Increasing access to cultural competency training for health care providers (helpful resources may include the Health Professionals Working with First Nations, Inuit and Métis Consensus Guidelines (http://sogc.org/wp-content/uploads/2013/06/gui293CPG1306E.pdf) and the Practice Support Guidelines for Mental Health (www.bcguidelines.ca/submenu_mental.html))

- In so far as possible, ensuring that helping professionals are trained in recommended best practice therapies; particularly Cognitive Behavior Therapy (CBT) which supports the individual in adjusting their thinking and behaviour and identifies links to emotions

PREVENTION: Addressing Safety

Community

- Supporting the development of comprehensive, community-based mental wellness plans and emergency response protocols

System

- Involving Elders and adults in restricting access to the means of suicide (e.g., tighter control and storage of guns, other weapons, potential toxins and medications in the community including cleaning supplies, herbicides, pesticides, etc.)

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PREVENTION: Building Relationships

Community-level

- Addressing the stigma of suicide. Reducing stigma will decrease individuals' fear of telling others and will help them to reach out for assistance. This Suicide Awareness (www.bcguidelines.ca/ submenu_ mental.html) handout has a brief section on stigma and other good suicide information in an friendly format

- Developing strategies for maintaining long-term (even if infrequent) contact between vulnerable people and health care professionals

PREVENTION: Fostering Cultural Connections

Individual/Community

- Involving cultural leaders, Elders, youth and suicide survivors in prevention planning activities

- Connecting youth with traditional culture practices, teachings and spirituality

- Cultural programs and activities for the community at large (e.g., recording and transmitting the traditions of Elders, camping, ceremonial feasts, First Nations language courses)

- Incorporating cultural teachings and practices into mental health promotion programs that aim to reduce the stigma of suicide and mental health concerns and increase resiliency

System

- Consistent incorporation of local culture into prevention programs

- Opportunities for culturally relevant early childhood education and lifelong opportunities to engage with cultural and traditional practices

- Developing age-specific programs for children and youth that focuses on the cultural beliefs and teachings regarding respect for each other and for life, suicide awareness, and that explains the permanency of death

- Accessing existing training for primary care providers in cultural competency (e.g., Indigenous Cultural Competency (www.culturalcompetency.ca) training)

For more information see the *Planning Tools and Templates* section in *Appendix 3* (pg. 173) at the end of this toolkit.

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Leah
Jaffray Elementary School

Links to additional resources

If you are interested in further information about Prevention, here are some helpful resources:

- Aboriginal Resource Toolkit: Inuit, Aboriginal, First Nations, Metis Suicide Prevention Resource Toolkit (Centre for Suicide Prevention, 2013)

- Adolescent Suicide Prevention Program Manual: A Public Health Model for Native American Communities (Serna, 2011)

- Darkness Calls (Healthy Aboriginal Network, 2006)

- Just a Story (Breaking down the stigma of mental health) (Keewatin Sanderson, 2009). Available at: www.thehealthyaboriginal.net/comics/js.pdf Numerous comic books addressing various risk factors are also available at this site.

- Miyupimaatisiiuwin Wellness Curriculum (MWC). A Canadian school-based suicide prevention program to promote a wide range of healthy lifestyle choices to counteract the long-term incidence of suicide, as well as substance use and violence. It focuses on "wellness" and targets children from kindergarten to Grade 8. This holistic program emphasizes Aboriginal culture and was developed with the Cree community to encourage active participation of the family and community.

- Preventing Youth Suicide: A Guide for Practitioners (White, 2013).

- Promising Strategies. Aboriginal Youth: A Manual of Promising Suicide Prevention Strategies (White & Jodoin, 2004)

- Suicide Prevention and Mental Health Promotion in First Nations and Inuit Communities (Native Mental Health Research Team, 1999)

Help
Promising Practices for HELP (Intervention)[35/36/37/38]

The help given to individuals who are struggling with suicidal thoughts, behaviour and/or attempts is referred to as suicide intervention, and includes the immediate support provided and follow up services. Interested and willing individuals can be trained to provide effective help. Though we know that not everyone who receives support will choose life, most do; making the work of suicide intervention fulfilling, rewarding and necessary! We encourage you to select ideas that fit the community's needs, and weave cultural traditions and community teachings throughout your suicide intervention activities. Promising practices for suicide intervention may include:

INTERVENTION: Enhancing Knowledge and Skills

Individual

- Increasing healthy coping skills (e.g. seeking social support, eating well, moving your body, sleeping well, using relaxation techniques, finding humor in daily life, singing, dancing, writing, drumming, or talking to a friend or loved one), increasing problem solving skills

Community

- Providing family support programs and resources to parents and family members of suicidal children or adolescents. (Though often Manitoba specific information is cited, "After a Suicide Attempt: A Guide for Family and Friends" (www.klinic.mb.ca/docs/booklets/Klinic%20After%20Suicide%20Attempt%20WEB.pdf) provides excellent supportive information, specifically the sections on "Support for You", "Caring for Yourself" and "What You Can Do to Help"

- Providing cultural and community supports and counselling programs to educate and support family members and friends of those struggling with suicide.

System

- Ensuring important follow up supports are in place for the suicidal individual. This could include meeting with Elders, spiritual leaders and/or traditional healers willing to support a person struggling with suicide

- Providing educational programs to support youth/peers to recognize and respond to friends struggling with suicide by connecting them to adult supports

- Accessing/connecting with existing training for primary care providers (nurses, physicians, social workers, etc.) in suicide risk detection and crisis intervention

- Developing assessment and intervention services for parents of youth at risk (e.g., individual, couple or family interventions for substance use, family violence, effects of residential school experiences etc.)

35 Fraser Region Collaborative Partnership Response to Youth Suicide (2012). Fraser Region Aboriginal Youth Suicide Prevention Collaborative: Suicide Prevention, Intervention and Postvention Initiative. Retrieved from: www.fraserhealth.ca/media/AH_suicide-prevention.pdf

36 National Aboriginal Health Organization (2005). Assessment and Planning Tool Kit for Suicide Prevention in First Nations Communities. Retrieved from: www.naho.ca/documents/fnc/english/FNC_SuicidePreventionToolkit.pdf

37 Kirmayer, L.J. Hayton, B., Malus, M., Jimenez, V., Dufour, R., Quesney, C., Ternar, Y., Yu, T., & Ferrara, N. (199-). Suicide in Canadian Aboriginal Populations: Emerging Trends in Research and Intervention: A Report Prepared for the Royal Commission on Aboriginal Peoples. Culture and Mental Health Research Unit Report No. 1. Montreal QC: Institute of Community and Family Psychiatry, Sir Mortimer B. Davis- Jewish General Hospital & Division of Social and Transcultural Psychiatry, Department of Psychiatry, McGill University.

38 Health Canada First Nations and Inuit Health Branch (n.d.) Acting on What We Know: Preventing Youth Suicide in First Nations. Retrieved April 2, 2014 from: www.hc-sc.gc.ca/fniah-spnia/alt_formats/fnihb-dgspni/pdf/pubs/suicide/prev_youth-jeunes-eng.pdf

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INTERVENTION: Strengthening Health and Social Supports

Individual

• A safe response involves reducing the risk of suicide for an individual by interrupting his or her suicide plan, accessing supports to address his/her reasons for suicide and increasing protective factors

Community/System

• Encouraging culturally sensitive use of professional counselling techniques which have been found especially helpful for children, youth, and vulnerable/high risk populations; and are showing promising outcomes for all ages

• Providing phone or video-conference counseling for individuals living in remote locations (e.g. connect with local health authority mental health and substance use team)

• Ensuring access to proper medicines (e.g., for depression, anxiety, Post Traumatic Stress Disorder (PTSD))

• Providing Community Gatekeeper Training to teach key people in the community how to recognize and respond to the early warning signs of suicide, including how to do a basic suicide risk assessment (see pg. 44), and making appropriate referrals

• Safe response involves reducing the risk of suicide by interrupting their suicide plan, accessing supports to address their reasons for suicide and increasing protective factors

• Training of key community members (e.g., Community Health Representatives, nurses, counsellors) to provide thorough suicide risk assessments (see pg. 44), including documentation and transmittal of pertinent information to health care services

• Develop linkages with non-local hospital/specialized services to ensure community caregivers are included in discharge plans and coordination occurs to enable smooth transition back to the community

• ASIST (Applied Suicide Intervention Skills Training) is a standardized internationally recognized 2-day training model for providing immediate suicide intervention

• Planning specific training for frontline workers who work with youth from ages 15-24- River of Life (http://riveroflifeprogram.ca/) is an online course developed by the Centre for Suicide Prevention to address Aboriginal Youth Suicide. The course is self-paced and takes approximately 20 - 24 hours to complete. A certification of completion is available

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Community/System con't

• Creating a suicide crisis response team to provide culturally and community appropriate 24/7 telephone and/or mobile suicide intervention and/or postvention response

• Using resources to assist in the discussion of suicide when engaging children and/or youth. Darkness Calls, a comic book originally produced in 2006 by Healthy Aboriginal Network unfortunately is no longer in print. However, copies can be accessed via the following link, in pdf from (www.turtleisland.org/healing/abcomic1.pdf). A further excellent resource is a video on YouTube (www.youtube.com/playlist?list=PLAFACC4E6C54DCFED) that is presented in the traditional language of the Gitxsan (with subtitles)

• Ensuring confidential crisis/distress hotlines are available in your area. Have information of your community's contacts in order to assist in a quick intervention

• Creating community-based mental health emergency response plans and intervention (critical incident response) protocol

• Ensuring accessible and integrated mental health programs and services that provide continuous/coordinated care and follow-up

• Planning holistic community suicide intervention response needs to include intervention services for the Elderly. Often it will be in-home support service workers who will be first aware of Elders struggling with suicide. Though not Aboriginal specific, helpful information can be discovered at the Centre for Suicide Prevention Resource Toolkit, Plus 65 At the end of the day (http://suicideinfo.ca/LinkClick.aspx?fileticket=cmFwRL4DMJw=)

• Locating children and youth-serving counseling services in youth friendly settings where young people meet may increase the likelihood of them accessing such services

Questions for a more thorough suicide risk assessment:

- How long have they been considering suicide?

- Is it simply a wish that they could die, or an established thought?

- How frequent, and for how long, do they think about killing themselves?

- Do they have multiple plans by which to die?

- How lethal are their plans/what is the likelihood that they would die?

- How available is what they need to die? Have they gathered what they need to suicide?

- Have they been practising?

- Where do they plan on suiciding?

- Do they have an exact date to suicide? Is the date based on an event occurring, or not occurring?

- If they attempted in the past, how lethal was their attempt and what was the likelihood of them being discovered prior to dying?

- How alone are they? What are their resources/connections to others for support?

Questions for a basic suicide risk assessment:

- How does the individual plan to die?

- How prepared are they to carry out their plan?

- When do they plan on suiciding?

- Have they attempted before?

- Do they have close family members or friends who have made a serious attempt and/or died by suicide?

- Any previous or current mental health concerns for the individual or within their family?

- Have they received prior counseling or treatment? To what degree was it effective?

- List their risk and protective factors.

- How willing are they to receive support?

- What cultural and/or community supports are available to support the individual?

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INTERVENTION: Addressing Safety

Individual

- Developing a list of reasons for living. This can include things like people the individual loves, enjoys doing, places to see, want to do, friends and family you care about, pets, cultural and spiritual values and beliefs. For ideas of what has kept other people alive, see: www.1000reasonstolive.org/list.php

- Reading stories written by others who have made a suicide attempt and chose life at Reasons to go on Living Project (www.thereasons.ca/stories.php#stories)

- Attending community based, culturally informed support groups for those struggling with suicide

Community

- Providing emergency cards that list local cultural and community supports, emergency contacts (e.g. Elders/spiritual leaders/traditional healers/suicide survivors who are willing to speak with persons at risk of suicide), Wellness programs, Transition Shelters, National Native Alcohol and Drug Abuse Program (NNADAP) workers, Community Health Representatives, local crisis lines/programs and 24 hr. emergency services, including 1-800-SUICIDE (1-800-784-2433)

- Providing Emergency cards as above that appeal to youth and children, including links to Honouring Life Network: Aboriginal Youth Suicide Prevention Resources (www.honouringlife.ca/) and Youth in BC (http://youthinbc.com/)

System

- Improving the skills of health workers and community members in detection and crisis intervention (see Strengthening Health and Social Supports section)

- Ensuring immediate availability of crisis intervention for those at acute risk

- Targeting people who attempt suicide and enrolling them in a suicide prevention/aftercare program could reduce the likelihood of future attempts

- Introducing safety planning and helping the person at risk of suicide develop their personalized Safety Plan. For more information on how to develop a Safety Plan and when to use it, see pg. 50

HOPE HELP HEALING

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INTERVENTION: Building Relationships

Community/System

- Developing strategies for maintaining long-term (even if infrequent) contact between vulnerable people and health care professionals

- Building collaboration between First Nation communities and local health/emergency services to ensure suicidal individuals receive respectful and culturally competent care

INTERVENTION: Fostering Connections with Culture

Community/System

- Having Elders as part of the community-based emergency response team to provide cultural teachings and interventions when appropriate

- Developing a crisis centre or other designated safe or "time out" space. This can be based in the community or in an adjoining community to provide an opportunity for intensive intervention. It can be staffed by helpers such as Elders, traditional healers with mental health and cultural/traditional professional assistance if available

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HOPE HELP HEALING

Creating a Safety Plan

Whether it is you or someone you care about who is struggling with suicide, having a safety plan helps.

1. What three things can I do to have fun and relax?

2. What friends can I call when I am starting to feel sad or worried?

3. What are my reasons for living? (Include cultural teachings that promote life)

4. Who are my trusted resources I can call if I don't feel better after talking with friends? (Like an Elder or spiritual leader, Community Health Representative, youth worker) Include their phone numbers.

5. Where I can go that I feel safe from suicide? (Maybe a friend's home, a local basketball court, a grandparent's home.)

6. What local professional can I call or go see? (Someone similar to a counsellor, NNADAP worker, school staff, doctor.)

7. What are my local crisis lines & suicide safe websites that I would use? Include 1-800-SUICIDE/1-800-784-2433, and one or two of the following:

- 1-877-209-1266 (Native Youth Crisis Hotline)

- 310-6789 (Mental Health Support Line)

- Honouring Life (www.honouringlife.ca/) (youth friendly)

- Youth In BC (www.youthinbc.com) (youth friendly)

- Here to Help (www.heretohelp.bc.ca/) (provides information on a number of mental health issues, including suicide)

8. What are my local emergency services and how do I contact them?

Carry your Safety Plan with you. Having a Safety Plan lets you know what you are going to do when you feel unsafe.

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How it works: When you begin to feel sad, worried, blue….

- Start at #1.

- If #1 doesn't help, then do #2.

- If you are still thinking about suicide, then remind yourself of your reasons for living.

- Continue with #3 - 7 as needed

- If you have done #1 to #7 and still are thinking about suicide or feeling an urge, then call your local emergency service - such as 911 or ambulance - or go to the hospital immediately.

For more information see the Planning Tools and Templates section in Appendix 3 (pg. 173) at the end of this toolkit.

Links to additional resources

If you are interested in further information about Intervention:

- *Coping With Suicidal Thoughts* **(Centre for Applied Research in Mental Health and Addiction, 2007)**

- *Working With a Client Who is Suicidal: A Toolkit for Adult Mental Health and Addiction Services* **(Centre for Applied Research in Mental Health and Addictions, 2007)**

- *Working With the Suicidal Patient: A Guide for Health Professionals* **(Centre for Applied Research in Mental Health and Addictions, 2007)**

Individuals can also find healing and support from those close to them. Friends and family in particular can be very valuable in the healing process. Ways that friends and family members can help include:

- Listen and respond with empathy

- Know when the person needs to talk of his or her loss

- Serve as a sounding board for emotional relief

- Provide a safety-valve for relief and expression of feelings

- Help with concerns relating to other family members

- Help in practical ways (e.g., cleaning the house)

- Suggest professional help when appropriate

HOPE HELP HEALING

Healing

Promising Practices for HEALING (Postvention)

Suicide postvention refers to support for those grieving from a death by suicide. Postvention involves all activities undertaken after a death occurs. This includes addressing traumatic after-effects among survivors, grief and trauma recovery and education to reduce the risk of more suicides. Because post-vention helps people to grieve and heal from their loss, it can also serve to prevent further suicides from occurring.

Limited research and literature is available in the area of promising practices for postvention services; and no research is available to provide best practice recommendations. The following combines what is available for promising practices, and makes some additional suggestions. Postvention approaches may include:

POSTVENTION: Individual-level actions

Individual

- Participating in cultural, traditional and spiritual ceremonies that supports the grieving process and promotes individual, family and community healing

- Practicing self-reflective such as writing in a journal, writing a letter to the deceased, meditation

- Being creative with art forms such as beading, drumming, painting, carving, weaving, knitting, etc.

- Exercising to release endorphins which helps to feel better - even a walk around the block will help

- Joining a group activity that focuses an individual beyond his or herself

- Seeking support when needed (e.g., from Elders, friends/family, doctors, counsellors, traditional healers etc.)

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POSTVENTION: Enhancing Knowledge and Skills

Community

- Developing and hosting community, workplace, school and/or youth educational workshops addressing suicide grief; and providing informational packages and crisis numbers

- Developing community guidelines and protocols for media releases and how local media can report on suicide. To reduce the likelihood of copycat behaviour:
  - o Avoid reporting on details of the method of suicide; sensationalizing or romanticizing accounts of the death; printing the story on the front cover; using the word "suicide" in the headline; or printing a picture of the person who died by suicide
  - o Include suicide awareness education; suggestions for healthy coping strategies; community resources; cultural teachings that promote life
  - o Further information available at:
    http://suicideprevention.ca/media-guidelines-2/

- Developing a community based suicide postvention response plan incorporating suicide crisis response and bereavement support. Having a well-crafted plan increases the likelihood that suicide survivors are supported in a manner that encourages healing and wellness; and reduces the likelihood of further suicides.

- Sharing key teachings to support suicide survivors:
  - o There is no right or wrong way to grieve
  - o No matter the exact nature of their grief response, they are having a normal reaction to a traumatic event
  - o How a person dies does not define who the individual was or the relationship the survivor had with them
  - o Suicide does not negate or take away the love that was between the survivor and the one who died

- Providing a list to survivors of local bereavement programs/services and resources containing information similar to this Manitoba based booklet, "After a Suicide: A Practical and Personal Guide for Suicide Survivors" (www.klinic.mb.ca/docs/booklets/After_a_Suicide_-_A_Practical_and_Personal_Guuide_for_Survivors.pdf)

System

- Identifying suicide postvention roles and responsibilities of local emergency services, counsellors, service providers, Elders, traditional healers and spiritual leaders which reduces duplication of service and ensures all survivors are provided with necessary support

- Collaborating with work/school representatives to support survivors in returning to work/school by identifying site supports, creating a time out space, and developing a gradual return to work/school schedule

HOPE HELP HEALING

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POSTVENTION: Strengthening Health and Social Supports

Community

- Whenever possible, including suicide survivors in the development of community-based postvention response plans and activities

- Training local support staff, counselors and service responders in suicide postvention response including the provision of trauma, grief and follow up suicide bereavement support

- Providing counselling and support groups for the bereaved (those grieving) and identifying among them those who may be at risk for suicide themselves

- Identifying opportunities to strengthen community response

- Supporting access to substance use treatment programs

- Supporting and caring for front line workers

- Providing outreach to schools who have lost a member of their school community to suicide

- Developing Postvention (response) protocols

- Developing resource packages/pamphlets outlining community based bereavement and counselling services, including contact information for community responders, local crisis programs, internet based services and 1-800 numbers

System

- Utilizing Critical Incident Stress Management (CISM) activities that can support healing following a traumatic incident, including but not limited to, formal and informal debriefings and response evaluation. Debriefings can be likened to a structured talking circle that provides education and a safe location for a group of individuals to address the facts, thoughts and feelings regarding a traumatic incident. Information on CISM training can be accessed through the Programs and Courses link at the Justice Institute of BC (www.jibc.ca/)

- Collaborating to establish or enhance school district protocols outlining postvention activities. "After a Suicide: Toolkit for Schools" (www.sprc.org/sites/sprc.org/files/library/AfteraSuicide ToolkitforSchools.pdf?sid=35690) has been developed by the American Association of Suicidology and is available through the Canadian Association for Suicide Prevention

- Training local service providers and community helpers in suicide postvention provision including:

    o The traumatic nature of suicide

    o Typical death responses, (e.g., shock, disbelief, numbness, denial, sadness)

    o Suicide death responses not typically felt with other types of death, (e.g., shame, blame, extreme guilt, unworthiness, intense feelings of abandonment)

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POSTVENTION: Addressing Safety

Community

- Conducting a compassionate and sensitive suicide risk assessment and, if needed, developing a safety plan. Suicide survivors may be asked directly if they are considering suicide. A gentle way to begin this conversation is by asking:

    o "I know that your loved one died by suicide and this must be very difficult and overwhelming. Sometimes when others experience the suicide of someone they love, they think about taking their own life. I am just wondering if you are thinking about suicide?"

- Seeking help from the family members and close friends of the person who died in identifying others who might now be at increased risk for suicide, (e.g., romantic partners, close friends, individuals who have attempted suicide in the past, those who closely identify with the person who suicided)

- "Journey to Healing: Suicide Postvention for Supporting Aboriginal Youth" examines the effects of suicide deaths on bereaved youth in the hope of developing effective community-based postvention supports. The training incorporates the Left 2 Live video documentary wherein bereaved youth discuss the impact of the suicide death of a close family member or friend. The project brings youth workers, service providers, community and youth leaders, Elders, school personnel, and others together to find ways to help affected youth in the after-math of a suicide that honours and respects the community's traditional practices. The ultimate goal of the training is to prevent adverse mental health effects for bereaved and vulnerable youth, reduce suicide contagion, and strengthen community capacity

System

- Educating service providers on suicide clusters and addressing contagion (e.g., copycat behavior). See these school-based suggestions (www.nasponline.org/resources/principals/Suicide_Clusters_NASSP_ Sept_%2009.pdf) to address contagion. The information could be adapted to most environments.

HOPE HELP HEALING

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POSTVENTION: Building Relationships

Individual

- Ensuring follow up services are provided to the close family members and friends of the person who died by suicide, and to vulnerable/high risk individuals

- Determining ways to identify individuals who are particularly vulnerable or at higher risk of suicide and ensuring they receive a minimum of one suicide screening interview with a trainer counselor, and referred for further support as needed

- Providing in-home, strength-based family support to the immediate family including grief and childcare support

- Assisting the family with advising children, teens and others in an age appropriate and non-traumatizing manner acknowledging the death as a suicide

- Implementing group therapy - this is showing promise as an effective suicide postvention practice

- Encouraging the development of survivor groups where suicide survivors provide peer support to each other; have an Elder/spiritual leader and a mental wellness worker attend the meetings to provide spiritual support and support the grieving process

- Providing immediate grief and trauma support to the family and close friends of the lost loved one

POSTVENTION: Fostering Connections with Culture

Individual

- Involving Elders and knowledge keepers in the development and provision of community-level postvention responses to ensure inclusion of traditional healing practices and cultural teachings

- Planning community-wide grieving and healing ceremonies and/or programs

- Arranging community talking circles to address suicide grief. Include Elders/spiritual leaders to address cultural/faith issues, and a counselor to provide grief education. Having printed information available that includes community based supports and crisis contacts

For more information see the *Planning Tools and Templates* section in *Appendix 3 (pg. 173)* at the end of this toolkit.

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Links to additional resources

If you are interested in further information about postvention:

- A Guide for Early Responders Supporting Survivors Bereaved by Suicide
(Winnipeg Suicide Prevention Network)

- After a Suicide: A Practical and Personal Guide for Survivors
(Klinic Community Health Center)

- CDC Recommendations for a Community Plan for the Prevention and Containment of Suicide Clusters (US Department of Health and Human Services, 1988)
(may require modifications to be more culturally relevant)

- Health Support Services for Former Indian Residential School Students
(Truth and Reconciliation Commission of Canada)

- Hope and Healing: A Practical Guide for Survivors of Suicide
(Centre for Applied Research in Mental Health and Addiction)

- Media Guidelines and Social Marketing (Canadian Association for Suicide Prevention)

- Principles for Providing Postvention Responses to Individuals, Families and Communities Following a Suicide Death (Queensland Government, 2008)

- Suicide Postvention is Prevention: A Proactive Planning Workbook for Community Affected by Youth Suicide. (2005) Available for purchase from BC Council for Families (www.bccf.ca/)

- Suicide Postvention Toolkit: A Guide for Secondary Schools (Headspace, 2012)

Responding to Critical Incidents

Although this toolkit is mostly about planning for suicide prevention, a community may have a parallel need to plan for how to respond when a suicide attempt has been made, or when a community member has died by suicide. Some communities choose to create a Volunteer Suicide Response Team (VSRT) - a team of volunteers trained in suicide intervention, and telephone and/or mobile response (for more information of VSRTs, see pg. 95). Other communities develop response protocols that set out who will respond, who else will need to be involved and provide a 'roadmap' for the steps that will need to take place during the response (see pg. 106). Some communities may have both Volunteer Suicide Response teams and response protocols already in place; other communities may have neither. Depending on your community's needs and existing critical incidence response resources, you may find the information in the Planning Tools and Templates section helpful.

Gathering

Maria
Grade 2, Jaffray Elementary School

Section 3: Gathering
Tools and processes to bring a committee together, determine your community's needs and gather local data.

Learning Checklist
☐ Learn about a common planning process (steps).

☐ Review tools to help you organize a planning committee and other meetings.

☐ Become familiar with planning tools and resources.

☐ Collect data about suicide in your community.

☐ Identify existing suicide-related programs and resources in your community.

Resources (Tools)
• Multiple planning templates with examples that will be helpful to your PIP planning process.

• Internet reference links to provide more information to communities on one of the steps.

Preparing to Plan

Planning for suicide prevention, intervention and postvention can seem like a big job. To support your work please read through the planning section. You will see many examples you can use in your own planning process.

Planning answers these questions:

1. Where are we now? What is the current and historical information on the issue?

2. Where do we want to go to strengthen our community? What opportunities exist to do so? What gaps must we overcome?

3. How will we get there? What are our priorities, what steps do we take, and by when?

PLAN
Form your committee

ASSESS
Gather and analyze data and identify needs

SHARE
Engage the broader community to confirm you're on the right path

WRITE YOUR PLAN
Develop the plan to meet your needs

ACT & REFLECT
Implement your plan and evaluate plan's progress

On the next page you will find a Suicide PIP plan template as well as a checklist of the steps you will go through to complete YOUR plan. Blank copies of most of the tools and templates presented in this toolkit can be found in *Appendix 3 Planning Tools and Templates* (pg. 173).

The template below provides you with an example of the CONTENTS of your Suicide PIP Plan. Having this template up-front in this planning process can help paint a picture of the steps (tasks) you will need to do to develop your plan.

HOPE HELP HEALING

Suicide PIP Plan Template Sample

Cover Page	• Your community's name and a title that will inspire action.
Acknowledgements	• Acknowledge your planning team and others who helped. • List your Committee members who came together to help out.
Table of Contents	• A list of each section of the plan and its page number.
Section 1 Introduction	• State why suicide PIP is important to your community. • Briefly describe the steps you took to develop the plan and who was involved. • Describe who suicide affects in your community and why.
Section 2 What our community thinks and knows about suicide	• Include information you have gathered from your Committee members and others, any relevant statistics (numbers) you might have, and past experiences in your community around suicide. • Any facts, figures or stories relevant to this topic.

Section 3 - PIP Description of Community Resources and Gaps	
HOPE (PREVENTION) Describe what your community has in place as fully as possible.	• Use the information your committee came up with when using the tools and templates in the toolkit. You can use the titles provided in the circles or create your own (e.g., Peer Counselling, Cultural Programs). • Add in other information you gathered about the strengths and weaknesses of these services, strategies or activities. This may include: is it being measured / monitored / reported anywhere? **Identify GAPS in this area your team thinks exist:** • Existing activities that could be improved (e.g. building in data gathering and evaluation to improve a service). • Activities that don't exist in your community yet. • Describe these strategies, services, programs or activities your team thinks could fill in these gaps.
HELP (INTERVENTION) Describe what your community has as fully as possible.	*Same as above*
HEALING (POSTVENTION) Describe what your community has as fully as possible.	*Same as above*

Section 4 - PIP Action Plan to Address Community Gaps			
PREVENTION	**Key Actions**	**Timeline**	**Responsibility**
	What should be done?	By when?	Who will do it
INTERVENTION	**Key Actions**	**Timeline**	**Responsibility**
POSTVENTION	**Key Actions**	**Timeline**	**Responsibility**

HOW TO WRITE YOUR PLAN

1. Set up your Coordinating Committee or use an existing group if one is already in place and is a good fit for the work.

2. Hold your first meeting - develop an agenda. Develop terms of reference.

3. Talk about rules around confidentiality and develop confidentiality agreement for committee members.

4. Assess how ready the community is to deal with the issue of suicide if your committee thinks this is needed to decide where to start (optional).

5. Develop your work-plan and budget to support your work.

> **TOOLS TO SUPPORT YOUR PLANNING**
>
> **Tool 3.1:** Template to Set Up your Coordinating Committee
>
> **Tool 3.2:** Draft Agenda for Your First Coordinating Committee Meeting
>
> **Tool 3.3:** Draft Terms of Reference Example for the Coordinating Committee
>
> **Tool 3.4:** Sample Confidentiality Agreement
>
> **Tool 3.5:** Draft Budget Template for Coordinating Committee
>
> **Tool 3.6:** Example of a Letter to Chief and Council, Health Board or Health Council

FINDING OUT WHAT IS AVAILABLE NOW IN YOUR COMMUNITY

6. Talk to the community about the planning effort (engage them).

7. Develop a community information gathering template (e.g., identify what information is needed and who will get it, and by when).

8. Analyze the information and identify gaps.

9. Hold a planning meeting with the committee to prioritize the gaps.

> **TOOLS TO SUPPORT YOUR PLANNING**
>
> **Tool 3.7:** Community Readiness Assessment Example
>
> **Tool 3.8:** Community Information Gathering Template
>
> **Tool 3.9:** Identifying Strengths and Gaps in your Community
>
> **Tool 3.10:** Analysis of Information
>
> **Tool 3.11:** Prioritize Your Issues and Needs Template
>
> **Tool 3.12:** Sample Workplan

SHARE YOUR INTENTIONS

10. Engage your community in a discussion to confirm you're headed in a good direction.

WRITE YOUR PLAN

11. Write your draft suicide PIP plan.

12. Consult on your draft plan.

13. Determine your implementation budget.

14. Get your plan approved/endorsed.

TOOLS TO SUPPORT YOUR PLANNING

Tool 4.1: Workplan Tasks and Actions

Tool 4.2: Monitoring and Reporting on the PIP Plan Implementation

IMPLEMENTING & EVALUATING YOUR PLAN

15. Develop an evaluation strategy.

16. Develop work-plans for each project or program and develop a budget (look for funding if needed. You can use your plan in your proposals).

17. Monitor and report on the work (e.g., Chief and Council, Health Director, the whole community).

18. Do the evaluations you have planned in your Suicide PIP plan and present results to key stakeholders.

Checklist of Planning Activities, Tasks and Related Tools

Tool 3.1: Template to Set Up Your Coordinating Committee

Find members for your committee.

- Consider working together with neighboring communities, communities within your cultural group, or within your community engagement hub to share resources and staff time.

- If your committee already exists, you can move to the next step. You can also add members to an existing committee. You can decide this at the first meeting.

- If you need a NEW Committee think about whom to invite to be members. Using the table below, identify who you need to have on your Committee. If you need help with choosing members, get another person to work with you and do the exercise together. Write some names in the spaces below.

When thinking about who to have on your committee, consider:

- Respecting all community members regardless of the kind of work they do.

- Looking for people who are respected and have trust with others in the community.

- Involving community members from different groups, such as mental wellness, health, school, and people with healing skills.

- Using culturally appropriate ways to invite involvement of people, especially Elders.

- Including partners and people working outside of the community who may be able to share staff and resources.

Potential Members for Our Committee		Potential Members for Our Committee	
Youth/Youth Council		Public School	
Elders (healthy)		Community Watchmen	
Traditional healers		Survivors (healthy)	
Cultural Workers		Parenting Program People	
People in Health		Mental Wellness Counsellors	
People in Child and Family		Recreation, Sport and Activity	
People in Early Childhood Development		Police/RCMP	
People in Education		Hospice, Victim Support	
Emergency responders		Suicide Crisis Workers	
Chief & Council & Band Office		Other(s) – "go-getters"	

Once you come up with these members, you will need to invite them to join and gain their commitment to be on the committee. You can do this in person, email and by phone.

Hint - Sometimes one person takes on the job of writing something to bring to the meeting for everyone to review. This can speed up the planning work and uses face to face time efficiently.

Tool 3.2: Draft Agenda for First Coordinating Committee Meeting

Use the agenda below to guide your first meeting activities. You can change this as needed. For example, it may take you two meetings to get through all the agenda items.

Potential Members for Our Committee		Potential Members for Our Committee	
Meeting Invitees: List the people here - *Sue Smith, Carla Jones, and Paul Holmes.*			
Agenda Item	**Description**		**Item Lead**
1. Welcome and review agenda	• Opening prayer. • Introductions of members.		*Identify who will do what e.g., Sue.*
2. Meeting purpose	• Kick-off (1st) meeting for the _____ Community Suicide PIP Coordinating committee.		
3. Name the committee	• Discuss and brainstorm what to call your committee. It doesn't need to include the word suicide. You may want to use an uplifting word.		*Sue and Paul*
4. Develop Terms of Reference	• See example Terms of Reference on the next page. • Be sure that the goal is to develop your PIP Plan and then overseeing its implementation and review.		*Paul*
5. Review membership	• Consider inviting others to help you plan - use the template on the previous page to give you ideas.		*All members*
6. Determine roles	• **Chair(s):** Attends and facilitates meetings, helps resolve conflicts, seeks ideas from others on major decisions, acts as spokesperson for matters agreed to by the group, and approves things that the group clearly gives them power to do. You may want a Co-Chair who can act if this person is away. • **Members:** attend meetings, do any pre-reading and preparation for meetings, and often given tasks to take away to do for the group within their own organizations. • **Coordinator:** Takes the minutes and sends out for approval; organizes the agendas with the Chair and members and sends these out before the meeting; organizes any catering (if there is a budget) and meeting room; does tasks for the committee which may include some typing or letter writing, may also coordinate a project.		*All members*
7. Determine meeting frequency	• Agree on how often you will meet and develop a schedule so people know in advance. You can use a calendar and send it out to members with the dates on it – or use Outlook to invite people to meetings so that it is locked into their Outlook calendars.		
8. Next steps	• Determine next steps - book your ***planning meeting*** to start assessing your community needs and existing resources. You may wish to hold a planning meeting to develop your committee's work-plan - see examples below. • Closing prayer		

The purpose of a Terms of Reference document is to lay out the purpose and structure of a project, committee, meeting or negotiation. It will help define who will make up the committee, what is expected of the committee members and details about the how of the committee will meet, for how long, etc.

Tool 3.3 Draft Terms of Reference for the Coordinating Committee

Purpose of the Coordinating Committee (CC)

The (X) Committee has been formed to carry out a planning process to identify needs/gaps in suicide prevention, intervention and postvention (PIP) activities for the _____ (insert your community's name or band's name) community and to develop a community suicide PIP plan to address the gaps.

Responsibilities of Chair(s)

Within the assigned area, the responsibilities of the chair (s) are to:

- Develop the Terms of Reference (TOR) for the CC, which are to be approved by X (to be determined if this committee reports to a formal group e.g., Chief and Council).
- Monitor and report on the CC's progress as required by (X).
- Engage with other groups, as needed.
- Ensure the business processes of the meetings are maintained (e.g., TOR, agenda).

Responsibilities of Coordinating Committee Members

Coordinating Committee members are expected to represent their stakeholder group and/or professional discipline in the following ways:

- Facilitate and gather input from their colleagues, and other stakeholders and bring their interests forward to the CC meetings.
- Analyze the current PIP resources in the community and identify any gaps.
- Develop goals and objectives, and strategies for the plan.
- Represent their professional expertise during discussions.
- Communicate decisions and outcomes of the CC meetings to their colleagues, and other stakeholders, as appropriate.
- Review documents (e.g., plans, budgets, reports) and provide feedback to the Chairs.

Membership and Term

- The committee will have __ voting members that include the following:
- Chair (s): fill in name or names and Members: fill in names

Decision Making

- Decisions will be made by consensus if there is a quorum (70% of members) present. If consensus cannot be reached in the meeting, then all of the CC members present will be polled and the vote must be 80% of members present to pass the decision, AND/OR;
- Decisions will be made through documented cultural protocols copied below (e.g. consider incorporating cultural protocols and processes for decision-making into your terms of reference)

Terms of Reference Review

• Reviewed every year or as required.

Frequency of Meetings

• The CC will meet ____ times a year. The Chair(s) may call additional meetings.

Minutes will be:

• Circulated to all CC members. Others - to be decided who and why?

Expenses and Budget - Optional...

• It is expected that CC member's expenses will be taken on by their employers or other. The CC chairs may develop a budget or resource plan.

Confidential Information and Discussions

• CC members may hear confidential material and sensitive discussions. Members will not discuss sensitive issues with, or disclose confidential information to, a person outside of the CC without permission.

• CC members will sign a confidentiality agreement when joining the CC (template on next page)

Privacy, Confidentiality, and Disclosure of Personal Information

Respecting a person's privacy and confidentiality may be particularly challenging in small, rural or remote communities where most people are familiar with each other and often know of each other's activities and daily lives.

In a small community, the relationship between a health care provider and a client can be a complex and long-term relationship that involves both friendship and professional responsibilities. A health care provider may also care for a person's friends and family, complicating relationships and privacy.[39]

Deciding whether or not to breach a person's confidentiality is a difficult decision. BC's Personal Information Protection Act (PIPA) and the Freedom of Information and Protection of Privacy Act (FOIA/FIPPA) both pertain to the collection, use and disclosure of personal information. The decision to disclose personal information should be done on a case-by-case basis and must be able to demonstrate that the person's best interests were clearly considered.

BC Personal Information Protection Act
(www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/00_03063_01#section18)

BC Freedom of Information and Protection of Privacy Act
(www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/96165_00)

39 Townsend, T. (2009). Chapter 7: Ethics Conflicts in Rural Communities: Privacy and Confidentiality. In Nelson, W.A. (Ed.) Handbook for Rural Health Care Ethics: A Practical Guide for Professionals. Hanover, NH: University Press of New England).

The tool below provides a sample confidentiality agreement that you may get committee members to sign upon joining the committee.

Tool 3.4: Sample Confidentiality Agreement

CONFIDENTIALITY AGREEMENT

During my association with the [Name of Committee], I will have access to information and material relating to clients, employees and other individuals of the [Name of Health Provider or Community], which is of a private and confidential nature.

I agree to respect the confidentiality of matters dealt with in the course of my time spent on the [Name of Committee] and I shall respect the privacy and dignity of the [Name of Health Provider or Community]'s clients or members, employees, and all associated individuals. I agree that the terms outlined in this agreement will remain in force even if I cease to have an association with the [Name of Committee].

I understand that during my association with the [Name of Committee], I may be sharing information and databases with other committee members, employees of [Name of Health Provider or Community] or other individuals or health professionals, and I will protect all information to ensure full confidentiality. This obligation applies to information in any form (e.g. written, electronic or oral).

I agree to respect the following rules regarding the treatment of confidential information:

• I will only access confidential information that I need to know to perform my job duties or to meet my responsibilities with the [Name of Committee].

• I will not search for or access any client or employee information for any reason not related to the performance of my duties.

• Where I am sharing information and databases with other committee members or employees, I will abide by my responsibilities to ensure the confidentiality of information for clients of the [Name of Health Provider or Community].

• I will not engage in discussions about confidential information in public areas.

• I will keep all confidential and/or personal health information to which I have access secure from unauthorized access, use, disclosure, copying, modification or disposal and I will follow all steps required to do so.

• I will immediately report the fact that confidential information in my possession has been stolen or lost as well as any other violations of the above rules to the [Name of Committee] Chairperson without threat of penalty for doing so.

• I understand that the [Name of Committee] may conduct regular audits to ensure confidential information is protected against unauthorized access, use, disclosure, copying, modification or disposal.

I have read this Agreement. I understand and agree that if I fail to comply with the conditions outlined in this agreement, I may be subject to corrective action, up to and including termination of my position, or any similar action as determined by the [Name of Committee].

Name _____ Role _____
(please print)

Signature _____ Date _____

Knowing how much money you have to spend on the planning process will help allocate your financial resources appropriately. Tool 3.5 is a sample budget that you can use as a template for your own budget.

Tool 3.5: Draft Budget Template for the Coordinating Committee[40]

This budget example will help you keep track of all the funding for your work, as well as all the actual costs to do your planning. You can change or delete the sample content, as you fill out the table with your own details.

SOURCES OF INCOME

1. Income Source	2. Amount
Brighter Futures Program funding	$20,000
Grant – BC Healthy Communities	$3,000
Chief and Council	$5,000
TOTAL	**$28,000**

PROJECT EXPENSES

3. Expense (Cost)	4. Amount
Salary of Coordinator	$7,000
Suicide Media trainer contract	$4,000
Travel to training event	$5,000
Catering for three community meetings	$4,000
Advertising for community events	$500
Printing of resources and promotion material for events	$1,500
Venue rental	$800
Honorariums or gifts for Elders	$1200
Mental Health Clinician time and flights	$2,000
Contingency for unexpected issues	$2,000
TOTAL	**$28,000**

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40 Australian Government Department of Health (2012). Part 4: Project Planning and Implementation Templates, Community Health Action Pack.
Retrieved April 2, 2014 from: https://livelonger.govspace.gov.au/files/2012/04/Template-11-Funding.pdf

Notes on how to prepare your budget - you may need to adjust this, if you find out the actual cost is higher or lower than you planned for.

1. **Income Rows:** on the top of your page, list all your sources of 'Income' (money coming in for the project), including any funding for which you are applying.

2. **Amount Rows:** write the amount for each item from column one.

3. **Expense Rows:** this is the planned cost of the resources (people, materials, events and products) that your planning effort will require. You should also include a contingency amount (generally about 5–10% of the budget) to allow for any unexpected or increases in costs.

4. **Amount Rows:** this is for the estimated cost of each expense item you put under the expense column.

Note: The totals for the 'Income' and 'Expense amounts should equal the same amount.
For information on resources you may need to support your work see the following resourcing template:
http://livelonger.health.gov.au/2011/08/30/step-7-what-resources-do-i-need/

Once a committee has been brought together, the first task to consider is gaining the political support of the Chief and Council/Health Board or Health Council. This will help to ensure that the Chief and Council/Health Board recognize and understand the importance of planning for suicide prevention, intervention and postvention in your community.

• Planning defines where you as a community want to go, how to get there and the timetable for the journey.

• Planning creates a link between community needs and resources.

• Planning can help make a positive difference in addressing the issues of communities.

Tools or actions to help you:

• There is a draft letter for you to adapt and use to gain support (below)

• Try talking to someone you know who did a similar project to see how they gained support from Chief and Council or your health board / committee

• Develop a work-plan describing your planning activities and a budget if you need more resources. You can attach this to the letter.

Tool 3.6: Example Letter to Chief and Council, Health Board or Health Council

Suicide is a serious issue in our communities and is one of the leading causes of death for First Nations and Aboriginal young people.

To support our community in preventing and responding to suicide, we have received a toolkit that supports a planning process to develop a suicide prevention and/or response plan. It was developed by First Nations for First Nations. Planning for suicide prevention and response is important because it will allow our community to take actions towards preventing suicide, and to be better prepared to respond if a death by suicide should occur.

Through this planning process, we will be able to determine our community's priorities as they relate to suicide prevention, intervention and postvention. For example, our planning group may determine that we want to focus our efforts on one (or more of the following): (*choose which to include or you may have another goal*)

- **Helping our community enhance mental wellness:** Strengthening our prevention efforts can promote our community's wellness and resilience against suicide.

- **Helping our community with understanding and acknowledging the effects of suicide:** Attitudes of shame and denial can act as barriers to suicide prevention. We will develop community strategies to overcome negative feelings about suicide.

- **Helping our community's youth and working with the school system:** Our youth are vulnerable to suicide and also to suicide pacts and clusters. We will work with the school and other partners to develop programs supporting youth. We will engage our youth leaders (youth council) in this part of the plan.

- **Helping get our community mental wellness and emergency response team trained:** Suicide prevention requires trained personnel to carry out prevention, intervention and post-vention approaches. We will look at strategies for training personnel.

- **Helping our community to improve (or work on improving) how we coordinate community services during a response to a suicide crisis:** Coordinating community services is important. We will develop a plan on how we can improve coordination both inside and outside our community.

- **Helping our community provide culturally appropriate services to reduce the likelihood of a mental health and/or substance use crisis:** We will connect people with meaningful, appropriate services when they need them, which will help offset the risk of a mental health and/or substance use crisis that may lead to suicide.

Working with others in our community, we would like to help our community look at this issue. We will need your help as our leaders. For example, we will need to form a committee or work with a group that is already working on mental wellness issues, such as the _____ committee. We will require some support to help us plan, to put our plans into action, and to get the greater community involved.

Once we develop our plan, we will present it to _____ (e.g., Chief and Council) for your approval. We will also provide regular updates on the progress we make. We may also come to you if we experience challenges where we need your help to resolve them.

Lastly, planning for suicide prevention, intervention and/or postvention can be a difficult journey, and it may be that some members of our planning committee are on their own healing journey because of suicide. To support our planning group members, we will develop our own safety plan and identify resources we may need. This is included in our budget for this planning work (see the attached budget),

Sincerely,

_____, Community Worker or _____ Coordinating Committee

Note: consider developing a draft budget with activities that you can attach with this letter. See budget template in section four.

Assessing Community Readiness

Sometimes sensitive issues like suicide are hard to talk about in a community. People find it uncomfortable. Some people may have lost family members to suicide and be feeling sensitive and emotional. Leadership in your community may not want the issue discussed for fear that it will cause people to consider suicide. You may wish to do a "community readiness exercise" that assesses how ready your community is to address and discuss suicide. This will look at whether you need to focus on raising awareness (e.g., *I don't know much about suicide in our community…or….it's not an issue is it?*) – or whether there is a true momentum and readiness to do something NOW (e.g., *no more talk – let's do something!*).

Tool 3.7: Community Readiness Assessment Example[41]

Action: This assessment can be as simple as asking your committee to review the stages below and choose where they believe the community is at in terms of their readiness to address the issue of suicide OR **your team could use a more comprehensive approach.**

Once you agree with your team what stage you are in, you may wish to review the "things you can do" to see what the goal and strategies could be or brainstorm your own.

Stages of community readiness	Definition	Things you can do
1. No awareness: issue not recognized as a problem.	There is no recognition of the problem by community leaders.	Raise awareness of the issue and how it affects the community (e.g. through information sessions, pamphlets, radio, kitchen-table discussions, community newsletter, etc.).
2. Denial / resistance: issue recognized but not as occurring here.	The problem is recognized, but not acknowledged to be a local problem. Community climate may be passive or guarded.	Raise awareness of the issue and how it affects the community (e.g. through information sessions, pamphlets, radio, kitchen-table discussions, community newsletter, etc.).
3. Vague awareness: local concern recognized, but no immediate motivation to tackle it.	There is recognition of the problem and that something should be done, but there is no immediate motivation to act.	Raise awareness that the community can help address the problem (e.g. through information sessions, pamphlets, radio, kitchen-table discussions, community newsletter, etc.).

4. Preplanning: recognition of concern but efforts are unfocused.	There is recognition of the problem and the need to act, but there is no definite plan about how to do this.	Raise awareness with concrete plans for how to address the problem (e.g. through information sessions, pamphlets, radio, kitchen-table discussions, community newsletter, etc.).
5. Preparation: active planning and modest community support.	Planning to address the problem is in process and practical details are being discussed. Modest support of efforts.	Gather information to help in developing a plan of action (e.g., conduct an assessment).
6. Initiation: effort justified by community and activities underway.	Action has been initiated to address the problem. Community is moderately engaged.	Provide information to keep community engaged and informed.
7. Stabilization: activities supported by leadership with trained and experienced staff.	Programs are running to address the issue and have resources and leadership support to maintain a stable status.	Stabilize efforts to address the issue.
8. Confirmation & expansion	Program evaluation is occurring; efforts to expand and resource new initiatives are underway.	Expand and enhance effective services (this may involve stopping services that are deemed ineffective).
9. High level of community ownership	Sophisticated data is available for analysis (risk of the problem and effectiveness of interventions).	Maintain programs, improve and expand as required. Share results with the community.

If you determine that your community is ready to address the issue of suicide, you may now want to determine (assess) what programs and resources already exist in your community and where to best focus your efforts. The tools on the following pages can help you map out the strengths and gaps in your community as they relate to suicide prevention, intervention and postvention.

Organize a planning day for the Committee to review all of this information and determine what it is telling you. This might include who your high risk groups are, what services you have and don't have, etc.

41 Plested, B.A., Edwards, R.W., & Jumper-Thurman, P. (2006). Community Readiness: A Handbook for Successful Change. Fort Collins, CO: Tri-Ethnic Centre for Prevention Research. Retrieved April 2, 2014 from: www.nami.org/Content/NavigationMenu/NAMI_Center_for_Excellence/Tools_for_Excellence/CommunityReadinessHandbook.pdf

HOPE HELP HEALING

Now that you've brought a Coordinating Committee together, it's time to begin collecting the information you will need to create an informed plan. In suicide prevention planning, it is important to understand what your community is like in terms of demographics, experiences of suicide, attitudes and beliefs about suicide, community risk factors, community protective factors, programs and resources, community responses to suicide, and community strengths.[42]

Tool 3.8: Community Information Gathering Template

Action: With your coordinating committee, brainstorm ideas for where you may get the information you think is important (information that you won't get from the planning exercise). This may be your chance to learn about other strengths your community has that can support your planning and community development process.

Community Information Gathering Template			
Information Template and Tasks	**Who will gather the information**	**By when**	**Notes**
EXAMPLE • Identify numbers of attempts and death by suicides for the past 5-10 years (if no data is available, ask people what they remember). Identify the age group (s) if possible.			
EXAMPLE • Gather other information you need, such as the number of calls members of your community have made to the local Crisis Line - this data can tell you how your community is doing and if it is at risk (it may take some time to collect information from outside of the community e.g. from Crisis Lines or Regional Crisis response teams).			
• **Other -** to be developed by the coordinating committee.			

42 National Aboriginal Health Organization. (2005). Assessment and planning Toolkit for suicide prevention in First Nations communities. Retrieved from: www.naho.ca/documents/fnc/english/FNC_SuicidePreventionToolkit.pdf

Tool 3.9: Identifying Strengths and Gaps in your Community

Tool 3.9A: Hope / Prevention[43] – Building Community Resiliency

In suicide prevention planning, it is important to assess the strengths and gaps in your community right now. This would be things like programs and resources, community responses to suicide, and community strengths.[44]

How to Use this Tool: Read the information in the circles, then move to the next page for an assessment activity. You may need to use this page to remind you what the program or activity means.

PEER COUNSELLING
groups of youth, adults and/or Elders that are trained in basic listening skills and are identified as resource people for others in crisis.

SCHOOL CURRICULUM
reinforcing positive mental health; learning about substance use, suicide and other serious mental health issues; exploring cultural heritage to support healthy coping skills.

SUPPORT GROUPS
for individuals and families at risk e.g. young mothers and fathers, people recovering from susbtance use problems; ex-offenders returning to community.

CULTURAL PROGRAMS AND INTERVENTIONS
Activities for the community at large (e.g. recording and sharing the stories and traditions of Elders, camping on the land, ceremonial feasts, First Nations language courses)

SPORTS & RECREATION
for children and young people to combat boredom and alienation, and to foster peer support, community connections and a sense of belonging.

FAMILY LIFE EDUCATION
parenting skills workshops for new parents and adults; training in mental health promotion approaches and suicide risk factor awareness for workers, volunteers and helpers.

LIFE SKILLS EDUCATION
problem solving, and communication for children and young people (e.g. youth as role models).

HOPE HELP HEALING

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43 Health Canada First Nations and Inuit Health Branch (n.d.) Acting on What We Know: Preventing Youth Suicide in First Nations. Retrieved April 2, 2014 from: www.hc-sc.gc.ca/fniah-spnia/alt_formats/fnihb-dgspni/pdf/pubs/suicide/prev_youth-jeunes-eng.pdf
44 National Aboriginal Health Organization. (2005). Assessment and planning Toolkit for suicide prevention in First Nations communities. Retrieved from: www.naho.ca/documents/fnc/english/FNC_SuicidePreventionToolkit.pdf

How to Use this Tool:

Building on the ideas in the coloured circles from the previous page, ask the Coordinating Committee or planning group to begin listing all the programs or activities that are in your community in the blank circles below. You can draw this diagram on sheets of paper or a large whiteboard if you want others to see the ideas at the same time. If you don't have a program or activity write "nothing" or "don't know" or "find out" in the circle. Later, this information will let you know what needs to be investigated or organized as part of your PIP plan.

PEER COUNSELLING

SUPPORT GROUPS

SCHOOL CURRICULUM

CULTURAL PROGRAMS AND INTERVENTIONS

FAMILY LIFE EDUCATION

SPORTS & RECREATION

LIFE SKILLS EDUCATION
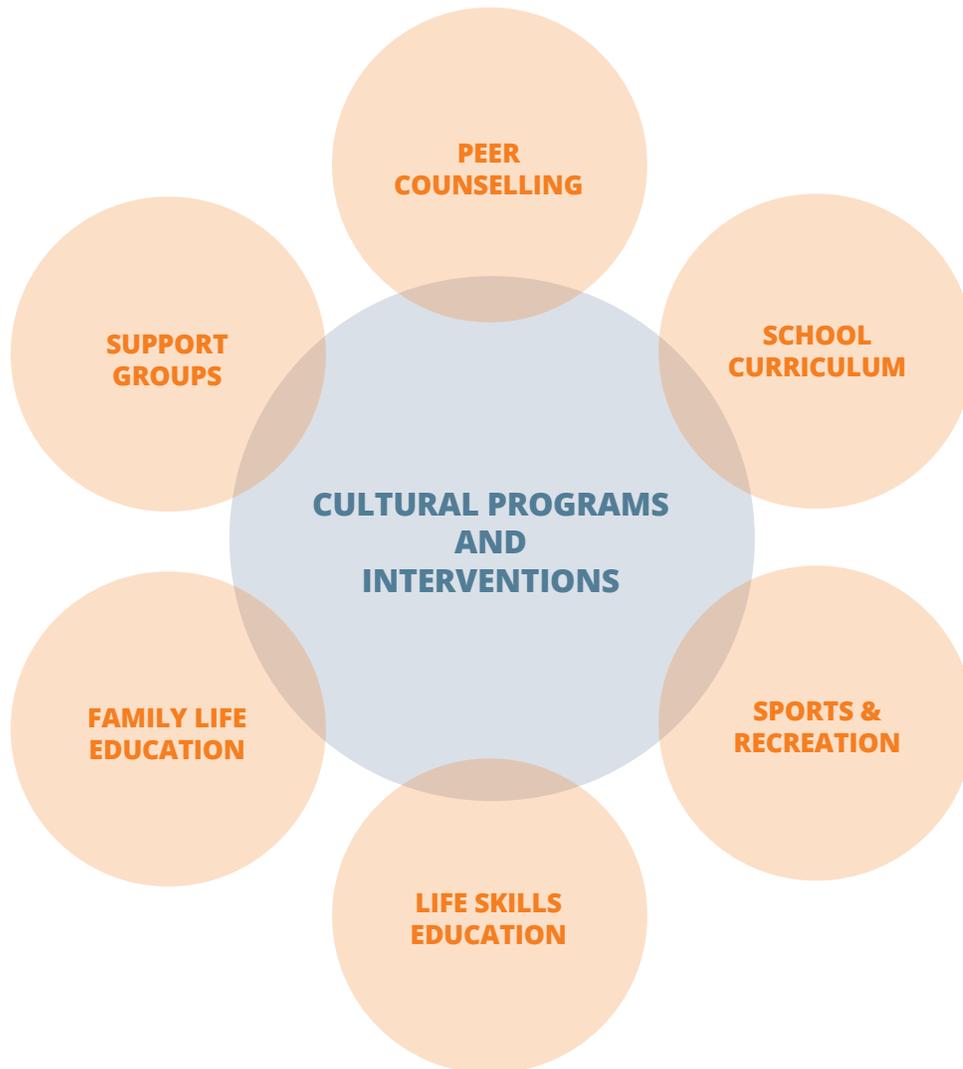
Tool 3.9B: Help / Intervention – Being Ready to Respond in a Crisis

Intervention[45]

The circles below contain examples of the types of programs and services that may help address the intervention needs of individuals at risk for suicide. Read the information in the circles below, then move to the next page for an assessment activity - you may need to use this page to remind you what the program or activity means.

TRAINING OF PRIMARY CARE PROVIDERS
in detection and crisis intervention, treatment of depression, substance use problems and other mental wellness issues that can lead to suicide.

ASSESSMENT AND INTERVENTION SERVICES
for parents of youth at risk (e.g. individual, couple, or family interventions for substance use, family violence, effects of residential school experiences, relocations, etc.).

CULTURAL PROGRAMS and INTERVENTIONS
(e.g. taking people into the longhouse or to the water; including Aboriginal healers, counselling by Elders)

CRISIS LINE
ideally outside the community for confidentiality, but accesibly linked to the community.

CRISIS INTERVENTION
for those at an acute risk for suicide behaviours. Family therapy and social network interventions fit the family- and community-centred values of many Aboriginal people. For instance ASCIRT (Aboriginal Suicide Critical Incident Response Teams).

CRISIS CENTRE
in the community or in an adjoining community to provide a safe place, "time out," and opportunity for intensive intervention. It can be staffed by lay helpers and "big brothers or sisters," along with professional assistance as available.

HOPE HELP HEALING

45 Health Canada First Nations and Inuit Health Branch (n.d.) Acting on What We Know: Preventing Youth Suicide in First Nations. Retrieved April 2, 2014 from: www.hc-sc.gc.ca/fniah-spnia/alt_formats/fnihb-dgspni/pdf/pubs/suicide/prev_youth-jeunes-eng.pdf

How to Use this Tool:

Building on the ideas in the coloured circles from the previous page, ask the Coordinating Committee or planning group to begin listing all the programs or activities that are in your community in the blank circles below. You can draw this diagram on sheets of paper or a large whiteboard if you want others to see the ideas at the same time. If you don't have a program or activity write "nothing" or "don't know" or "find out" in the circle. Later, this information will let you know what needs to be investigated or organized as part of your PIP plan.

TRAINING OF PRIMARY CARE PROVIDERS

ASSESSMENT AND INTERVENTION SERVICES

CRISIS LINE

CULTURAL PROGRAMS AND INTERVENTIONS

CRISIS INTERVENTION

CRISIS CENTRE

Tool 3.9C: Healing / Postvention – Critical Response and Supporting People After a Loss[46]

Ideas for Postvention Programs or Activities

Read the information in the circles, then move to the next page for an assessment activity - you may need to use this page to remind you what the program or activity means.

MANAGING THE RESPONSE
includes training and development of a crisis response team.

MEDIA REPORTING GUIDELINES
includes developing community protocols, promote help-seeking and resource awareness, and guidelines for telling suicide stories.

GRIEF PROGRAMS
includes counselling and support groups for those grieving.

CULTURAL PROGRAMS and INTERVENTIONS
(e.g. taking people into the longhouse or to the water; talking circles with First Nations/Aboriginal healers, sweats / smudges, counselling by Elders)

POSTVENTION PROTOCALS
includes stabilizing the crisis, and aftercare for survivors.

CARE FOR THE WORKER
includes rest and debriefing to support front line workers.

SUPPORTING GRIEVING FAMILIES
includes short term treatment and community response teams.

46 Joshi, P., Damstrom-Albach, D., Ross, I., Hummel, C. (2009). Strengthening the Safety Net: A Report on the Suicide Prevention, Intervention and Postvention Initiative for BC. Retrieved July 20, 2013: http://suicidepipinitiative.files.wordpress.com/2009/05/suicide-pip-initiative-full-report.pdf

How to Use this Tool:

Building on the ideas in the coloured circles from the previous page, ask the Coordinating Committee or planning group to begin listing all the programs or activities that are in your community in the blank circles below. You can draw this diagram on sheets of paper or a large whiteboard if you want others to see the ideas at the same time. If you don't have a program or activity write "nothing" or "don't know" or "find out" in the circle. Later, this information will let you know what needs to be investigated or organized as part of your PIP plan.

MANAGING THE RESPONSE

GRIEF PROGRAMS

MEDIA REPORTING GUIDELINES

CULTURAL PROGRAMS AND INTERVENTIONS

CARE FOR THE WORKER - REST, & DEBRIEFING

POSTVENTION (RESPONSE) PROTOCOLS

SUPPORTING GRIEVING FAMILIES - COMMUNITY

Tool 3.10: Analysis of Information

Analyze the information (write down and think about the information to look at trends, issues or themes) and identify gaps. Bring this information to your committee. One person can pull it together and package it for the members to read and consider. The analysis should include these sections, if you have data:

Services and Supports

Describe all the services and resources that you have identified for:

- Prevention
- Intervention
- Postvention

If you can, note how many kilometers away from home (off-reserve) the services are. What does the community and nearest municipality(s) have in place for specific PIP activities? Identify strengths and areas for improvement for the services/programs at-home and away from home (on and off-reserve).

Key Groups in the City Close to You

List these - these may be your partners or you may identify new groups to partner with in order to strengthen your PIP resources. Describe what they can provide or help with. This could be part of a partner (stakeholder) identification exercise.

Identify/Describe other Factors/Programs that are Positive

This could include a youth recreation centre in community (on-reserve), a good relationship with the municipality or local hospital, or a volunteer family support program in the community.

Community Readiness Report

If you did a Community Readiness assessment, include this in your information analysis.

Interview Notes if you did Focus Groups or One to One Discussions

Summarize what all the meetings and interviews are telling you (key themes). Bring your original notes to your Committee meeting in case someone asks for more specific detail.

Organize a planning day for the Committee to review all of this information and determine what it is telling you. This might include who your high risk groups are, what services you have and don't have, etc.

Tool 3.11: Prioritize Your Issues and Needs Template

The table below may help you and the Coordinating Committee in identifying and prioritizing needs and issues to bridge the gap between what currently exists and what they would like to see in place. You may want to sort the needs/issues you identify as follows (with 1 being hardest to address and 3 the easiest) – or develop your own way of sorting the needs/issues:

1. This NEED requires collaboration across a number of agencies to resolve.

2. This NEED requires community leadership approval and support with funding

3. This NEED can be dealt with at the operational level of one agency

For example, you may find that there is no "Media Response Guideline" and people who will use it (e.g. Chief) need media training to support them. Or you might find you have a media guideline you can adapt for suicide response. You can put this need on your list and then decide who will be responsible to complete it and the timeline:

Need Prioitization and Analysis Template					
Need/Issues Suicide PIP	**Resource**	**Category**	**Steps of Action**	**Actions by Whom/ When**	
What gaps need to be addressed to reach the desired PIP goal (s)?	List any existing resource you can start from.	1 2 3	What actions / tasks are needed to address the gap(s)? What resources?	Who is responsible for addressing the gap?	When will you complete this work?
1. No Suicide Media Response Guideline	Media guidelines are available for adaptation from www.suicide-prevention.ca Search: Media Guidelines	3	*a. Develop a draft Media Response Guideline for approval, review with Committee and seek opinion from local media.*	*Coordinating committee members*	*By May 2014*
			b. Get approved by Chief and Council.	*Band Manager*	*By September 2014*
2. Training for leaders to the new guideline.		3	*a. Enrol Chief & Council leaders in media training to implement the Guideline*	*Band Manager*	*By December 2014*

Organize a planning day for the Committee to review all of this information and determine what it is telling you. This might include who your high risk groups are, what services you have and don't have, etc.

Tool 3.12: Sample Workplan (Who Does What)

	Community Worker	Committee Chair or Members	Community Members	Leadership
Pre- Planning Activities				
1. Create a Coordinating Committee	☑			
2. Committee members secured	☑	☑		
3. Kick off meeting held a. Terms of Reference developed - draft and final b. Work plan developed c. Budget developed		☑		
4. Tell the community about the planning work - each community will need to decide what process they will follow based on their resources and whether the community is ready to engage		☑ - do the actual work	☑ - come and share their ideas	☑ - encourage community member engagement by announcements
Assessment Activities				
1. Engage your community members about suicide		☑	☑ - come and share their ideas	
2. Develop a community information gathering template e.g., identify what information is needed and who will get it, and by when		☑		
3. Analyze the information and identify gaps. Remember to include section four's information here as well about PIP gaps	☑	☑		
4. Hold a gaps planning meeting with the committee - prioritize gaps		☑		
Write Your Plan Activities				
1. Write your PIP draft plan		☑		
2. Develop evaluation plan, measures, reporting timing, data sources - link with Evaluation # 1		☑		
3. Consult on your draft PIP plan		☑	☑	
4. Get your PIP plan approved				☑ - to approve
Act (doing) Activities				
1. Develop a work plan for all tasks		☑		
2. Develop a budget for all tasks		☑		
3. Monitor and report on PIP plan implementation activities		☑		☑ - receive report
Reflect (Evaluation) Activities				
1. Do your evaluation planning	☑	☑		

In this section, you worked on bringing a Suicide PIP committee together, determining your budget for the planning process, figuring out what programs and resources already exists in your community and identifying some areas where you might want to focus your efforts. Congratulations on getting this far - it's been a lot of work!

Sharing

Steven
Grade 1, Sts'ailes Community School

Section 4 – **Sharing**

Tools and processes for bringing your community together and writing, implementing, and evaluating your plan and the results.

> ### Learning Checklist
> ❑ Share the information you have gathered with the broader community and ask for their input/feedback
> ❑ Write up your plan and get it endorsed
> ❑ Implement your plan
> ❑ Evaluate the results

Resources (Tools)

• Workplan Tasks and Actions

• Monitoring and Reporting on the PIP Plan Implementation

Now that you have compiled all of the valuable information you need, it's time to engage the broader community to verify you're heading in a good direction and start to write up your plan.

Preparing for Community Engagement

Engaging the community means informing them about the planning process you and your Committee are carrying out. It also means seeking information, input, knowledge and ideas from them to contribute to the plan.

Successful community sessions require preparation. It is crucial that coordinators familiarize themselves with the material they designed or are expected to deliver and discuss with the community. There are four main steps you need to go through in the stage of preparation:

Have a Clear purpose – Make sure you know the purpose, need for and outcomes for the session (what you want to get clear direction on from the community?). Based on your requirements, make sure YOU are ready through creating your own self-care plan for the engagement process. Do you have mental health support in place for yourself and for people attending the training if the issues are sensitive? Do you think that the topic could cause emotional and traumatic responses for some people? Are you prepared for this with Elders and support workers in attendance?

Timing and Promotion/Invitation

How much advance time is required to organize the session(s) so that everything is in place? Will it clash with another important community meeting OR can it be added to another meeting to save people time and to save costs? How will you advertise the session and make it "attractive" to attend so people come out of their homes to your meetings? Timing is important. People are less productive in the time period after lunch. Earlier in the day is better, and if it is an evening meeting, do not go on too long so people can get home – especially in cold conditions. Get the information out and develop a poster. These can be posted at: tribal council, post office, band office, health centre, day care, grocery stores, churches, gas stations, restaurants, schools, etc. Talk to the local radio station about advertising the meeting on-air, or have it mentioned in local newsletters/newspapers. Tell people what you have to offer, such as food. If you have a budget, maybe consider a gift for attending to acknowledge their time is of value.

Identifying participants

By knowing who your target audiences are, you can promote your meetings better. If you want youth to attend, what might your invitations and methods be to encourage them to attend? What time of the day suits them best? What will attract youth to come? Ask a few youth to give you some ideas. If you want Elders – use a similar process. You may want to select people for a focus group to get more in depth discussion going rather than have an open public meeting where you cannot predict who will come. Think about daytime and evening meetings to attract the group you want. If people have to come from remote distances, can you offer some travel support to encourage their attendance? Do you want people of different ages and genders? Think about childcare options or activities and offering a meal if you have the budget. If you put out a general meeting invite you are likely to get "the usual attendees" at these public sessions. Tailoring your promotion efforts and invitations will help to reach the audience you are after.

Also identify who from the Coordinating Committee is coming to support the engagement so that they all get involved. Encourage these members to present and to attend different meetings. Make sure everyone involved "shows their face" and talks beforehand (including mental health support workers) so that the team knows how to respond if someone becomes upset or emotional during the session.

Venue, Material and Presentations

Ensure your venue has good natural light, air circulation, plenty of comfortable seating, disability access, clean toilets (with supplies) and a place to serve food if you are having a meal. Circular seating arrangements work best. Prepare your materials/handouts and any presentations if using PowerPoint, Prezi or other visual tools and have your Coordinating Committee review them. Make sure the font is of sufficient size and a dark colour so the back of the room can see. Adapt your content for specific audiences for example youth-related pictures and terms for young audiences.

Think about what equipment you need. A suggested list is:

- Laptop computers and projector
- Easels - Flipcharts, paper and markers
- Writing paper and pens for participants
- Masking tape, Blue Tack and/or pins (for hanging flip charts)
- Name cards for presenter(s)
- Photocopied handouts and slides to hand out (especially if technology does not work on the day for some reason)
- Attendance sheet(s)
- Gas cards or envelopes and signing forms for any payments made (e.g. travel expense claims)

Preparation Checklist

❑ Has your budget been approved and funding confirmed for the engagement meetings? How do you access that funding (what forms need to be filled out)?

❑ Has an appropriate venue been chosen?

❑ How long is the meeting? Does your booking allow enough time to go in and set up and to tidy up afterwards?

❑ Does the venue have enough seats for your expected numbers?

❑ What marketing, promotion and/or invitations are needed for your audience?

❑ Who from the Coordinating Committee will support and present at each meeting?

❑ Have facilitators been selected or are you facilitating?

❑ Have you organized who is taking the notes? Are you using tape recorders or cameras (and do you need a waiver to use the images of the audience?)

❑ Have meeting materials been prepared? Handouts been copied?

❑ Do you need to purchase, rent or borrow any supplies - projectors, flip charts, stationary, etc.?

❑ Will you have access to Internet service if you need it (WIFI)?

❑ Has consideration been given to how the meeting will open and close? Perhaps with an Elder's prayer and who will do this? Do you have a gift of acknowledgement for the Elder?

❑ Have caterers been organized and specific times been given? Will they supply eating utensils, plates and clean up afterwards?

Facilitator Role at the Community Engagement Sessions

What is a facilitator?

A facilitator is someone who is present to help a group achieve the meeting purpose or objectives.

Facilitator's role:

- Make sure those who talk a lot do not take over. Encourage others to contribute, particularly those who are less vocal (perhaps do a round table to ask each person their thoughts).

- Think of non-aggressive, friendly ways to deal with difficult participants. Such as those that are over talkative, argumentative, and refuse to follow the rules of the meeting.

- Avoid conflict from escalating:

    o By stepping in if necessary to help participants find areas of agreement.

    o By analyzing what has caused the conflict so that participants can find a more objective and less emotional perspective.

- From time to time, take a 'health break' so people can stretch their legs if it is a long session.

- Break the group up into smaller groups of 4-5 to encourage quieter people to talk.

- Ensure individuals receive positive feedback about their ideas and contributions.

- Staying quiet is often the facilitator's most powerful tool. Silence provides people with the space to contribute.

- Ensure that the discussion is brought to a close when the meeting has achieved its intended outcomes or at the end of the allotted time.

- Look for anyone who is emotional or upset so you can quickly put in place your prepared response methods (e.g. your support worker or mental health counsellor taking them outside or aside to comfort them and talk). You can also have a break in the meeting so that they can have time and support to calm down.

- Keep to the time that you advertised as people may have organized transportation to pick them up. Start on time – people who come on time get frustrated if left sitting too long. Being prompt and organized shows you are in control of your meeting and know what you are doing, People are also more likely to come back to your next session. Reschedule if necessary to carry on if you do not finish on that day. You can always come back again.

Questions you might ask to stimulate discussion at the meeting(s)

Example of questions you may ask people in the community or your outside partners.

- What do you know about suicide in our community?
- Is it a problem? With what group(s)?
- What are the current strengths of the community to respond to this problem?
- What do you see as the needs?
- What are some of the barriers to change?
- What do you see as the top 2-3 priorities in the community and why?
- Who can help us?

Effective Communication Skills as a Presenter or Facilitator

STRONG OPENING – GET THEIR ATTENTION EARLY!

Introduce yourselves. Then get the participants' attention right away. In your opening try to make people curious, explain the purpose of your session and connect the participants to the topic. There are many different ways to do this. Consider asking a question, sharing a personal story, displaying an eye-catching visual, making a provocative statement, or sharing a thought-provoking statistic from the materials provided in your Toolkit.

Introductory Comments - Clearly explain the purpose and process

- Cover the purpose of the session slowly and clearly
- Address "What is in it for you", explaining why the information presented during the session is important for the attendees
- Use "icebreaker" style exercises to help group members connect with each other and build trust
- Establish guidelines for sharing (e.g. what is said in the circle stays in the circle, no talking over or interrupting other people, being respectful, etc.)
- Encourage attendees to speak up and share their experiences and examples – state that honest contributions help to make your plan better and more meaningful for your community
- Check your use of time to maintain a speed that will help you finish on time
- Limit the time that you are talking to be able to listen to your attendees

HOPE HELP HEALING

Avoid Presentation Downers

- Awkward beginning or weak ending.
- Minimal eye contact or facial expression.
- No humour.
- Vague objectives and poor preparation.
- Poor visual aids.
- No audience involvement.
- Reading handouts in front of your audience.
- No movement from you (stagnation).
- Turning your back to the audience.

Model Effective Facilitation Skills

Try to remember these basic facilitation strategies throughout the meeting:

- Ask open-ended questions. For example, you might say, "What did you learn from experiencing that situation?" instead of "Did you feel hurt or angry by that situation?"
- Listen carefully to the discussion and try to be sensitive to any charged feelings that may accompany it.
- Rephrase participants' contributions for clarity when necessary, and without judgment. (e.g. "John, I'm hearing you say….. am I understanding you correctly?").
- Respect every participant's feelings, perspectives, and contributions.
- Make the handout and presentation material clear by speaking slowly and using language that everyone understands.
- Make sure that each individual can express their own views.
- Avoiding interrupting another speaker.
- Encourage participants not to put down the views of other participants. Instead, encourage a commitment to support each other.
- Ensure that no one "pulls rank" - all attendees are equals no matter their job or position in the community.

Review and Closing

Review the meeting objective at the end and summarize the key points you think you have heard. Check with the audience that you heard right…and be prepared to change things in the notes if you didn't! Confirm with the audience you have heard and recorded the changes.

Evaluation after the Engagement Meeting(s)

The following checklist can be used after the session for your own self-assessment and review by the Committee. Or ask the audience to complete an evaluation for you.

Note: Not all the questions may be relevant on each occasion.

1) Was the material we provided appropriate?

2) Did we cover the main points we wanted/needed?

3) Was there too much or too little material?

4) Was the attention and interest of the group consistent through the whole meeting or was there a "slow patch"? Why?

5) Did everyone appear to hear and understand what was being said? If yes, how do you know? If no, why not? Have they asked for more information? (especially if you promised to do this). Do you need to come back and keep talking with the community?

6) Was the time used well? If not, why not? Was the meeting held at the right time of the day and in a good venue? If not why not?

7) Did we get the attendees we hoped for? If not why not? What can you do better next time to reach the people you need?

The community likely had some valuable feedback for you during the community engagement process. If not all of the committee members were present during the community session(s), take the information and feedback provided back to a committee meeting. You can use a similar analysis process that you completed when you were identifying the strengths and gaps in suicide-related programs and resources in your community (e.g., identify trends). Use this feedback to help inform your plan.

Use these Links for Planning and Facilitation Resources

- Community Strategic Planning Toolkit (Ortiz, J., Broad, G., & Bobiwash, L. 2005) (www.nadf.org/upload/documents/community-strategic-planning-toolkit2005-with- appen-dices.pdf)

- Community Engagement Toolkit (Ortiz J., & Broad, G. (2005) (www.nordikinstitute.com/wp-content/uploads/2012/11/Community-Engagement- Tool-kit.-July-25.-2006.pdf)

- Comprehensive and Sustainable Community Planning Resources (http://fnbc.info/resource/comprehensive-and-sustainable-community-planning)

HOPE HELP HEALING

I walk my dog.

Ben Commodore Gr.1 Sardis Elem.

Ben
Grade 1, Sardis Elementary School

Writing and Completing Your Plan

1. Write your draft Suicide PIP Plan

Your suicide PIP plan should provide you with a detailed 'roadmap' on how your community intends to address suicide. Draw on the tools and templates you completed in section 3 and the feedback provided in the community engagement process. Remember once your plan is done it will show ALL of the activities and strategies that you have in place already. It will also show those things you want to put in place in the future in order to create a holistic and comprehensive PIP approach in your community.

2. Consult on your draft Plan

Once your Committee has completed the draft Plan (and remember this may take several meetings before you feel it is complete) you should then plan some consultation around the draft with key stakeholders to make sure there is strong support and buy-in. This may include talking with:

- Chief, Council and Band Council staff
- Other Departments (education, child and family, recreation etc.)
- Departments, Teams or Agencies that the Committee members belong to or work for
- Community meetings
- Elders gatherings
- Youth gatherings or focus groups
- Mental health professionals and clinicians who work for you and the local Health Authority that serves your community
- Other service providers who come into your community

Gather their ideas and feedback. Meet again as a Committee to review their feedback and agree on changes to incorporate into the draft Plan to complete it.

3. Budget Needs

You may need to develop a budget or resource plan for some of the tasks and depending on what has been approved and funded - you will need to keep track of this budget.

Make sure you have a way for tracking your expenses against the budget and that each task with a budget is reported on and recorded properly. You may wish to assign someone on the Committee to be the financial controller to keep track of the budget(s) and report to the Committee on financial progress or risks.

Some existing services may be able to build some of the tasks into their current programs (e.g. the Brighter Futures, NAYSPS or NNADAP program or Building Healthy Communities programs which incorporate suicide prevention).

The Health Director would be involved in approving the integration of some tasks from your PIP plan into the program delivery within your Health Centre or Program. You may need to apply for a grant or other types of funding. Note: you may wish to do this earlier in the process or as part of your work plan. See Tool 3.5 for the budget example.

> **Resource: Outline for Writing a Grant Application for Funding and Examples**
> (http://ctb.ku.edu/en/writing-grant-application)

4. Get your Plan Approved/Endorsed

The best way to engage leadership is to have your Chief and Council or your leaders in your Aboriginal organization approve or at least endorse the plan for the community.

Once approved you can then take the word DRAFT off and make it your final plan. Make copies for everyone and then begin implementation! Set a date 12 months from the approval to review the plan with the Committee and keep it active and updated.

Community-based Volunteer Suicide Response Teams

Community Based Volunteer Suicide Response Teams
Developed by Judy North of End Suicide

Communities may decide to develop a Volunteer Suicide Response Team (VSRT) for various reasons. Oftentimes communities wish to ensure their members are provided local, culturally safe and informed suicide crisis support. Other times communities are geographically isolated making accessing outside support difficult.

Volunteer Suicide Response Teams typically consist of community members who have significant suicide intervention, and telephone and/or mobile response training. This preparation enables them to provide immediate, safe and culturally competent suicide intervention responses. Though some volunteers may be experienced counselors, this should not be a requirement for VSRT volunteers. Their role is to provide immediate crisis response, education, follow up, and referral. Volunteer Suicide Response Teams do not replace the need for other services; rather they are designed to enhance services already in place.

Though variations are possible, including shortening the hours or providing telephone support only; typically the Volunteer Suicide Response Team provides 24 hour telephone and mobile suicide crisis response.

Initial crisis contact with the team typically occurs over the phone or through text messaging. The caller may be the person at risk of suicide, or a family member or friend of someone at risk. In addition, some teams decide to respond to requests from emergency services, hospitals and/or community professionals. Often the crisis response ends with a supportive telephone conversation, at other times the volunteers provide immediate in person support.

The creation and development of a VSRT is done in the community and by the community, accessing outside support only when it is not easily available from within. It requires the collaboration of Band & Council, Elders and cultural leaders, community agencies and services.

Creating Community Based Volunteer Suicide Response Teams

1. Determine a Name

To make it easily recognizable have your community name followed by "Volunteer Suicide Response Team".

2. Planning Committee

Don't try and do this on your own; you need community buy-in. Identify possible planning participants. Think about agencies and individuals in your community who are likely to join the response team and be interested in planning. Consider the following:

- What organizations are actively interested in preventing suicide?
- Whose role might have a mandate to address suicide; (e.g., school counselor, mental health counselors, RCMP/local police; tribal police; night watchman?)
- What crisis services are already available in the community?
- Has your community had recent suicide intervention training? Who organized it and/or attended the training?
- If there has been a recent suicide attempt or death, who in the community provided crisis response?
- Are there individuals who have lost someone to suicide that have offered to support others?
- Include members from:
  - o Local emergency services
  - o Band council/local government
  - o Local counseling agencies
  - o School boards & major local businesses
  - o Spiritual/cultural representation
  - o Survivor(s)
  - o Youth

3. Service Recipients

As a planning committee decide which individuals or agencies will initially receive service. Start small. Once the team becomes established responses can be extended to more agencies and/or a larger area. Service recipients could include:

o Individuals at risk of suicide

o Concerned family members and/or friends

o Hospitals

o Emergency services

o Schools

o Community professionals

o Other group or organization

4. Service Type

Depending upon the size of your community and current community resources decide upon initial program components:

o 24/7 crisis call line   o Mobile response only

o Other service times   o Geographical area to be served

o Crisis line response only

5. Sustainability

This is key! You don't want to start something, have the community buy-in and use the service, and then shut down due to lack of volunteers and /or financial resources.

• Create interagency linkages from the start; include hospital, mental health, addiction, police, etc.

• Develop your programs' structure including a Terms of Reference (see sample) and signed Memorandums of Understanding to ease sharing of information and provide continuity of care.

• Though funding is not extensive, monies and/or gifts in kind need to be available for things like:

o cell phones   o photo-copying

o volunteer recruitment & recognition   o monthly meeting locations

o volunteer and/or program insurance   o volunteer meals

o training expenses & location   o mileage

o locked file cabinet   o clinical and Elder support

o computer access   o promotional materials

- The program needs a strong volunteer base; too few volunteers can lead to burn-out, however, too many can lead to boredom. Determine the nature of your community's response, e.g., 24/7 vs. after hours only vs. weekend only, and telephone and mobile response vs. telephone only vs. mobile response only; to estimate the number of volunteers needed.

- The planning team will have to determine who will provide responder training. Significant initial suicide intervention telephone and/or mobile response training may be required. Once the team is operating ongoing training, skill development and debriefing services may be needed.

- It is necessary for the team to have regular clinical support. It is recommended that the individual providing this service attends monthly meetings and is available for team and small group debriefings. Security clearance is required.

- Elder support is essential. When possible have an Elder as part of the team with the same security clearance as responders. This enables the Elder to join the monthly meetings, assist with talking circle debriefings and provide individual support to responders as they regularly deal with trauma.

6. Program Essentials

To begin training and operating a community based volunteer suicide response team you need:

- Multiple agency buy-in to assist with training, planning committee/board members, referrals to and from; funding and/or grant writing

- Completed Terms of Reference (see sample)

- Community awareness (local newspaper & radio; community, school and/or business bulletins) regarding the existence of the team and how to access their response

- If the team is providing telephone response, the crisis line will need to be ready for operation. This could mean developing the team's own response line or joining a local crisis line

- Confidentiality forms ready for signing (see sample)

- Record keeping procedures ready. It is recommended to keep report forms brief to ensure completion (see sample); determine where completed forms will be centrally and securely located; and to ensure confidentiality NO emailing or faxing of client records. Also, the team could provide monthly/quarterly statistical reports to community partners.

- A proposed on-call volunteer schedule

- Dates and location(s) for monthly Team meetings. Team meetings develop group cohesion and are used for ongoing training, to review previous calls & mobile responses, completion of on-call calendar and regular team debriefing.

- Training outline completed and speakers arranged (See sample)

7. Volunteer Responsibilities Include

 o Maintaining confidentiality

 o Providing regular on-call support

 o Crisis line and mobile response

 o Competing documentation

 o Attending team meetings

8. Volunteer Recruitment is Important and Involves

 o Promoting the team and need for volunteers

 o Gathering a broad, diverse and multi-generational cross section of community members; including health professionals and those with lived experience

 o Training as many community members as possible, even if not everyone joins the team

 o Including suicide survivors who are well established on their healing journey as team volunteers

9. Multi-Day Training

Listed below are primary areas for initial response member training. To reduce costs determine community agencies/individuals who could provide training on the following topics:

 • Confidentiality

 • Community specific cultural awareness

 • Community's historic response to suicide

 • Extensive suicide intervention training. This is the primary key to program success.

 • Active listening skills

 • Answering a crisis line call

 • Mobile response training

 • Introduction to related topics:

  o Family violence

  o Addictions

  o Mental health

  o Bullying

  o Community specific issues

- Community emergency services; including police, hospital, ambulance
- Community service agencies providing follow up services and/or referrals to the team
- Mechanics of operating the crisis program; e.g., 24/7 coverage
- Record keeping
- Maintaining personal wellness/self-care
- Regular debriefing

10. Recommendations & Reminders

- Start small
- Build credibility
- Have one or two main sponsoring agencies
- Ensure program mechanics are established as structure is important to maintaining volunteers
- Train more volunteers over what is estimated to be needed
- Whenever possible, have community members/agencies provide training
- Ensure team debriefing services are established
- Clinical and Elder support is absolutely necessary for the team
- Maintain confidentiality – nothing will undermine a program faster than gossip

Volunteer Suicide Response Team - Terms of Reference

DEVELOPED BY THE NUXALK NATION - USED WITH PERMISSION

1. Title

The name of the committee shall be _____ Volunteer Suicide Response Team (VSRT)

2. Purpose

The Volunteer Suicide Response Team shall provide the following to all people in the _____ (identify area).

- counseling support to persons
- operation of a suicide intervention telephone line
- intervention for people who are contemplating suicide
- support for persons who have attempted suicide
- support for families dealing with death from suicide
- raised awareness and education about suicide
- regular meetings for the purpose of the VSRT

3. Structure and Accountability

The VSRT will be under the support of the _____ (e.g., Health & Wellness Department), and is ultimately responsible to the elected _____ Chief & Council.

4. Governance

The VSRT has the authority to provide supports for prevention, intervention and postvention of suicide to persons through the _____(area).

Further to this, the VSRT has the authority to establish networking relationships with service providers throughout _____ for the purposes of prevention, intervention and postvention of suicide.

5. Reporting

The VSRT will provide ongoing reports to update supporting parties on the activities of the committee. These reports will include regular and special reports. These reports will be provided in form template format.

Information in the reports may include the number of calls the team has received, the number of attempted suicides the team has had to deal with, the number of completed suicides the team has had to deal with, the number of meetings the team has had, how many meetings the team has had with service providers. This information will be strictly statistical and will be offered with the utmost of confidentiality.

Regular reports will be provided:

- To _____ Chief & Council. Written reports will be provided on a quarterly basis and in person reports will provided at least once every 6 months.
- To the _____ Service Providers. Email reports will be provided once a week.
- At special town meetings
- To the _____ membership on a monthly basis through the _____ _____ (e.g. flyer, newspaper, website)

Special reports will be provided:

- To the _____ Chief & Council as special issues arise
- To the main contact people in _____ which include the _____ schools, _____ Administration, _____ Health & Wellness, _____ Support Society, _____ General Hospital and the Community Health Nurse.

6. Membership

6.1. Team members will consist of volunteers from the community

6.2. Members will cease their membership if they:

- Resign from the committee
- Are charged of a serious or criminal offence until proven not guilty
- Fail to attend 3 consecutive meetings without providing reasons to the chairperson
- Breach the Oath of Confidentiality
- Are asked to resign by a quorum of the membership

6.3. All members will abide to the VSRT's Oath of Confidentiality, are required to sign a VSRT job description and are required to obtain a criminal record check from the _____ before being permitted to be a member.

7. Chairperson

7.1. The Chairperson shall be elected by the committee for a period of 12 months.
Their responsibilities include:

- Prepare agendas

- Invite specialists to attend meetings when required by the committee

- Guiding the meeting according to the agenda and time available; and

- Ensuring all discussion items end with a decision, action or definite outcome

8. Secretary

8.1. The Secretary shall be elected by the committee for a period of 12 months.
Their responsibilities include:

- Notify committee members of meetings and ensure all necessary documents requiring discussion or comment are attached to the agenda

- Distributing the agenda 3 days prior to meetings

- Taking notes of meetings and preparing minutes from these meetings

- Distributing the draft minutes to all committee members 4 days after the last meeting and an extra copy made available for storage at the _____ office

9. Meetings – Schedule & Duration

9.1. A quorum of members must be present before a meeting can proceed.
A quorum consists of _____ members.
If quorum is not met, a meeting with the same agenda is automatically set for one week hence, at which point, the meeting will commence even if the quorum is not met.

9.2. Special guests may request or may be invited, by the members through the chair, to attend meetings to provide information, advice and/or assistance where necessary. They have no voting rights and may be requested to leave the meeting at any time by the chairperson.

In honour of the organizational structure of the VSRT, members of the _____ elected Council are welcome to attend whether they are members or not. The _____ Elected Chief is an automatic ex-officio member as well.

9.3. Decisions of the committee will be made during properly announced meetings by a quorum of members through majority vote.

9.4. Regular scheduled meetings will be held on the _____ of each month for the period of _____ hours at the _____. If the _____ is unavailable then the meeting will be held at the _____.

9.5. Annual General Meetings are to review & evaluate goals, achievements, update plans, review membership and elect chairperson and secretary. This meeting will be on the date scheduled for _____ (identify month) regular meeting.

9.6. Special Meetings maybe called by:

• The Chairperson

• Quorum of the committee

• At the request of the _____ Health & Wellness Director

• At the request of the _____ Chief & Council

10. Data Management

Documentation, originals and copies, arising from the VSRT will be securely stored within the _____ office under the responsibility of the _____ Director.

11. Amendments

These terms of reference shall be reviewed at least once a year at each annual general meeting of the VSRT. At this meeting, they may be altered to meet the current needs of all committee members, by agreement of the majority of membership.

HOPE HELP HEALING

Volunteer Suicide Response Team - Oath of Confidentiality

- I, the undersigned, understand that personal information maintained with the Volunteer Suicide Response Team is confidential

- I further acknowledge that information collected by the Volunteer Suicide Response Team may only be accessed, used, or disclosed for team related purposes

- I agree that client consent will be obtained before sharing any information, unless client is deemed or determined to be at high risk or imminent risk of suicide

- I agree not to discuss or release information about client or fellow volunteers that I may overhear or see during or after normal duty hours

- I agree to not send confidential or identifying information via email, text or internet

- I agree to treat everyone with the utmost respect and sensitivity

- I agree to be free from drugs and alcohol while on call

- I have read and understood this statement. I agree to respect this oath as a condition of my membership with the Volunteer Suicide Response Team

- I understand that failure to abide fully by this agreement is grounds for discipline up to and including termination as a member of the Volunteer Suicide Response Team

Name (print): _____

Signature: _____ Date: _____

Name of Witness (print): _____

Signature: _____ Date: _____

Community Suicide Crisis Response Coordination Template

While this tool focuses on suicide crises, this tool can be adapted to a number of crisis situations. A crisis may result from a series of violent acts, a number of losses within a short period of time, or a variety of other scenarios where the community's capacity to cope is overwhelmed or exceeded, requiring a coordinated approach to stabilize the community.

The purpose of a coordinated suicide crisis response is to provide clarity among community, regional, and provincial partners about their roles and responsibilities to support organized, efficient, and effective suicide crisis response.

When a crisis takes place in a community, the immediate response will differ depending on the resources available within the community, the network the community has established with its partners (partner communities and/or regional/provincial partners), the circumstances of the crisis, local traditional protocols, and existing crisis response protocols.

The FNHA responds to a crisis in community when notified by the community (e.g. Chief, Community Health Lead, Band Manager, or equivalent). Some communities may choose to address the suicide crisis internally or with identified partners - not involving the FNHA. In other cases, the FNHA may be notified and become involved in supporting the community, drawing in partners, and activating crisis response funds.

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WHAT IS A COORDINATED RESPONSE?

A coordinated response includes:

- A documented crisis response protocol
- Organized service response between community, regional, and provincial levels
- Identification of clear roles and responsibilities of all those involved in crisis response
- Access to acute mental health services
- Provision of cultural and counselling support to those who are grieving the loss
- Identification and support of individuals at high risk of suicide
- Delivery of follow-up services
- Evaluation and improvement to crisis response process

Community, regional, and provincial collaboration is needed to ensure that those most in need of services receive support and that service providers and cultural leaders are themselves supported to prevent burn out.

Some communities have found that signed Memorandums of Understanding (MOUs) or protocols to help in coordinating services and sharing information when crisis occurs.

WHO MAY BE INVOLVED IN COMMUNITY CRISIS RESPONSE?

The following list is helpful in identifying and engaging with those that may be involved in a coordinated crisis response:

- Community Health Centre staff (e.g. Health Director, Counsellors, CHRs, etc.)
- Emergency Medical Services
- Regional Partners (e.g. regional health authority, local hospital staff, MCFD etc.)
- School or workplace of the deceased
- RCMP
- Traditional Healers, Elders, Cultural Workers
- Community in general
- If requested, FNHA Regional and Central Support staff
- Others?

POTENTIAL ROLES AND RESPONSIBILITIES

The following generally describes the roles and responsibilities of many players in the crisis response process (those specifically involved in the "Community Command Center" are outlined on the next page). Imagine these potential roles and responsibilities as a starting point – these suggestions can be tailored as your committee sees fit:

Community Team Lead	FNHA Regional Team Lead
COMMUNITY HEALTH LEAD e.g. Health Director, Band Manager, or equivalent) acts as the community lead during crisis response; notifies emergency medical services of suicide occurrence; if needed, connects with FNHA Regional Director to draw on FNHA crisis mental health supports (e.g. activation of acute mental health supports, including crisis counsellors); coordinates community response to crisis; mobilizes volunteer crisis response team; supports family and community during the crisis.	*FNHA REGIONAL DIRECTOR or Regional Mental Wellness Advisor* acts as external lead during crisis response; provides leadership for FNHA interface with community; confirms community needs; notifies regional partners of crisis; utilizes financial authority to mobilize crisis response funds from FNHA finance; mobilizes regional supports; maintains connection with Community Health Lead; provides leadership for mobilization of FNHA support; draws on support of FNHA Regional Health Liaison and Community Engagement Coordinators.
Community Team Members	**FNHA + Regional Team Members**
ASCIRT/FAST/DART/VOLUNTEER SUICIDE RESPONSE TEAM COORDINATOR if available, connects with Community Health Lead to provide supports to those affected by the loss as outlined through work plan; connects with FNHA Senior Advisor for Mental Health/Wellness as necessary to mobilize additional supports and make efficient use of existing resources.	*FNHA DIRECTOR OF COMMUNICATIONS* if requested, works with Regional Director and Community Health Lead to develop and/or mobilize a communications protocol; supports community in media response to suicide crisis.
COMMUNITY COUNSELLORS (e.g. IRS Resolution Health Support Workers, NNADAP Workers) provide crisis counselling; connect with close friends and family member of the deceased to ensure supports are available to them; create safety plans with those who are identified as vulnerable to suicide.	*FNHA NURSING TEAM/NURSING MENTAL HEALTH CONSULTANT* provides clinical support to Nurse in community (who is engaged depends on whether or not the community is transferred).

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COMMUNITY ENGAGEMENT COORDINATORS work with Community Health Lead, Regional Director, and, if requested, FNHA Director of Communications to ensure messaging about the loss is accurate, honest, and not sensationalized.	**FNHA SENIOR MEDICAL OFFICER** provides physician expertise in mental wellness, ensuring response reflects current initiatives and partnerships in place; as needed, supports community health lead during long-term planning phase.
COMMUNITY HEALTH NURSE completes FNHA occurrence reporting form to submit to FNHA Nursing and shares form with the Regional Director to update the incident report; connects with FNHA Nursing Team/Nursing Mental Health Consultant as needed.	**FNHA REGIONAL SUPPORT STAFF** On-the-ground emergency support may be provided by FNHA Environmental Health Officers or other regionally-based staff; their role would be limited to making an in-person connection where not feasible for the Regional Director and providing connection to appropriate support within the FNHA if sought from community.
ELDERS/CULTURAL WORKERS/SPIRITUAL LEADERS/TRADITIONAL HEALERS support family and loved ones of the decreased; provide cultural support, traditional healing, and arrange ceremonies for community members.	**FNHA DIRECTOR, MENTAL WELLNESS** maintains regional list of certified counsellors in collaboration with Regional Directors.
EMERGENCY MEDICAL SERVICES (e.g. Ambulance, Emergency Medical Technicians) respond to the emergency call; connect with Community Health Lead to activate community crisis response protocol.	**FNHA CHIEF MEDICAL OFFICER** acts as the internal FNHA lead in crisis response; responsible for logistical support in mobilizing community health and wellness staff during crisis response; provides executive oversight as required supporting the FNHA crisis response team; if CMO is unavailable, the appropriate Senior Medical Officer takes on this role during crisis response.

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MCFD REPRESENTATIVE Ensures mental health supports are available to affected children and youth.

REGIONAL PARTNERS are mobilized by Regional Director; draw on existing resources and supports to assist community in crisis (e.g. Regional Health Authority).

RCMP REPRESENTATIVE Acts as a first responder in the case of a suicide threat or attempt; Ensures supports are available to those who are affected.

SCHOOL Ensures messaging about suicide is timely, honest, accurate, and does not sensationalize the death; shares messaging about suicide with students; ensures supports are available to affected students (e.g. school counsellor or teachers are available to talk to students); remains cognizant that affected students may require time off school to attend ceremonies and/or counselling.

WORKPLACE/EMPLOYER OF DECEASED contacted by Community Health Lead and notified of the loss by suicide; ensures messaging to employees is honest and does not sensationalize the death; offers information about where employees may access grief and loss counselling; remains cognizant that affected employees may require time off work to attend a funeral, cultural proceeding, or bereavement service.

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DRAFT IMMEDIATE SUICIDE RESPONSE PROTOCOL (DAYS 1 – 3+)

The actual crisis response protocol will differ depending on who is involved and what supports they bring to crisis response. Ensure your protocol is accessible and covers all those who are involved in the crisis response process, including regional partners and urban agencies. Here is a draft example protocol to get you started in drafting your community suicide crisis response coordination plan:

1. Family or friends of the deceased notify Community Health Lead of loss by suicide; or, the Community Health Lead becomes aware of the crisis via Emergency Medical Services or other partners in the crisis response process.

2. If Emergency Medical Services have not yet been contacted, Community Health Lead contacts Emergency Medical Services; if needed, Community Health Lead contacts FNHA Regional Director for support through the FNHA; if available, Community Health Lead connects with ASCIRT/FAST/DART/ Volunteer Suicide Response Team to mobilize existing protocols and supports.

3. FNHA Regional Director connects with central support within the FNHA to activate mental health crisis response funding and supports as needed; as requested, Regional Director connects with and draws in regional partners (e.g. regional health authority for counselling support etc.); Community Health Lead maintains connection with Regional Director throughout the crisis response process.

4. Community Health Lead brings together a "Community Command Center". Individuals involved in the "Community Command Center" may also be part of the Suicide PIP Coordinating Committee:

A. ASCIRT/FAST/DART/VOLUNTEER SUICIDE RESPONSE TEAM COORDINATOR

If available, connects with Community Health Lead to provide supports to those affected by the loss as outlined through work plan; assesses suicide risk level of friends and loved ones of the deceased; creates safety plans for individuals at risk of suicide.

B. Community Councillors(s)

(e.g. IRS Resolution Health Support Workers, Mental Health Counsellors, NNADAP Workers) provide crisis counselling; connect with close friends and family member of the deceased to ensure supports are available to them; create safety plans with those who are identified as vulnerable to suicide; if a community does not have access to a community counsellor, the community engagement coordinator could connect with a neighbouring community who has a counsellor to establish an arrangement (e.g. Memorandum of Understanding) for support during crisis response.

C. Community Engagement Coordinator

Works with Community Health Lead, Regional Director, and, if requested, FNHA Director of Communications to ensure messaging about the loss is accurate, honest, and not sensationalized.

D. Community Health Lead (e.g. Health Director, Band Manager, or equivalent)

Notifies emergency medical services of suicide; if needed, connects with Regional Director to draw on FNHA crisis mental health supports; ensures a coordinated community response to crisis; if available, mobilizes volunteer crisis response team; ensures supports are in place for family and community during and following the crisis.

E. Community Health Nurse

Completes FNHA occurrence reporting form to submit to FNHA Nursing and shares form with the Regional Director to update the FNHA incident report form.

F. Elders/Cultural Workers/Spiritual Workers/Traditional Healers

Offer support to families and loved ones of the decreased; offer to provide cultural support, traditional healing, and arrange ceremonies for community members.

G. School Representative

Ensures messaging about suicide is timely, honest, accurate, and does not sensationalize the death; shares messaging about suicide with students; ensures supports are available to affected students (e.g. school counsellor or teachers are available to talk to students); remains cognizant that affected students may require time off school to attend ceremonies and/or counselling.

H. RCMP Representative

Acts as a first responder in the case of a suicide threat or attempt; Ensures supports are available to those who are affected.

I. MCFD Representative

Ensures mental health supports are available to affected children and youth.

5. The "Community Command Center" provides a space where those involved in crisis response can touch base, exchange information, provide information, and direct response activities. The "Community Command Center" manages a coordinated response to the suicide crisis, using existing protocol and related documents; draws in FNHA and regional supports as needed; conducts a stress debrief for staff involved in the crisis response; Community Health Lead, with input from the coordinating committee, conducts a suicide crisis response evaluation to identify the strengths and areas of improvement for coordinated responses in the future.

DRAFT LONG-TERM PLANNING AND SUPPORT
(2 WEEKS – 3 MONTHS AFTER CRISIS)

Regional Director follows up with community on the crisis response process, gathering feedback for FNHA process improvements and additional information for ongoing planning support. Community Health Lead, Regional Director, Senior Medical Officer, Services Funding Advisor(s), and Clinical Nurse Specialist in Mental Health work together to support community in long term planning efforts to prevent and respond to mental health crises, drawing on FNHA central services and utilizing the community health and wellness plan, "Hope, Help, and Healing" Suicide PIP Toolkit, regional partner resources, and other existing supports.

This phase could include creating of an intersectoral coordinating committee to support the development of a crisis response protocol and long term mental wellness plan (if not complete already), enhancing access to regional and provincial mental health services, and/or developing a plan for monitoring and/or evaluating community crisis response activities.

Tool 4.1: Workplan Tasks and Actions (example from PIP Plan)

This toolkit does not focus on how to implement your plan, however there are some templates and examples that might help you to implement specific projects in your community.

Each task you identify in your PIP plan is a job in itself, so having a smaller action plan for each task that outlines more specific details can be helpful. This can help to keep things organized and focused, and also helps to keep track of progress. To manage your project, you should track time, scope (what's included in the project and what's not), and how much money is being used.

- To help you track your PIP Plan's activities/tasks, the work-plan below provides an example.
- If you plan an event, it is helpful to work backwards (and forwards) from the event date to work out when you need to have each activity completed by.
- If you are working with people outside your team or community, make sure you give them enough time to get their part of the work done. It's a good idea to first check with them how long they will need to finish their part of the plan. It is also helpful to check with them a week or two before their work is due to see if there are any delays or issues.

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Suicide PIP Implementation Workplan				
Prevention				
Activity Description	**Responsibility**	**Start Date**	**End Date**	**Notes**
Example: • Form a band school working group (WG) to develop mental wellness promotion programs for youth • Invite other outside partners to be members of WG • Develop a Terms of Reference • Develop an action plan based on the gaps identified during the assessment step • Seek funding • Implement activities • Evaluate results	Youth Council supported by the Coordinating Committee	Sept 30 20XX	Ongoing as determined by the coordinating committee	We will focus on all youth from ages 5 to 20
Intervention				
Example: • Implement gatekeeper training program	Mental Wellness committee	Dec 1 20XX	Mar 31 20XX	We will need to determine how many gatekeepers to train
Postvention				
Example: • Develop a response protocol with outside partners	Committee supported by CC	Sept 1 20XX	Ongoing	Once developed will need to have practice sessions to keep skills up

Congratulations on getting this far! Now it's time to put your plan into action.

Make sure there is a method to track each of the tasks and progress with the work plans. You may wish to put each TASK from the PIP Plan onto your Committee agenda and have each person responsible for the task report back on progress at every meeting. For this purpose you need to decide how often your Committee will meet to track progress. It may be monthly at first and then later, as progress is made, you might move to quarterly meetings (4 times a year). Report on the work to Chief and Council, Health Directors and other groups – especially the agencies that the Committee members belong to. Think about community newsletters to let the community know about new happenings in the community; new services; or new crisis response services available to them. Communicate! Communicate! Communicate! Below is a status report template example that can be used to track your progress, and identify risks or issues.

After you have a plan, discuss how your community will keep track of your progress. Do you need to have regular committee meetings? Will the Health Director take on monitoring? Do you want an ad hoc committee to get together once or twice per year?

Teresa
Grade 3, Sts'ailes Community School

Tool 4.2: Monitoring and Reporting on the PIP Plan Implementation

Suicide PIP Planning Status Reporting Template				
Start Date & End Date	January 27, 20XX to March 31, 20XX	**Project Sponsors**	Leadership and Council or Health Director	
Planning Leads	Mrs. Jean Smith	**Team Members**	Jean, Sam, Joe, Moira	
Project Purpose	To develop a suicide PIP plan for X community.			
Deliverables:	**Target Date**	**1st Delivery Date**	**Comments**	
Suicide Assessment Report	Feb 5	Feb 19	Report is delayed by two weeks due to X.	
Suicide PIP Draft # 1 Plan	Feb 28	Feb 27	Plan draft provided to X group.	
Revision of PIP Plan	Mar 17	Mar 20		
Finalized Plan	Mar 29	Mar 27		
Ongoing	**Dates**		**Comments**	
Status reports	Monthly		Due every Wednesday.	
Project related meetings	Weekly		Future meetings: Mar 22 (2 to 3), 2014	
Current Status	**Key Activities Week 7 - (March 10, 20XX to March 17, 20XX):**			
	Other Project Activities • Current work to analyze all data and info collected in developing the final plan. **Project Related Meetings** • Community engagement and other interviews. • **Other:** Interview held with Dr. X on Mar 8th. • Meeting scheduled with Sue W. on Mar 22, 2014. • *Requested TC with X organization last week. No response yet.* **Review of Final Report** • Final plan review meeting scheduled for March 29, 20XX from 2 to 4 pm at X meeting room. All Coordinating committee to attend in person. **Outstanding Issues** • None.			

Best Practices

ADDITIONAL READING ON PREVENTION PROGRAMS

You might wish to read about other prevention programs that are already happening in other communities, or get more details on prevention programs. This section lists some of these programs.

Fraser Health Report: Fraser Region Collaborative Partnership Response to Youth Suicide at:

www.fraserhealth.ca/media/AH_suicide-prevention.pdf

https://suicidepipinitiative.wordpress.com/about/

• This report describes a lot of different programs and resources. Here are some examples:

• School Based Programs (pg. 30 to 40)

  - These are school-based programs for children and youth. They focus on mental health promotion and preventing mental health and substance use problems and disorders. They integrate behavioural changes, coping skills and social supports.

• Culturally Appropriate Services (pg. 41 to 54)

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

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

    ~ Coping skills training and workshops for emotional regulation and coping

    ~ Providing stigma reduction, social inclusion, mental health awareness and education messages through TV, newspapers, and radio

    ~ Two-spirited lesbian, gay, bisexual and transgendered (LGBT) sensitivity training administered by LGBT agencies and/or service providers

Healthy is being like...
people running, life is good!!?!
eating Healty.
I am running everyday!!!

Joan
Grade 5, Cultus Lake Elementary School

Sts'ailes Community School Outreach Program

The Sts'ailes (Chehalis) Community School Youth Outreach Program provides youth outreach services for the students of Chehalis community school. It helps students deal with personal, school, and family issues, and it is one of the best support services available to students. It has made a true difference in their lives. Program activities include:

- facilitated talking circles
- coached sports teams (e.g. soccer, volleyball, baseball and basketball)
- connections to Big Brothers and Big Sisters
- spirit days
- school dances
- social skills development programs
- an in-school mentoring program
- weekly girls group
- team meetings for kids at risk

Inuusiqatsiarniq Ìnuit Youth Suicide Prevention Strategy
- Guide to Implementing the National Aboriginal Youth Suicide Prevention Strategy 2008

Suicide prevention and mental wellness are the number one health priority for Inuit. From an Inuit perspective, for a suicide prevention strategy to be successful, it must have a major focus on Inuusiqatsiarniq. This means having a focus on the positive, and working together to encourage healthy lifestyles and overall well-being in a holistic way. In order to create positive change, we have to approach it in a life-affirming and positive manner. We need to celebrate and embrace life! The Inuusiqatsiarniq Strategy is the name given to the Inuit-specific approach developed by Inuit to implement the National Aboriginal Youth Suicide Prevention Strategy (NAYSPS) in Inuit communities.

Strategy Elements

The Inuusiqatsiarniq Strategy supports Inuit working together and community-based approaches to suicide prevention. Communities will be supported to design and implement suicide prevention plans. The Inuusiqatsiarniq Strategy supports activities in five areas:

- Wellness (promotion and prevention)
- Management (crisis response planning)
- Maintenance (sustainable programs over the long term)
- Knowledge / Monitoring / Evaluation (increasing what we know)
- Human Resources - Investing in people (volunteers, frontline workers, youth, adults, parents, Elders, communities, organizations and governments) to better understand the issues and realities related to Inuusiqatsiarniq.

International Program Examples

The Zuni life skills development program was designed in collaboration with the Zuni Pueblo community in New Mexico. It is included in the curriculum at the Zuni tribal high school. The Zuni Life Skills Development curriculum has seven parts:

- building self-esteem,
- identifying emotions and stress,
- communication and problem-solving training,
- recognizing and eliminating self-destructive behaviour,
- suicide information,
- suicide intervention, and
- personal and community goal setting.

The program follows the norms, values, beliefs and attitudes of the Zuni. The program was delivered by teachers and individuals from the local community and received support from the community.

Suicide prevention interventions in rural and remote communities

If you are planning suicide prevention programs in a rural or remote community, you may find some of these ideas helpful:

- **Focus on health and wellbeing,** rather than illness or mental health problems. Many people from rural and remote communities prefer to focus on finding solutions, rather than dwelling on problems and difficulties.

- **Promote understanding** of signs of distress and despair. Encourage people to **seek help early** before things get worse.

- Use community networks to **build resilience and coping strategies** among people in rural and remote communities. If communities can work together and support each other, they will have the skills to respond effectively to people in need. For example, social and sporting groups provide an opportunity to build awareness of suicide, mental health needs and related issues, encourage social connectedness, and build community capacity.

- **Provide supports** for people at higher risk of crisis to get them through hard times.

- **Promote acceptance** of talking about emotional issues and difficulties.

- **Provide education,** awareness and resilience-building programs. Some examples are financial planning, communication and coping techniques, managing complex workloads and dealing with relationship and family issues.

- **Involve people** in the community in designing and implementing programs. People in rural and remote communities can identify the best ways to provide support and care in their community. They can contribute their skills to suicide prevention initiatives in the community.

- **Create networks** within rural and remote communities where people can meet, discuss issues and socialize, whether in person or via phone or the internet. Identify local community leaders who can maintain regular contact with community members and build awareness and support for suicide pre-vention activities and initiatives.

- Ensure that community members, especially community leaders, emergency services personnel and health professionals are **aware of the available support services in the region,** including by posting a list of services and other important contact numbers at commonly visited locations (e.g. store, band office, doctor's office).

- **Promote awareness among service providers** of the different ways in which people in rural and remote areas may respond to difficult or traumatic circumstances, and of their varying needs.

- **Give training** for health professionals working in rural and remote areas (e.g. local doctors, visiting health services workers) to recognize and respond to the warning signs of suicide, suicidal behaviours and mental illnesses that are strongly associated with suicide (e.g. depression).

For more information see the **Suicide Prevention Toolkit for Rural Primary Care Providers** developed by the Suicide Prevention Resource Centre, 2009, available at:
www.sprc.org/for-providers/primary-care-tool-kit

ADDITIONAL READING ON INTERVENTION PROGRAMS

Fraser Health Report: Fraser Region Collaborative Partnership Response to Youth Suicide:

www.fraserhealth.ca/media/AH_suicide-prevention.pdf
This report describes many programs and resources.
Here are some examples (pg. 56 to 61):

Gatekeeper training for key community members including:

• Peers, health professionals, community leaders, spiritual advisors, within school and postsecondary settings, the workplace, acute care settings and long term care facilities, justice system

• Training focused on how to identify individuals at risk of suicide, and support their access to suicide intervention and mental health and substance use resources

Gitxsan Project, Northern Region, BC (AFN NAYSPS report):

The First Nation Action & Support Team (FAST) is a project in 15 Northern communities. It aims to build skills and expertise for a team of front line workers to prepare them to respond to crisis situations. Persons selected for the training are a diverse group with the youngest being 20 years of age, to Elders in the senior age range. Employers of selected team members were asked to donate 20 days of paid time to support the work.

The training consists of the following elements:

> • A "Train the Trainers" model;
>
> • Suicide risk symptoms;
>
> • Intervention;
>
> • Dealing with difficult people;
>
> • Developing a process and procedures in responding to crisis;
>
> • Clinical assessments process;
>
> • Dealing with the health of the team;
>
> • Crisis response;
>
> • Personal development;
>
> • Who should be called;
>
> • Building schedules so that someone is always on call;
>
> • A program called "Through the Pain";
>
> • Cultural and traditional components.

HOPE HELP HEALING

Applied Suicide Intervention Skills Training (ASIST)[47]

ASIST is a two-day, interactive workshop designed by Livingworks Education Inc, a public service corporation. It prepares all caregivers including professionals and lay people to intervene in a suicide crisis. ASIST is the most widely used suicide intervention workshop in the world. It has been in place for nearly 25 years, has been translated into languages other than English and has over 3,000 trainers worldwide. This workshop talks about attitudes and how they affect one's work as a caregiver (a caregiver in this case is anyone whose work—professional or volunteer—involves suicide prevention). It also gives the caregiver an understanding of who may be at risk for suicide and how to do a risk assessment. Participants have the chance to practice talking to a person at risk. They use role play, where they follow the intervention model taught through ASIST. Further information and to access trainers see: www.livingworks.net

Emery
Grade 5, Tyson Elementary School

47 Aboriginal Healing Foundation. (2007). In Fraser Health 2013 Report.

The Aboriginal Suicide and Critical Incidence Response Team (ASCIRT) Approach[48]

Some First Nations and Aboriginal communities in BC have adopted the Aboriginal Suicide and Critical Incidence Response Team (ASCIRT) approach to suicide prevention and response. There are currently seven ASCIRT in the province, each focusing on different aspects of primary, secondary and tertiary prevention. Each team has a unique name and has adapted this approach to fit their communities. The teams focus on building community capacity, mobilization, education and support. The purpose is not to replace what already exists, but to increase knowledge, awareness, capacity, and support a community in crisis.

The main goal is to have a community-based response team that will enhance primary suicide pre-vention efforts (such as public education to raise awareness and decrease stigma), and the existing community capacity to respond to community crises. The approach involves a group of communities or Nations coming together and choosing members to participate in an incident response team. The members from each community obtain Band Council Resolutions (BCR) that require that the response team members are allowed up to 20 days during the year to be a part of the incident response team, while still maintaining their employment within their respective communities.

Members from the communities that are represented on the ASCIRT teams receive basic mental health training to build capacity in responding effectively to a critical incident, including both suicide attempts and other crises within the community. The team includes many different types of responders such as clinical, knowledge keepers, traditional healers, and youth support. The training is based in culturally relevant knowledge and traditions. The teams are also a part of a circle of outside clinicians and respond-ers that can work in cooperation with the traditional methods to provide a holistic path to healing.

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48 ASCIRT Coordinator Gathering 2009, FNHC.

ADDITIONAL READING FOR YOU ON POSTVENTION PROGRAMS

You might wish to read about other postvention programs that are already happening in other communities, or get more details on postvention programs. This section lists some of these programs.

If you wish to access more examples and resources, you can download the Fraser Health Report called Fraser Region Collaborative Partnership Response to Youth Suicide: www.fraserhealth.ca/media/AH_suicide-prevention.pdf (pg. 70 – 74)

Suicide Postvention Protocol

In the event of a suicide, a postvention protocol can serve to coordinate an effective response to the community crisis. The protocol can act to build the self-esteem of the community as a whole: normalizing the bereavement process, ensuring that those who need support get it, and providing education. The following includes references to the roles of the community postvention team at each of the levels of the community – family, individual youth and adults, community and the outside community. Some of the tools identified in Appendix 3 may be relevant here as well.

Family

- Ensure that support is offered to the whole family: In many cases families provide their own support system in the event of a death. However, a suicide can have a shattering effect on a family system which can lead to blaming, fear, hopelessness and disharmony.

Individual Youth and Adults

- Offer assistance: Seek out and offer assistance to those close to the deceased as well as other individuals who may currently be in crisis. As well, ensure that friends of the deceased are interviewed to determine if there is a "suicide pact".

- Temporary counselling centre: For others who need support, it may be important to set up a temporary counselling centre (staffed by a counsellor and arranged by an organizer) to provide a safe place for grieving. This is particularly important for fellow students/co-workers and school staff, if the deceased was attending a local school. In this event, a room in the school could be employed for this process.

Community

- Memorials: Minimize the glamourizing effect of large memorials or school assemblies which may entice a suicidal person to make an attempt in order to receive the same validating attention.

- Guided sharing circles: When appropriate, encourage guided sharing circles in schools or community centres, particularly if the deceased was a child or youth.

- Factual information: Have a single spokesperson provide factual information about the suicide to prevent the spread of rumours and mis-information.

- Suicide prevention education: The tragedy can become an opportunity to offer basic suicide awareness/prevention information to the community. Have materials as well as educational events prepared ahead of time.

- Spiritual services: Community members and places identified as spiritually significant should be invited to participate in the process when appropriate.

Outside Community

- Media coverage: Where possible, encourage the media to avoid sensational or romanticized accounts of the death.

- Outside services: In smaller communities where many of the workers may be related to the deceased, it may be useful to engage counsellors and services from outside the community.

- The use of a Critical Incident Response Protocol that incorporates these postvention recommendations can make a significant impact on reducing the risk of further suicides in the community. The protocol also provides guidance on dealing with a suicide pact and on responding to the media.

Evaluation Guidelines and Examples

What Is Evaluation?[50]

An evaluation is a purposeful, systematic, and careful collection and analysis of information. This information is used to record the effectiveness and impact of programs. An evaluation process helps to establish accountability, and identify areas needing change and improvement. Note that an evaluation of the effectiveness of a program or activity (the product) is different than evaluating the implementation of the community PIP plan (the process). Both are important.

Evaluating your community's PIP activities is important – you need to know if something is working and why so you can repeat the activity. You also need to know if something is not working so you can make changes and improve it. Sometimes when you get grants, the people who give you money want to see how it was used and what difference it made. Evaluation is different than monitoring the completion of the **tasks** in the plan – **this is about checking whether the tasks (project) have made a difference – whether they have improved or increased something good!**

For each activity, project or service you plan for and carry out, there should be a 'mini-evaluation" done that can be brought to the Coordinating Committee for approval. Each of these mini-evaluations will form part of a bigger evaluation of the whole PIP Plan.

1. Define the purpose of the evaluation.

It is important that your Committee decides what it wants to evaluate, and to include these measures in your Suicide PIP Plan. For example, you may want to undertake an evaluation to address problems identified in one aspect of a program. Let's say you identified a gap in PIP services during the assessment step (e.g., community members report that they do not feel culturally safe when attending a certain community program).

2. Define your specific evaluation focus – an example is below

Objective:

 • Work with X community program to explore ways to improve the cultural safety of the program.

Strategies/Activities to help you meet this objective include:

• Build relationships and trust between yourself and the program staff and manager.

• Explore with the program manager what s/he thinks they may need to promote greater cultural safety in the program.

• Locate resources that can help, like Indigenous Cultural Competency (ICC) training.

• Together, develop a plan of action that meets their needs and your needs.

• Main strategy: Provide opportunities for ICC training to program staff.

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50 Wall, J.E. (n.d.) Program Evaluation Model - 9 step process. Retrieved Aug 28 2013 from:
   http://region11s4.lacoe.edu/attachments/article/34/(7)%209%20Step%20Evaluation%20Model%20Paper.pdf

3. Develop your evaluation question. What do we need to know?

Hint: Write your evaluation question clearly and completely. You may have more than one question, but it's important to narrow it down because evaluation can be expensive to do.

Looking at the strategy of providing training
Possible questions:

1. How successful was the training? How will you measure this?

2. Did the training help improve staff cultural competency? How will we measure this?

3. Did the training result in more community members using the program? How will we measure this?

As a group what do we really need to know?

• For this scenario, we likely want to know the answer to question number three.

• The program manager may also wish to know the answer to question 1 and 2, but that is outside of the scope of PIP work and more related to her internal quality improvement work.

Feasibility Check:

Do we have enough resources to answer the question? Do we have the expertise to do this evaluation? Do we have enough time to answer the question?

4. What indicators (numbers, people's opinions, etc.) could answer this question?

• Did the training result in more community members using the program?

• The indicators likely have to do with the number of people accessing the program from your community.

5. What data collection method will I use?

• In discussions about data collection, you all agree that it makes most sense for the community program to use the data they routinely collect about clients as the main method.

• The program will have to pull their data differently and at a different time, but they agree this would be most efficient and also helps them see how they are performing.

6. When will we collect the data?

• You can collect data immediately after an activity program or project is completed, during its implementation, and on an ongoing basis if the program will continue to run.

• In this case, it's important to determine if the program found an increase of clients from the community one month after training, three months, six months and maybe even one year later in order to determine if things are continuing to work well, and that everything you hoped the training would accomplish has happened.

7. Who will collect and analyse the data?

- This depends on the type of evaluation you agree to do as a team or committee. In this scenario, the program has agreed they will collect and analyze the data. They will have to agree to report to the committee, where they report a summary of results (maybe just percentages or they use numbers instead of names) to protect their clients' confidentiality.

8. How will we use the results? How will we share the results with the community?

- There are different ways you may wish to use the results. It also depends on what you learn in the evaluation process.

- For example, if the results show no increase occurred (and you know the training was successful because the program manager evaluated the training activity with her staff), you may need to look for other reasons why you didn't see the results you hoped the training would bring.

- In your discussion with your committee and the program manager you may realize that no one talked about the change or improvement in the service to your community.

- In this case you would have to implement another strategy (advertise or promote to the community members that the program has made changes and is looking to serve them better) to re-evaluate its effect.

- Sometimes you have to be like a detective looking for clues along the path and acting on them to determine if what you planned has actually happened.

Evaluating the difficulties, the successes and how you achieved the successes will provide you with important information that can also be shared with neighboring communities, schools and organizations. Sharing "best practice" information with one another may allow one group to avoid making the same mistakes that another had to deal with. It can also help implement successful projects more quickly and easily, without going through a trial-and-error process.

> **Links to Evaluation Resources**
>
> - Developing an Evaluation Plan
>   (http://ctb.ku.edu/en/table-of-contents/evaluate/evaluation/evaluation-plan/main)
> - Program Evaluation Model - 9 step process
>   (http://region11s4.lacoe.edu/attachments/article/34/%287%29%209%20Step%20
>   Evaluation%20Model%20Paper.pdf)

Expanding beyond Evaluation to Surveillance as a Community

Evaluating your specific programs and activities is one thing. Checking whether these activities are actually changing patterns in suicides and the risk of suicide is another. This kind of work is often done over longer periods of time. One of the roles your Coordinating Committee can play is performing "surveillance" – the routine monitoring of what is happening related to suicide. This will truly help you to determine the impact of your efforts. The ability to do surveillance depends on the capacity of the community and may require partnerships with other communities in the area. Some communities may decide that a surveillance plan is beyond what they can undertake, and that's okay - not doing surveillance doesn't mean not doing suicide PIP work.

> **Surveillance:** Systematic, ongoing collection, collation, and analysis of health-related information that is communicated in a timely manner to everyone who needs to know which health problems require action in their community. Information that is used for surveillance comes from many sources, including reported cases of hospital admissions, population surveys, reports of absence from school or work, and reported causes of death (Public Health Agency of Canada, 2005)
>
> **Source:** www.phac-aspc.gc.ca/php-psp/ccph-cesp/glos-eng.php#information

The regular collection and rapid, but careful sharing of suicide-related data is needed to guide appropriate First Nations and Aboriginal community action. The time between when an event takes place and when the data is being sent to those who need it must be brief. This is no simple task, as it involves collecting information on a number of behaviours (e.g., suicidal thoughts, attempts, deaths) that may be available at many levels, or through different organizations (e.g., community, regional, provincial and national). The information may come from several different sources, including vital statistics, emergency departments, crisis lines, inpatient hospital records, and crisis care centers.[51] Furthermore, obtaining data from an external organization can be challenging because of privacy and ownership issues.

Developing a surveillance component as part of PIP is needed to support First Nations and Aboriginal community action. Some suggested planning objectives are:

• Improve and expand local community ability to routinely collect, analyze, report, and use suicide-related data in order to inform prevention and response decisions.

• Improve the speed of data reporting to enable timely intervention.

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51 Office of the Surgeon General (US), National Alliance for Suicide Prevention (2012). National Strategy for Suicide Prevention: Goals and Objectives for Action: A Report of the U.S. Surgeon General and of the National Action Alliance for Suicide Prevention. www.ncbi.nlm.nih.gov/books/NBK109916/

Surveillance Information You May Collect:

- Numbers of suicide attempts and deaths by suicide (current year compared to previous years). Are there any patterns, increases, decreases? What might be the reasons for this?

- Age and gender of the individuals involved each year. Are there are any patterns in this information such as more women than men, or more youth than adults?

- Methods of suicide attempts and deaths by suicide. Are there patterns as to the methods being used? Can access to things that support those methods be reduced or prevented (e.g. tighter control and storage of guns and other weapons in the community)?

- Are there patterns in repeat events? The majority of people who attempt suicide will do so more than once. Therefore, targeting people and enrolling them in a suicide prevention/ aftercare program could reduce the likelihood of future attempts.

- Are there specific settings or places where people attempt suicide? Do people usually attempt suicide at home, at school, in the forest, in rivers? Are there any strategies that could make these safer places?

- What information can you obtain (without breaching personal privacy) from mental health professionals and clinicians about some of the common reasons for considering suicide? Are there any trends they are aware of? What are some of their recommendations for action?

- What else would the Committee or the community like to know about from a surveillance perspective to help improve the situation? How will you collect the data?

- Make sure you think about how you will protect people's privacy, especially if you are reporting on a small number of suicide attempts or deaths (e.g., removing any ability to link the data to a particular person). Some communities have responded to this privacy concern by reporting on a geographical area which includes their community and surrounding communities. As suicides impact surrounding areas this actually enhances your information gathering. For example, though a suicide death occurs in a nearby community, family members and friends may reside within your community.

Best Practices in Surveillance and Prevention

The Secwepemc Nation Injury Surveillance & Prevention Program

The Secwepemc Nation Injury Surveillance & Prevention Program was started in 2003, when 8 Health Directors representing 16 of the Secwepemc communities in the Interior Health region, came together to explore the possibilties of collecting community specific injury data. They recognized that for prevention strategies to be effective, the strategies needed to be matched to relevant injury problems. The group moved forward with the implementation of the Aboriginal Community Centered Injury Surveillance System (ACCISS). This System collects data on injuries occurring in the community and used this data to plan prevention activities in the community.

The White Mountain Apache Suicide Surveillance System

In the US, the White Mountain Apache tribe in east-central Arizona, following a cluster of youth suicides, enacted a resolution to mandate tribal members and community providers to report all suicidal behaviour (including ideation, attempts, and deaths) to a central data registry (citation below). The resulting surveillance system is the first of its kind, gathering data from both community-based and clinical settings. The surveillance system was in place between 2001 and 2006. Based on data captured in the surveillance system, the creators of the system were able to identify trends in suicide-related behaviours and activities, and have used this information to develop and implement prevention strategies that are reflective of the needs of the White Mountain Apache community.

Source: Mullany B, Barlow A, Goklish N, Larzelere-Hinton F, Cwik M, Craig M, et al.
Toward understanding suicide among youths: results from the White Mountain Apache tribally mandated suicide surveillance system, 2001-2006. Am J Public Health. 2009 Oct;99(10):1840–8.

Practical Tools and Resources

This section lists practical tools that are easy to access. They can help with:

1. Recognizing suicide risk

2. Assessing suicide risk

3. Responding to suicide risk and deaths

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

Intervention-based Tools

Tools to Support Recognition of Suicide Risk

IS PATH WARM is a helpful device for recognizing the warning signs of suicide. This tool was developed by the American Association for Suicidology. It can be used as an educational resource when training gatekeepers to recognize potential signs of suicide.
www.counseling.org/resources/library/ACA%20Digests/ACAPCD-03.pdf

Responding to People at Risk For Suicide: How Can You and Your Organization Help? is a practical guide to promote awareness of the warning signs of suicide and how to help. It is produced by the Queensland Government (Australia).
www.spinz.org.nz/file/downloads/pdf/file_411.pdf

Tool for the Assessment of Suicide Risk in Adolescents (TASR-A) is a clinical evaluation tool developed by Dr. Stan Kutcher for documenting imminent risk of suicide among youth following a clinical interview.
http://teenmentalhealth.org/for-health-professionals/clinical-tools/

Suicide Risk Assessment: A Resource for Health Care Organizations is a comprehensive guide that is designed to help Canadian health care organizations with understanding and standardizing the practice of high-quality suicide risk assessment www.oha.com/KnowledgeCentre/Documents/Final%20-%20Suicide%20Risk%20Assessment%20Guidebook.pdf

The Suicide Assessment Five-step Evaluation and Triage (SAFE-T) is a helpful pocket card that guides clinicians through the process of suicide risk assessment through the use of five key steps. https://store.samhsa.gov/shin/content/SMA09-4432/SMA09-4432.pdf

The Suicide Risk Assessment and Management Protocol: Emergency Department were developed in Australia in recognition of the important role played by hospital emergency departments in the management and treatment of suicidal individuals. www.health.nsw.gov.au/pubs/2004/emergency_dept.html

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

Guidelines for Developing Suicide Risk Assessment and Response Tools

• Identify who will respond to the call and in what way (in-person, telephone-based)

• Gather client information for follow-up (e.g. name, address, phone number, email, etc.)

• Determine the individual's suicide plan (e.g. How? How prepared? How soon?)

• Identify risk factors for suicide (e.g. what are the caller's reasons for considering suicide?)

• Identify protective factors for positive mental wellness (e.g. what are the caller's reasons for living?)

• Create a Safety Plan with the individual (e.g. identify distractions, friends/supportive adults, service providers, coping skills/activities, safe places, emergency services)

• Develop a follow-up protocol and support everyone to follow the guidelines

Suggestions for Prioritizing Those in Need of Support

A suicide or suicide attempt in a community may increase the risk of suicide in some individuals. Individuals at increased risk for suicide may need to be proactively contacted. The following list is in order of priority. Service providers and cultural leaders will need to determine how many people can be provided with individualized suicide intervention services. It is recommended to identify those most in need of intervention support and prioritize those individuals at highest risk of suicide:

• Previously suicidal persons

• People identified with previous or current depression, anxiety disorder, PTSD, sleep disorders and/or substance misuse

• Bullied and bullying individuals

• Those experiencing ongoing conflict

• Those who have had a recent major loss: including the death of a family member or close friend, a romantic breakup, divorce, etc.

Protocol for Supporting High-Risk Individuals

It is recommended those identified as being at higher risk of suicide:

1. Receive immediate, in-person, crisis debriefing – including presentation of factual information and the opportunity to discuss their thoughts and feelings regarding the suicide attempt

2. Are connected to Elders/spiritual leaders/traditional healers and/or cultural practices

3. Education regarding suicide awareness; including knowing someone who has attempted/died by suicide can increase suicide risk in self or others

4. Receive a suicide risk assessment (pg. 44)

5. Are supported to create a Safety Plan (pg. 47)

6. Know of the services available to them, including further on- and off-site counselling and information on community supports, internet supports crisis lines; handouts regarding suicide; etc.

7. Self-care information

8. Are referred for ongoing support

9. A request for their assistance in identifying others of concern

Those deemed to be at lower risk should receive individual or group support, including:

1. If possible, factual information to ward off rumours

2. Education regarding suicide awareness and intervention

3. Suicide risk assessment and development of safety plans

4. Description of response services available including on-site or off-site counselling, available spiritual practices – Elders, smudge, prayer

5. A request for their assistance in identifying any others of concern

To respond to the overall community, a community recovery session could be hosted. Ensure spiritual leaders and additional trained mental wellness service providers are present to assist those needing extra support. During these sessions provide suicide awareness education and intervention information, and community support information. Be sure to include handouts with community resource and emergency services information, and crisis lines and website links.

Debriefing

Regular responder debriefing is vital. It is recommended this group of service providers and cultural leaders meet at the beginning or end of each day for the first three to seven days for a brief personal and operational debriefing. This debriefing provides group members the opportunity to:

a. Debrief initial thoughts and feelings related to the suicide threat/death and response provided

b. Provide responders with a wellness reminder

c. Review services provided to date and identify gaps

d. Identify at risk individuals and ensure each have been, or will be, contacted

e. Ensure follow up support is being provided to higher risk individuals

Tools to Support Organizational Responses to Suicidal Behaviours

Principles for Developing Organizational Policies and Protocols for Responding to Clients at Risk of Suicide and Self Harm is a practical tool developed by the Queensland Government (Australia) to support the development of proactive organizational policies for responding to clients at risk for self-harm.
www.togethertolive.ca/sites/default/files/principles-for-developing-protocols.pdf

Practice Tool for Exercising Discretion: Emergency Disclosure of Personal Information was recently produced by the Office of the Information and Privacy Commissioner of BC to support decision making when working with individuals at risk for suicide.
www.ipc.on.ca/images/Resources/ipc-bc-disclosure-edu_826594762500.pdf

Following a suicide or a significant suicide attempt, it is recommended that services providers and cultural leaders meet to:

• Identify individuals at highest risk of also attempting suicide by name

• Determine which agency or individual is best able to respond and to which at-risk person they can respond

• Ensure those most trained and experienced in suicide intervention respond to those at highest risk. Individuals at lesser risk of suicide can receive support from those with less suicide intervention experience. Also, an individual with little or no suicide intervention training/experience could be partnered with someone with greater skill for mentorship training and support.

• Identify individuals and agencies that can provide follow up support

Postvention-based Tools

Tools to Support Responses After a Suicide

The Hope and Healing Booklet is a practical guide for supporting survivors of a loved one's suicide in BC: www.health.gov.bc.ca/library/publications/year/2007/HopeandHealing.pdf

The Lifeline Online Postvention Manual provides guidelines for reducing contagion and constructively responding to a suicide death through social networking sites: www.sprc.org/library/LifelineOnlinePostventionManual.pdf

After a Suicide: A Toolkit for Schools was developed to provide direction and guidance to schools and communities following the suicide death of a community member: www.sprc.org/sites/sprc.org/files/library/AfteraSuicideToolkitforSchools.pdf

Principles for providing postvention responses to individuals, families and communities following a suicide death was developed in Australia and provides key principles and good practice suggestions around supporting families and the wider community after a loss by suicide: www.togethertolive.ca/sites/default/files/principles-for-developing-protocols.pdf

Responding to Critical Incidents, A Guide For Schools is intended to assist schools in developing protocols for responding to critical incidents and focuses on proactive plans to deal with the traumatic aftereffects of a critical incident which affect some or all members of a school community: www.bced.gov.bc.ca/specialed/rci/consid.htm

The Need for a Suicide Risk Assessment with Survivors

1. The suicide death of a family member or close friend increases the suicide risk of survivors.

2. A suicide risk assessment needs to be conducted early within the postvention response, preferably within the first or second meeting with the survivor.

3. Possible script: "Sometimes when someone we love dies by suicide we become so sad we want to join them, and we think about suicide. I am just wondering if you have been thinking about killing yourself?"

4. If the individual has been considering suicide, then a risk assessment is completed including asking about how and when they plan to suicide.

5. In all cases develop a Safety Plan which helps individuals know what to do when they are starting to feel overwhelmed. The person works through their safety plan until they are confident they are safe and feeling better.

The more lethal the plan and the more imminent the date, the greater the individual's risk is for suicide. Appropriate safety measures need be put in place; including at a minimum, advising parents/guardians if supporting someone age 18 or under, and safety proofing the home/environment for lower risk situations. Access emergency service response for all higher risk situations.

Suggestions for Subsequent Supporting Visits

1. Continued revisiting suicide risk and safety plan on a regular basis

2. Further review of emotions typically associated with death, and particularly suicide death. It is possible to build an entire session around each of the following:

a. Shame

"What will other's think of my ____ who killed him/herself?"
"What will others think of me?"
"Will others judge me?"

b. Embarrassment

The location of the suicide death is initially treated as a crime scene, including having space cordoned off by crime scene tape. If the death occurred in the home or close by, some survivors may be particularly embarrassed by having police and other emergency services respond. This may be especially upsetting if the death occurred outside of the home and police members, crime scene tape, etc. is/was viewable to neighbours and others walking past.

c. Blame

Survivors often struggle with trying to find a reason for their loved one's death. In the process, fingers are pointed and others are held responsible for the suicide. Often survivors blame themselves, or others, for missing the signs, not doing more to prevent the suicide or being the reason for the suicide.

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d. Guilt

Guilt is a heavy burden to carry. Hindsight is 20-20 - warning signs that were not apparent prior to a suicide death are now easily noticeable. Often the one who dies by suicide provides small pieces of information to numerous individuals; pieces which in hindsight, given to one person might have been enough to cause notice. Individuals often feel they should have been, or done, more to prevent the suicide. Individuals can become obsessed with blaming themselves for the suicide.

e. Confusion

Thinking can become impaired and survivors may feel like they are losing their mind. Individuals may constantly replay the suicide and try to imagine what it was like for the person to die.

f. Rejection

Survivors may feel rejected by the one whom suicided. They may also fear other community members will judge and reject both, the memory of the one who suicided, and the survivor.

g. Relief

In rare circumstances there may be relief. Sometimes family members and friends have feared this suicide for so many years there is a sense of relief that the inevitable has occurred. Often, as soon as they feel this relief, guilt comes storming in and they feel horrible for being relieved.

h. Anger

Anger at the one who died for abandoning the survivor; anger at those the survivor blames for the suicide; and anger at themselves for not being able to stop the suicide.

i. Worthlessness

The survivor can feel worthless when they view the suicide as a sign they were inadequate to meet the needs of the deceased and save the one who died.

j. Abandonment

Often there are feelings of abandonment as survivors are left behind. Children particularly can feel abandoned by the parent that should have lived to love and protect them.

k. Longing

Sometimes there is a strong desire to join the deceased. This is common grief response to any type of death; however, in the case of suicide this is particularly concerning. It is advisable to ask the individual how strongly they desire to be with the deceased, and are they considering suicide.

l. Fear

Some fear the judgement of other family members, friends or the community as the survivor was unable to prevent the suicide. Some fear others will follow the actions of the deceased and suicide. Some fear life without the deceased, especially if the deceased was a partner or parent.

3. It is recommended that bereavement work reviews survivor's sense of:

      a. Loss and having been "left behind" by the one who suicided

      b. Isolation and seemingly less supports available for suicide survivors

      c. Any feelings of hopelessness that they can never heal from this loss

      d. Thoughts of helplessness to effect change within the self, others and/or the community

4. Know it is likely survivors will search out an answer to "why?"

      a. This search is an important part of the healing process

      b. It can be the longest and hardest part of the healing journey

      c. Often no answers are available

      d. On their own timeline, survivors need to find peace despite possibly having to accept that they will never fully understand why their loved one chose suicide

5. Additional

• Healing does not mean forgetting – rather life becomes livable in another way

• Grief work may include a healthy, tangible "ceremony" related to the death – release of a balloon, planting a tree, one-year prayers/life celebration. First Nation communities often have traditional ceremonies that assist with the grieving process

• Anniversaries and special days can be difficult – help the survivor to emotionally prepare for these dates

• Often others do not know what to say or fear making the survivor upset. Support the survivor in determining how to tell others what is needed

• Remind survivors that it is okay to be happy again! Laughing and having fun can seem disrespectful and some survivors may feel guilty

• Encourage self-care! (e.g. taking the time to nurture ourselves and take care of our needs, such as taking time to relax, eating a balanced diet, moving our bodies, visiting an Elder, or talking with friends and loved ones)

• Encourage participation in cultural healing events (e.g. sweat lodges, talking circles, ceremonies, etc.)

• Involve Elders, spiritual leaders and previous suicide survivors who are willing to help in supporting the bereaved

Tools to Support Responses to Suicide Clusters

CDC Recommendations for a Community Plan for the Prevention and Containment of Suicide Clusters outlines a set of recommendations to assist community leaders in public health, mental health, education, and other fields to develop a community response plan for suicide clusters or for situations that might develop into suicide clusters. http://wonder.cdc.gov/wonder/prevguid/p0000214/p0000214.asp

Information and Suggestions for Initial Suicide Postvention Support

1. The increased unexpectedness of a death typically increases the traumatic experience.

2. Acknowledge suicide as a traumatic experience.

3. Assist survivors with recognizing normal and suicide specific grief responses.

4. Typical grief responses as a result of a suicide death and feelings not commonly associated with general bereavement include:

> **a.** Shame
>
> **b.** Blame
>
> **c.** Guilt
>
> **d.** Confusion
>
> **e.** Anger
>
> **f.** Abandonment

5. Normalize survivors' grief responses by stating something similar to, "you are having normal grief responses to a tragic event".

6. Encourage survivors to talk about the death as a suicide. This helps to lessen shame and possibly opens doors of support from others who have lost someone to suicide.

7. Encourage correct terminology – "died by suicide", "death by suicide", "suicided". Not "successful" or "committed" suicide.

8. Encourage survivors to reach out to cultural support, friends, family and faith for help.

9. Encourage survivors to talk about their good memories of the person who died - this helps the grieving individual to find balance.

10. Individuals who have lost a loved one to suicide can become vulnerable and are at increased risk for suicide.

Children and Suicide Bereavement

- Provide correct information in an age appropriate manner. Answer their questions factually and briefly without providing gory details.

- Children may think they caused the person to suicide. They need to know that there was nothing they did to cause the death; and that there was nothing they could have done to have prevented the suicide.

- Children also need to receive the message that suicide was a choice and we wish the person had made other choices. This is a good place to brain storm with the child things they can do if they are feeling upset.

- Parents can show grief – this helps child to understand that grief is normal. Encourage healthy demonstration of grief that does not result in the child parenting the parent.

- Sometimes children can be overlooked when family members become consumed with their own grief. This is a good time to involve the help of other family members, friends and community members to assist with the care of the children, ensuring the child's emotional, spiritual, mental and physical needs are met.

- Children may regress from their current stage of emotional and physical development; (e.g., toddlers may return to bed wetting). This is a normal child response to grief; eventually with supportive care children will return to their pre-trauma state of functioning.

- Sometimes increased aggression can be seen by increased squabbling – particularly irritating at a time when the parent is already upset, tired, overwhelmed, etc.

- Children's moods change rapidly from play and happiness, to grief and sadness. This is normal. Parents may find this difficult, especially as they are coping with their own grief. Enlisting the help of aunties, grandmothers and grandfathers, or even other community teens may be extremely helpful.

- Children grieve in small doses, often express their grief through play, and will mix sadness and grief with play. Parent's may mistake this and think that the child becomes sad to get attention. This is not the case. Due to their limited ability to handle intense emotions they swing in and out of grief.

- Children may work through their grief by play acting the suicide death and funeral with toys or make believe. This is normal, and is the child's attempt at understanding the death and loss.

- As with teens, children may choose to talk about their grief with other children as opposed to adults

Children and adolescents will periodically revisit the death throughout major developmental stages as they gain a more mature understanding of suicide and its impact. They will often have new or the same questions. A healthy environment makes room for their enquiries by being patient, inviting questions and answering calmly.

HOPE HELP HEALING

Conclusion

Congratulations on coming full circle - your community will be strengthened because of your efforts. We hope you have found this toolkit helpful and relevant for the planning of suicide prevention, intervention and postvention in your community. Mental health and wellness programs and services can promote healing, change and wellness, while building upon the tremendous strength within First Nations and Aboriginal communities.

Suicide prevention, intervention and postvention can be thought of as strands that are interconnected and woven together, like a cedar hat or Métis sash. Through collaboration and partnerships, these strands can become even stronger, and work to improve the health of all First Nations and Aboriginal people.
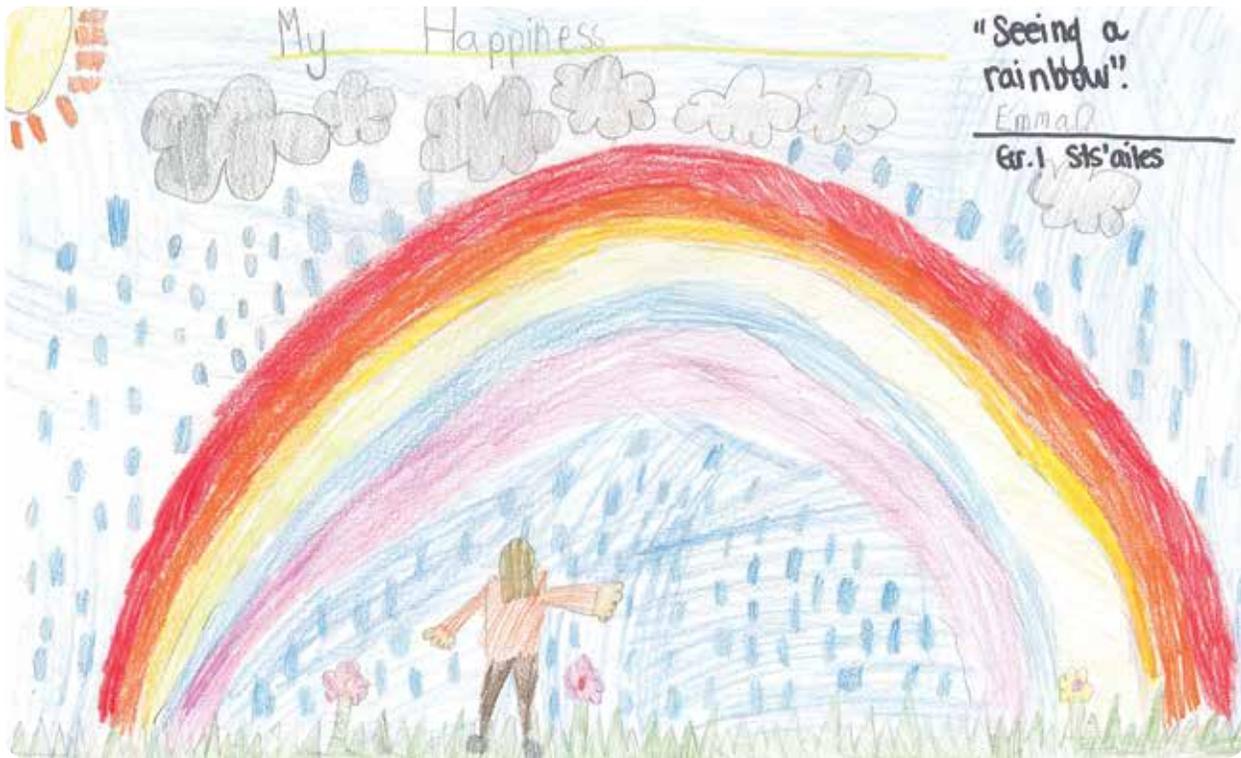
Emma
Grade 1, Sts'ailes Community School

Suicide Quick Reference Guide

What are some of the issues that contribute to suicide?

Suicide isn't usually caused by a single issue or event. It is usually the result of many combined issues that a person or community faces. Some risk factors that can increase a person's risk of suicide include:

- Low self-esteem
- Depression
- Substance use problems
- Intergenerational trauma
- Other known suicides in someone's peer group, family or community
- Feeling disconnected from family, peers, school, the community and one's culture
- Unresolved grief or trauma, as a person or in a community
- A history of emotional, sexual or physical abuse

Although these factors have been linked to suicide, they don't necessarily mean that people who have some or all of these traits will become suicidal.

How can I help?

- Ask a person directly if she/he is considering suicide. This will not 'give them the idea', but it does show that you care and are taking them seriously
- Listen and provide non-judgmental support
- Arrange for the person to get help, whether from a crisis centre, hospital, mental health centre, or another local resource
- Do not leave a suicidal person alone
- Do not agree to keep another person's suicidal thoughts a secret

HOPE HELP HEALING

How can I tell if someone is thinking about suicide?

There are warning signals that may appear in someone who is thinking about suicide. These signals include:

- Talks about or threatens to hurt or kill themselves, or looks for ways to do it
- Says things like, "I wish that I were dead" or "Life is hopeless"
- Increases their use of alcohol or other drugs
- Mentions having no reason to live or no purpose in life
- Shows increased anxiety and changes in sleep patterns
- Demonstrates significant changes in behaviour like giving away all personal possessions with dampened spirits (not including ceremonial gifting) or changes in spending habits
- Talks about feeling trapped - like there's no way out
- Expresses hopelessness about the future
- Withdraws from friends, family members or activities they enjoy
- Has experienced sudden losses (e.g., financial, relationship break-up, death of a loved one)
- Shows uncontrolled anger or suggests they want to seek revenge
- Engages in risky activities, seemingly without thinking about consequences
- Experiences dramatic changes in mood

If you see several of these behaviours, especially the first one, it is important to take them seriously and try to get them help right away.

Other Helpful Resources

• 1-800-SUICIDE

If you are in distress or are worried about someone in distress who may hurt themselves, call SUICIDE (1-800-784-2433) 24 hours a day to connect to a BC crisis line, without a wait or busy signal.

• KUU-US Crisis Line Society

First Nations and Aboriginal specific 24/7 crisis line based in Port Alberni and serving the entire province. Toll-free: 1-800-588-8717 - Youth Line: 250-723-2040 - Adult Line: 250-723-4050.

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

Answered by staff 24/7. Available throughout Canada and US.

• Youth in BC

Visit www.youthinbc.com for youth resources or chat with a counselor online.
You can also call 1-866-661-3311 (toll-free in BC) 24 hours a day.

• Trans Lifeline - 1-877-330-6366 - www.translifeline.org

Trans Lifeline is a non-profit dedicated to the well being of transgender people. We run a hotline staffed by transgender people for transgender people. Trans Lifeline volunteers are ready to respond to whatever support needs members of our community might have. This is a FREE helpline run by volunteers and supported by the community.

• Centre for Suicide Prevention

Visit www.suicideinfo.ca for information, research and links to national distress websites.

• 310-6789 (no area code needed) Mental Health Information Line

Answered 24/7/365 it provides empowering emotional support, information on appropriate referral options and a wide range of support relating to mental health concerns.
See the Here to Help website for more information, www.heretohelp.bc.ca/

• For a complete list of all crisis line numbers in BC go to:

www.crisislines.bc.ca/index_files/Page338.htm

HOPE HELP HEALING

Glossary

Helpful Definitions

ABORIGINAL
Aboriginal is a collective term used to describe the three constitutionally recognized Indigenous populations in Canada – "Indians" (First Nations), Métis and Inuit. While the term Aboriginal is commonly accepted, identifying each of these populations specifically by name is preferable where appropriate.

BEST PRACTICES
The provision of care and service using evidence-based decision-making and a continuous quality improvement approach focused on best outcome within the context of available resources.

CISSEXISM
A system of prejudice, discrimination, bias, and negative attitudes towards people who do not conform to Western gender expectations (e.g. the expectation that those who are assigned "male" at birth must identify and present as "men" through dressing and acting "masculine"). Someone who may be the target of cissexism could be a person who is assigned "male" at birth but identifies and/or presents as a woman (e.g. a trans or two-spirted woman). Those who do not identify as two-spirited or trans are referred to as "cisgender". Cisgender refers to people whose sex assigned at birth (e.g. "female") matches their gender identity and presentation (e.g. "femininity"). Cissexism advantages cisgender people while oppressing and marginalizing two-spirited and trans people.

COMMUNITY
Community refers to a group of people with shared identity or interests that has the capacity to act or express itself as a collective. A community may include members from multiple cultural groups. A community may be territorial, organizational or a community of interest. "Territorial communities" have governing bodies exercising local or regional jurisdiction (e.g., members of a First Nations resident on reserve lands). An individual may acknowledge being of First Nations, Inuit or Métis descent, but not identify with any particular community.

COORDINATION
Reasonable level of formal commitment to joint working, coordination around some areas of strategy.[52]

COUNSELLING
Providing either short term or on-going therapy - usually wellness focused.

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.

CULTURAL SAFETY
Cultural safety refers to what is felt or experienced by a patient when a health care provider communicates with the patient in a respectful, inclusive way, empowers the patient in decision-making and builds a health care relationship where the patient and provider work together as a team to ensure maximum effectiveness of care.

DISCRIMINATION
External behaviours and institutional arrangements that deny people their rights or limit their social inclusion.

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 outcomes.

FRAMEWORK
A basic conceptual structure used to solve or address a complex issue.

GATEKEEPER TRAINING
Training that provides the knowledge, skills and attitudes necessary for individuals to recognize the signs of potential suicidal crisis, and refer the person in question to appropriate support services.

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.

GOAL
A goal is a broad statement which provides overall vision and direction. It can be big and idealistic and it is not specific or measurable. A goal must have objectives linked with it in the planning cycle.

HETEROSEXISM
A system of attitudes, biases or acts of discrimination that advantages heterosexuals and oppresses people who identify as homosexual, bisexual, pansexual, or any other marginalized sexual orientation.

HOLISTIC
Holistic refers to the concept that promoting, protecting or restoring health requires understanding the individual as an integrated system—including physical, mental, emotional and spiritual aspects—which cannot be reduced to one or more separate parts.

HOMOPHOBIA
Discrimination, bias, and negative attitudes towards people who identify or are perceived to be gay, lesbian, and/or bi-sexual (e.g., those who engage in same gender relationships). Homophobia advantages heterosexual people who are not the targets of homophobia.

INTERVENTION
Intervention approaches increase protective factors in general, and work to reduce risk factors for those struggling with suicide. A help or crisis call-in line could be used by a community as an intervention approach.[53]

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 HEALTH PROMOTION

Interventions designed to improve personal well-being through strategies aimed at increasing personal strengths or system-focused interventions (like those directed at schools or communities) aimed at increasing social support and belonging.[54]

NON-SUICIDAL SELF-INJURY

The deliberate harm of someone's own body but without the intention to die. This does not include behaviours such as tattooing and piercing which are typically approved of by society.

OBJECTIVE

A specific result that a person/system aims to achieve within a timeframe and available resources. Objectives are realistic steps to achieve goal(s). They are always active, and use strong action verbs like "plan", "conduct", "examine", "collect", "produce", "analyze" and "write". Answer the questions: WHO?, WHAT?, WHEN?, WHY? - describe what action you will take.

PARTNERSHIP

Partnerships have been described as a joint working arrangement where the partners are otherwise independent bodies; agree to cooperate to achieve a common goal; create a new structure or process to achieve this goal and implement a jointly-agreed program. They may contribute staff, resources; relevant information; pool risks and rewards.

POSTVENTION

Activities that occur after a suicide, largely taking the form of support for family, friends, professionals and peers of the suicide victim.[55] Grief counselling is an example.[56]

PREVENTION

Strengthening resilience, reducing risk factors, and improving protective factors on both the individual and community levels.

PRIMARY PREVENTION

Efforts taken to prevent illness, diseases or conditions from occurring.

PROBLEMATIC SUBSTANCE USE

Problematic substance use refers to psychoactive substance use (e.g., alcohol, tobacco, cannabis, other drugs) that results in or increases risks for physical, psychological, economic, social or other problems for individuals, families/friends, communities or society.

PROGRAM

In its most general use, a program is a collection of organizational resources that is geared to accomplish a certain major goal or set of goals.[57]

PROJECT

A project is a component of a program, and is a discrete activity often undertaken at a specific location.[58]

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.

PSYCHOSOCIAL

The term psychosocial is used to describe the combination of psychological, emotional, behavioural, social and spiritual aspects and impacts of a disaster or traumatic event.

RACISM

Actions, practices or beliefs, or social or political systems, that consider different cultural or ethnic groups to be ranked as inherently superior or inferior to each other. The group historically or currently defined as white is being advantaged, and groups historically or currently defined as non-white (First Nations, African, Asian, Hispanic, etc.) are being disadvantaged.

READINESS

Readiness is the degree to which a community is prepared to take action on an issue.[59]

RESILIENCE

Resilience is often described as the capacity to overcome emotional, mental, physical or spiritual distress, and having positive life outcomes despite experienced challenges.[60]

RISK FACTORS

Risk factors are those characteristics associated with suicide. A combination of individual, relational, community, and societal factors contribute to the risk of suicide.[61]

SECONDARY PREVENTION

Early diagnosis and prompt treatment of an illness, disorder or condition that prevent it from spreading to others or becoming worse for the individual.

SEXISM

A system of biases, prejudice, and acts of discrimination against women and girls that advantages men and boys.

STAKEHOLDERS

A representative group of people, including organizations, groups and individuals, which are affected by and contribute to decisions, consultations and policies.

STIGMA

The shame or disgrace attached to something that is considered socially unacceptable or taboo.

SUICIDAL IDEATION

Thoughts of harming or killing oneself (the person tells you this).

SUICIDE

Intentional, self-inflicted death - died by suicide.

SUICIDE ATTEMPT

Any self-inflicted action (with or without sign of injury) taken where the person is trying to kill him/herself.

SUICIDE CLUSTER

A group of suicides or suicide attempts, that occur close together in time and space.

SUICIDE CRISIS

A serious increase in suicidal behaviour, which may involve thinking about, planning, intending, or attempting suicide.

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 PACT

An agreed-upon plan by two or more individuals to die by suicide.

SUICIDE PIP CONTINUUM

A part of a group of services whose goal is to prevent death and risk of death by suicide while raising awareness about reducing stigma associated with suicide.

SUICIDE SURVIVORS

Family members, significant others, or acquaintances who have lost a loved one to suicide.

SYSTEM

A collection of parts that interact with each other to function as a whole.[62] A network of independent components that work together to try and accomplish the aim of the system (organization).[63]

TERTIARY PREVENTION

Efforts taken to maximize the remaining capabilities and functions of a person who is already disabled by an illness, disease or condition.

TWO-SPIRIT

Two-spirit is a term referring to both the masculine and feminine spirit. Two-spirit can include both sexual orientation and/or gender identity and expression and defies colonial categorization. Lesbian, gay, bisexual, trans, queer, questioning, intersex, and asexual First Nations and Aboriginal people may or may not refer to themselves as two-spirit.

YOUTH

Persons 15-24 years old (overlaps with youth and adult life stages).

52 Primary Care Trust Network NHS Confederation (2010). Discussion Paper: Where next for health and social care integration? Retrieved April 2, 2014 from: www.nhsconfed.org/Publications/Documents/health_social_careintegration180610.pdf

53 National Aboriginal Health Organization. (2005). Assessment and planning Toolkit for suicide prevention in First Nations communities. Retrieved from: www.naho.ca/documents/fnc/english/FNC_SuicidePreventionToolkit.pdf

54 White, J. & Jodoin, N. (2007). Aboriginal Youth: A manual of promising suicide prevention strategies. Retrieved from: http://suicideinfo.ca/LinkClick.aspx?fileticket=xYw_rxl1F7w%3D&tabid=475

55 Centres for Disease Control and Prevention (2013). Gateway to Health Communication and Social Marketing Practice. Retrieved April 2, 2014 from: www.cdc.gov/healthcommunication/toolstemplates/entertainmented/tips/suicideyouth.html

56 National Aboriginal Health Organization. (2005). Assessment and planning Toolkit for suicide prevention in First Nations communities. Retrieved from: www.naho.ca/documents/fnc/english/FNC_SuicidePreventionToolkit.pdf

57 from: managementhelp.org/programmanagement/business-programs.htm

58 Ardal, S., Butler, J., Edwards, R., Lawrie, L. (2006). The Health Planner's Toolkit. Retrieved on Aug 2, 2013 from: www.health.gov.on.ca/transformation/providers/information/resources/health_planner/module_1.pdf

59 Plested, B. A., Edwards, R. W. Jumper-Thurma,P (2006). Community Readiness, A Handbook for Successful Change. Fort Collins, CO: Tri-Ethnic Center for Prevention Research.

60 Dion-Stout, M & Kipling, G. (2003). Aboriginal People, Resilience and the Residential School Legacy. Ottawa, ON: Aboriginal Healing Foundation

61 Centres for Disease Control and Prevention (2013). Suicide: Risk and Protective Factors. Retrieved April 2, 2014 from: www.cdc.gov/violenceprevention/suicide/riskprotectivefactors.html

62 Kauffman, D.L. (1980). Systems One: An Introduction to Systems Thinking. Future Systems Inc.

63 Deming, W.E. (1993). The New Economics for Industry, Government and Education. Cambridge: Massachusetts Institute of Technology Centre for Advanced Engineering Study.

Appendix 1: Important Contacts and Resources

VANCOUVER COASTAL ORGANIZATIONS

Vancouver Coastal Health www.vch.ca

Numerous mental health programs, including suicide and crisis programs, available for across one's lifespan.

AIDS Vancouver www.aidsvancouver.org

1107 Seymour Street Vancouver, BC V6B 5S8
Phone: 604.893.2201
Fax: 604.893.2205
Email: contact@aidsvancouver.org

AIDS Vancouver exists to alleviate individual and collective vulnerability to HIV and AIDS through support, public education and community based research.

Battered Women's Support Services www.bwss.org

PO Box 21503, 1424 Commercial Dr. Vancouver, BC V5L 5G2
Phone: 604.687.1868
Counselling Phone: 604.687.1867
Email: information@bwss.org

Provides support and advocacy for women who have experienced abuse, as well as, training and education about violence against women.

BC Schizophrenia Society www.bcss.org

Provincial Office #201 – 6011 Westminster Hwy. Richmond, BC V7C 4V4
Phone: 604.270.7841
Toll Free: 1.888.888.0029
Fax: 604.270.9861
Email: bcss.prov@telus.net

Dedicated to supporting each other, educating the public, raising funds for research and advocating for better services for people with schizophrenia and other serious and persistent mental illnesses. BCSS Provides service to families in centres throughout BC. For local contact info you can call the toll free number above.

British Columbia Society for Male Survivors of Sexual Abuse www.bc-malesurvivors.com

#202- 1252 Burrard Street Vancouver, BC V6Z 1Z1
Phone: 604.682.6482
E-mail: bcsmssa@hotmail.com

The British Columbia Society for Male Survivors of Sexual Abuse is a non-profit society, established to provide therapeutic services for males who have been sexually abused at some time in their lives.

CHIMO Crisis Services Crisis Intervention Program www.chimoyouth.ca

#120-7000 Minoru Blvd Richmond, BC V6Y 3Z5
Serves Richmond, South Delta, Ladner & Tsawwassen.
Phone: 604.279.7077
Fax: 604.279.7075
Email: chimo@chimocrisis.com
604.279.7070 Crisis 15 hrs (9am to midnight)

CHIMO provides diverse services from community building to prevention, from individual crisis support to advocacy, and from peer support to education.

Crisis Intervention & Suicide Prevention Centre of BC www.crisiscentre.bc.ca

763 East Broadway Vancouver, BC V5T 1X8
Phone: 604.872.1811
Fax: 604.879.6216
604.872.3311 Crisis 24 hrs   1.866.661.3311 Crisis 24 hrs
604.872.0113 TTY Crisis 24 hrs   1.866.872.0113 TTY Crisis 24 hrs

Youth in BC www.youthinbc.com
(One-on one online chat 2pm-10pm daily serving youth through the internet)
Serves Vancouver, North Vancouver city & district, Bowen Island, West Vancouver, Powell River and area, the Sunshine Coast, Squamish, Whistler, Pemberton and Howe Sound-the Sea to Sky corridor, through toll free number. Provides emotional support through distress line and web-based youth chats. In addition provides suicide classroom education workshops for students and professionals.
Greater Vancouver: 604-872-3311
Howe Sound & Sunshine Coast: 1-866-661-3311
TTY: 1-866-872-0113
Online Service for Adults: www.CrisisCentreChat.ca
The Seniors' Distress Line: 604-872-1234

Cross Cultural Clinic Vancouver VCH www.vch.ca/psychiatry/ccc.htm

715 West 12th Ave. Health Centre, Ground Floor
Vancouver, BC V5Z 1M9
Phone: 604.875.4115
Fax: 604.875.5386

Provides a full psychiatric assessment including diagnosis, medication, recommendations, and links with other resources available in the community. It provides short-term, individual psycho-therapy, case review and second opinion for community mental health services, as well as psycho-education for patients and families to provide further information on their disorders. The cross cultural clinic also supports mental health services provided by the Vancouver Association for Survivors of Torture (VAST) and Bridge Clinic. If appropriate, there is group therapy available with our Outpatient Psychiatry Program.

Josh Platzer Society for Teen Suicide www.teensuicideprevention.org

Prevention and Awareness
3294 West 37th Avenue Vancouver, BC V6N 2V4
Phone: 604.263.9831
Email: give@teensuicideprevention.org

Provides resources in education and awareness on the topic of teen suicide to counselors, students, teachers and families.

Living Through Loss Counselling Society of BC www.ltlc.bc.ca

201-1847 W Broadway Vancouver, BC V6J 1Y6
Phone: 604.873.5013
Fax: 604.873.5002

Provides professional grief counselling to adults and children who have experienced any type of loss. They provide individual and group therapy, as well as bereavement training for professionals.

Multicultural Family Support Services Society www.vlmfss.ca

5000 Kingsway Plaza III, #306 - 4980 Kingsway Burnaby, BC V5H 4K7
Phone: 604.436.1025
Fax: 604.436.3267

Provides a safe and non-judgmental environment for women and their children in their own language and culture. Individual counselling is provided at the office, out of the office and over the phone. Also provides group counselling and support, and individual counselling to women victims of sexual assault and to adult survivors of sexual abuse, emergency interventions and referrals to appropriate resources.

HOPE HELP HEALING

Qmunity BC's Queer Resource Centre www.qmunity.ca

Suite 610 - 1033 Davie Street
Mailing Address: 1170 Bute Street Vancouver, BC V6E 1Z6
Phone: 604.684.5307
Fax: 604.684.5309
Prideline Lower Mainland: 604.684.6869
1.800.566.1170 (toll-free) in BC

Services offered include Prideline, a peer support/information/referral phone line serving locally and provincially. As well as coming out groups, social support groups, free counseling and the Bute Street Clinic which provides free and confidential testing of HIV/STI/Hepatitis. Education and Outreach Services also is responsible for conducting awareness training with service providers.

S.A.F.E.R. (Suicide Attempt Follow-up, Education and Research)

#310 – 1669 East Broadway Vancouver, BC V5N1V9
Phone: 604.879.9251
Fax: 604.879.7463

Works to reduce suicide risk among those in crisis, to assist family and friends who care about them, and to promote healing among those bereaved by suicide. Vancouver and Burnaby residents: People age 12 and over who have made a suicide attempt, are currently suicidal, or have suicidal ideation, and are assessed as fitting program criteria, can receive individual counselling, advocacy, and hospital liaison within a six-month time frame. Also provides up to three one-on-one psych educational sessions to people concerned about suicide in a significant other. Anyone with concerns related to suicide can speak with an intake worker 8:30 am to 4:30 pm Monday to Friday. BC-wide services: Anyone bereaved by a suicide death who can attend the office may access one-on-one counselling and a structured support group. SAFER also offers training, education, and professional consultation in the areas of suicide prevention, intervention, and postvention.

Seniors 411 Centre Society www.411seniors.bc.ca

411 Dunsmuir Street Vancouver, BC V6B 1X4
Phone: 604.684.8171
Fax: 604.681.3589

An easily accessible, multi-purpose social and recreational drop in facility for seniors. Centrally located in downtown Vancouver, the Centre offers a variety of programs, services and special projects for seniors. It also houses several Associate Members who directly or indirectly work with seniors.

Women against violence against women www.wavaw.ca

WAVAW Rape Crisis Centre - Delamont RPO, PO Box 29084 Vancouver, BC V6J 5C2
Phone: 604.255.6228
Toll-Free 24-hour Crisis Line: 1.877.392.7583

Provides sexual assault support services to women 14 years of age and older, in Greater Vancouver for 23 years. They are open and accessible to all women survivors of violence. They operate within a feminist and anti-oppression framework, and are committed to non-violence.

NORTHERN HEALTH

Northern Health Authority www.northernhealth.ca

Crisis Prevention, Intervention and Information Centre for Northern BC www.northernbccrisissuicide.ca

5th Floor, 1600 –3rd Avenue Prince George, BC V2L 3G6
Phone: 250.564.5736
Fax: 250.563.0815
250.563.1214 Crisis 24 hrs
250.564.8336 Youth Line 4-11pm
1.888.562.1214 Crisis 24 hrs
1.888.564.8336 Youth Line 4-11pm (youth line call forwards to 24 hr line after hours)
250.699.6315 Fraser Lake

Serves from Quesnel, north to the Yukon border except Fraser Lake, Fort Fraser & Vanderhoof.

Intersect Youth and Family Services Society www.intersect.bc.ca

1294 3rd Avenue Prince George, BC V2L 3E6
Phone: 250.562.6639
Fax: 250.562.4692
Email: info@mail.intersect.bc.ca

An accredited, non-profit society that provides voluntary counselling for children and youth under the age of 19 years. Intersect offers a wide variety of programs to clients and their families at no cost. The Intersect multidisciplinary team represents a wide variety of experiences, education, and therapeutic interventions. Services are provided according to evidence based resources as defined in the standards of Child and Youth Mental Health and core clinical competencies.

Gitxsan FAST Team **www.gitxsanhealth.com**

P.O. Box 223 Hazelton, BC V0J 1Y0
Phone: 250.842.5165
Toll-free: 800.663.9935
Fax: 250.842.5587

Provides workshops and individual counseling as a suicide prevention tool. The Suicide Prevention Team provides crisis intervention, and post-vention services. The FAST team members represent four First Nations communities: Gitxsan, Nisga'a, Tsimshian and Wet'suwet'en.

MacKenzie Counselling Services Society **www.mackenziecounselling.ca**

220 MacKenzie Blvd Mackenzie, BC V0J2C0
Phone: 250.997.6595
Fax: 250.997.3903

Mackenzie Counselling Services is a non-profit society, providing multiple programs and specialized workshops to the community of Mackenzie.

Robson Valley Home Support Society **www.robsonvalleysupportsociety.org**

McBride office: 942 - 3rd Avenue McBride, BC V0J 2E0
Valemount office: 99 Gorse Street Valemount, BC V0E 2Z0 - Community Services Bld.
McBride: 250.569.2266 | rvssmcbride@telus.net
Valemount: 250.566.9107 | rvssvalemount@telus.net

Provides a variety of support services to the communities of McBride and Valemount. Services are provided to women, the Elderly and disabled, individuals seeking career counselling, children, and individuals or families in crisis.

INTERIOR HEALTH

Interior Health Authority **www.interiorhealth.ca**

Crisis & Counselling Program (Williams Lake) **http://williamslake.cmha.bc.ca/**

c/o Jubilee Care/CMHA
51 - 4th Avenue Williams Lake, BC V2G 1J6
Phone: 250.398.8220
Fax: 250.392.4456
250.398.8224 Crisis after business hours only

Provides crisis/suicide intervention, supportive counselling, community information and referral information. The Crisis and Counselling Program also offers: Short term counselling provided to individuals, couples, or families experiencing difficulties in their lives. Call Alert – Immediate response to emergencies for clients pre-registered in this system. Also, Telephone Contact - Daily communication with the aged, handicapped and those who feel isolated.

East Kootenay Crisis Line **http://kootenays.cmha.bc.ca**

c/o CMHA Kootenays
39 - 13th Avenue South Cranbrook, BC V1C 2V4
Phone: 250.426.5222
Fax: 250.426.2134
250.426.8407 Crisis 24 hrs or 1.800.426.8407

Serving entire east Kootenay region, from Golden to the Alberta and USA borders through their 1-800 number.

Kamloops Sexual Assault Centre **www.ksacc.ca**

Phone: 250.372.0179   **Fax:** 250.372.2107

Provides individual adult counselling, child and youth counselling, psycho-educational groups, ego-strengthening groups for girls and boys, community based victim services, education and prevention programs, and the Silent Witness Project.

Kelowna Crisis Line c/o Kelowna Community Resources **www.kcr.ca**

255 Lawrence Avenue Kelowna, BC V1Y 6L2
Phone: 250.763.8058
Fax: 250.763.6282
250.763.9191 Crisis 24 hrs

Serves Kelowna, Westbank, Winfield, and Lake Country.

Penticton & Area Crisis Line c/o CMHA-S. Okanagan/Similkameen

825 Westminster Avenue West Penticton, BC V2A 1L1
Phone: 250.493.2598
Fax: 250.493.2598
1.800.784.2433 Crisis 24hrs

Provides crisis management, community information and referral by way of a confidential and anonymous 24-hour phone-in service. Toll Free service is available from locations within the South Okanagan/Similkameen. Serves Penticton, Summerland, Oliver, Osoyoos & Princeton.

PIN Crisis Intervention Society- PIN Crisis Line www.peopleinneed.ca

103, 3402 – 27th Avenue Vernon, BC V1T 1S1
Phone: 250.545.8074
Fax: 250.558.9958
250.545.2339 Crisis 24 hrs
250.833.1488 Salmon Arm
250.838.0880 Enderby
250.837.6601 Revelstoke

A free 24-hour, 7 day a week support and referral service that provides anonymous, confidential, and non-judgmental emotional support for those in need. The Good Morning program is a telephone service offered to vulnerable individuals that are living alone or feeling isolated in the community.

White Buffalo Aboriginal Health Society www.whitebuffalo.name

517 Tranquille Road Kamloops, BC V2B 3X2
Phone: 250.554.1176
Toll Free: 1.877.554.1176
Fax: 250.554.1157

Aims to raise the health status of Aboriginal peoples by providing holistic health care which includes physical, emotional, spiritual, and mental health provision for individual, family, and community. White Buffalo Aboriginal Health Society is a culturally based agency dedicated to balanced and healthy lifestyles. Programs and services support traditional Aboriginal values encompassing the connectedness of emotional, spiritual, physical, and mental well-being.

FRASER HEALTH

Fraser Health Authority **www.fraserhealth.ca**

Adolescent Crisis Response Program (ARCP)

13750 96th Avenue Surrey, BC V3V 1Z2
Phone: 604.585.5561   **Fax:** 604.585.5560

Serves adolescents ages 12 to 18 who are in acute crisis. Provides assessment, short-term crisis intervention, resource and referral coordination, and up to six follow-up sessions. Provides child crisis assessments on a limited, non-urgent basis. Accepts professional telephone referrals only.

Fraser Valley Regional Crisis Line **www.missioncommunityservices.com**

Mission Community Services Society
33179 – 2nd Avenue Mission, BC V2V 1J9
Phone: 604.826.3634
Fax: 604.820.0634
604.820.1166 Crisis 24 hrs or 1-877-820-7444

Provides immediate telephone intervention, emotional support, referrals, and resource information for people living in the Central and Upper Fraser Valley. This service is free and confidential. Serves Mission, Abbotsford, Chilliwack, Agassiz/Harrison, Hope, Yale & Boston Bar

Greater Coquitlam Crisis & Information Line **www.sharesociety.ca**

c/o Share Family & Community Services Society
200 - 25 King Edward Street Coquitlam, BC V3K 4S8
Phone: 604.540.9161
Fax: 604.540.2290
604.540.2221 Crisis 24 hrs

Provides anonymous, confidential telephone crisis intervention and support, community information and referrals 24-hours a day. Serves Coquitlam, Port Coquitlam, Port Moody, Pitt Meadows, New Westminster, Belcarra and Anmore.

Mission Community Services Society **www.missioncommunityservices.com**

33179 – 2nd Avenue Mission, BC V2V 1J9
Phone: 604.826.3634   **Fax:** 604.820.0634

Offers a wide variety of services and support programs for people of all ages, backgrounds, lifestyles and income levels.

Share Family and Community Services Society **www.sharesociety.ca**

200 - 25 King Edward Street Coquitlam, BC V3K 4S8
Phone: 604.540.9161
Fax: 604.540.2290

Provides programs and services to residents of Coquitlam, Port Coquitlam, Port Moody, and sur-rounding communities. Programs are grouped below under the following headings: addiction services, child and family services, crisis and information services, free or low-cost goods, general counselling, and victim services. SHARE's sister agency, the 43 Housing Society, develops and manages low-cost family and senior housing in Port Coquitlam. Administration hours are 8:30 am to 4:30 pm Monday to Friday.

South Fraser Regional Crisis Line

c/o Surrey Community Services
9815 – 140th Street Surrey, BC V3T 4M4
Phone: 604.584.5811
Fax: 604.584.7628
604.951.8855 Crisis 24 hrs

Free, Confidential, Support & Resource Information. Serves Surrey, Whiterock, Langley and Delta

Options Surrey Community Services **www.options.bc.ca**

9815 – 140th Street Surrey, BC V3T 4M4
Phone: 604.584.5811
Fax: 604.584.7628

Through various programs and services, empowers people in the South Fraser Region to help themselves. Programs are grouped under the following headings: child and family services, counselling services, employment services, information and referral services, mental health support services, thrift stores, and volunteer services.

VANCOUVER ISLAND

Island Health Authority www.viha.ca

Campbell River Crisis Line c/o Campbell River Family Services Society

487 – 10th Avenue Campbell River, BC V9W 4E4
Phone: 250.287.2421
Fax: 250.287.4268
250.287.7743 Crisis 24 hrs

Central Vancouver Island Crisis Society www.cvics.ca

P.O. Box 1118 Nanaimo, BC V9R 6E7
Phone: 250.753.2495
Fax: 250.753.2475
Email: info@cvics.ca
250.748.1133 Cowichan Crisis Line 24 hrs
250.754.4447 Nanaimo Crisis Line 24 hrs
250.248.3111 District 69 Crisis Line 24 hrs

Public Access point for all three communities for mental health Crisis Response Teams. Provides Information about suicide, including facts, links, what you can do to help. In addition provides community education workshops, as well as ASIST training. Also runs Bereavement Support Group for those affected by the loss of a loved one to suicide.

Serving north of the Malahat, Cobble Hill, Cowichan Bay, Duncan, Lake Cowichan, Youbou, Chemainus and surrounding areas (Cowichan Crisis Line) Serving Nanaimo, Ladysmith and Gabriola Island and surrounding areas (Nanaimo Crisis Line) Serving Parksville, Qualicum, Bowser, Nanoose and surrounding areas (District 69 Crisis Line).

Cowichan Tribes – Kwun'atsustul Counselling www.cowichantribes.com

5760 Allenby Road Duncan, BC V9L 5J1
Phone: 250.748.3196
Fax: 250.748.1233

Provides support to members during difficult times. Counsellors are available to deal with immediate crises or provide regular, ongoing support. Work undertaken by the Counselling team includes: individual counselling, Native Sobriety Support Groups, Residential School Support Group, family violence intervention, Parenting Teens Support Group, and community outreach.

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Crossroads Crisis Centre Society
www.yourlifecounts.org/crisis-lines/crossroads-crisis-centre-society

P.O. Box 30011 Courtenay, BC V9N 2L5
Phone: 250-338-0512
Fax: 250-334-2996
Email: crossroads@shawcable.com
250-334-2455 Crisis 24 hrs

Public access point for the local mobile crisis intervention nurse. Serving the Comox Valley area, from Fanny Bay to Oyster River including Hornby and Denman Islands.

KUU-US Crisis Line Society www.albernihosting.com/kuu-us

P.O. Box 294 Port Alberni, BC V9Y 7Y7
Phone: 250-723-2323
Fax: 250-723-2382
250-723-4050 Crisis 24 hrs
250-723-2040 Teen line
1-800-588-8717 Crisis 24 hrs

24 hr outreach workers available in Port Alberni. Serving Port Alberni,Ucluelet, Tofino, Bamfield, and West coast of Vancouver Island.

Nanaimo Community Hospice Society - Suicide Bereavement Support Group

1080 St.George Crescent Nanaimo, BC V9S 1X1
Phone: 250-591-8811

NEED2 Suicide Prevention Education and Support www.need2.ca

P.O. Box 5501 Victoria, BC V8R 6S4
Phone: 250-386-6328   **Fax:** 250-386-9748
Email: admin@needcrisis.bc.ca

Promotes wellness by providing crisis and suicide prevention education, online emotional a crisis support and connections to related resources, within the Capital Regional District.

North Island Crisis & Counselling Centre Society www.nicccs.org

P.O. Box 5267 Port Hardy, BC V0N 2P0
Phone: 250-949-8333   **Fax:** 250-949-8344
250-949-6033 Crisis 24 hrs

Provide for the North Island Community through Advocacy, Crisis Intervention and Referral Services, Ongoing Counselling and Support Services.

PROVINCE-WIDE

1-800-SUICIDE

Phone: 250-743-3219 **Fax:** 250-753-2475
1-800-SUICIDE (784-2433) 24 hrs Crisis Line

1-800-SUICIDE connects callers, including those who are depressed or suicidal, or those who are concerned about someone they love, automatically to an accredited Crisis Center. Using the ANI (Automatic Number Identification) system, telephone calls are routed to the Crisis Center nearest to where the person is when the call is placed. In the event that the nearest Crisis Center is at maximum volume, the call is seamlessly rerouted to the next closest center. Callers should never encounter a busy signal or voice mail.

310-6789 (no area code needed) Provincial Mental Health Information Line

Answered 24/7/365 it provides empowering emotional support, information on appropriate referral options and a wide range of support relating to mental health concerns. See Here to Help website for more information, **www.heretohelp.bc.ca**

BC Bereavement Line **www.bcbereavementhelpline.com**

Box 53530, 984 West Broadway Vancouver, BC V5Z 1K7
Phone: 604-738-9950 **Fax:** 604-873-5002
Toll-free: 1-877-779-2223
Email: bcbh@telus.net

Provides the public and particularly the bereaved with information on how to seek help for themselves or individuals known to them who are in need of assistance through their grief. Services include: Helpline for referral and support, community network of support and information, and brochure of available support in B.C.

BC Council for Families **www.bccf.ca**

204 - 2590 Granville Street Vancouver, BC V6H 3H1
Phone: 604.660.0675 or 1.800.663.5638 (Canada/USA) **Fax:** 604.732.4813
Email: bccf@bccf.bc.ca

Provides leadership, training and support for an array of preventative programs and initiatives that are delivered in a variety of settings and through hundreds of organizations in communities in every region of BC. These include Parenting Education, Professional Development and Community Building, in particular the "Suicide Postvention in Prevention" program. The workshop program helps communities to strategize against youth suicide in a way that is tailored to their unique needs.

BC School Districts www.bced.gov.bc.ca/schools/bcmap.htm

Each BC school district has separate protocols for dealing with student suicide and mental health issues. Please contact the school district in your area to inquire about service available.

The F.O.R.C.E. (Family Organized for Recognition and Care Equality) Society for Kids' Mental Health www.bckidsmentalhealth.org | www.forcesociety.com

PO Box #91697 West Vancouver, BC V7V 3P3
Phone: 604.878.3400 **or** 310.6789
Email: theforce@bckidsmentalhealth.org

Provides families with information, support and education in children's mental health. See their website for a guide to available resources.

FNESC/FNSA: First Nations Education Steering Committee
www.fnesc.ca

113-100 Park Royal South
West Vancouver, British Columbia V7T 1A2
Phone: 604-925-6087
Fax: 604-925-6097
Toll free in BC: 1-877-422-3672

First Nations Schools Association
www.fnsa.ca

113-100 Park Royal South
West Vancouver, British Columbia V7T 1A2
Phone: 604-925-6087
Fax: 604-925-6097
Toll free in BC: 1-877-422-3672

First Nations Health Authority www.fnha.ca

501 - 100 Park Royal South, Coast Salish Territory, West Vancouver, BC V7T 1A2
Phone: 604.693.6500
Fax: 604.913.2081
Toll free: 1.866.913.0033
Email: info@fnha.ca

The First Nations Health Authority (FNHA) is the first province-wide health authority of its kind in Canada. In 2013, the FNHA assumed the programs, services, and responsibilities formerly handled by Health Canada's First Nations Inuit Health Branch – Pacific Region.

Ministry of Children and Families (MCFD) www.gov.bc.ca/mcf
Preventing Youth Suicide

Practice Guidelines for Working with Children and Youth at Risk for Suicide in Community Mental Health Settings: **www.mcf.gov.bc.ca/suicide_prevention/pdf/practice_guidelines.pdf**
Quick reference guide of the above resource:
www.mcf.gov.bc.ca/suicide_prevention/pdf/suicide_pip_pg_quick_ref.pdf

Trans Lifeline - 1-877-330-6366 - www.translifeline.org

Trans Lifeline is a non-profit dedicated to the well being of transgender people. We run a hotline staffed by transgender people for transgender people. Trans Lifeline volunteers are ready to respond to whatever support needs members of our community might have. This is a FREE helpline run by volunteers and supported by the community.

SAFER (Suicide Attempt Follow-up, Education and Research)

300 - 2425 Quebec Street Vancouver, BC V5T 4L6
Phone: 604.879.9251   **Fax:** 604.879.7463

Works to reduce suicide risk among those in crisis, to assist family and friends who care about them, and to promote healing among those bereaved by suicide. Vancouver and Burnaby residents: People age 12 and over who have made a suicide attempt, are currently suicidal, or have suicidal ideation, and are assessed as fitting program criteria, can receive individual counselling, advocacy, and hospital liaison within a six-month time frame. Also provides up to three one-on-one psych educational sessions to people concerned about suicide in a significant other. Anyone with concerns related to suicide can speak with an intake worker 8:30 am to 4:30 pm Monday to Friday. BC-wide services: Anyone bereaved by a suicide death who can attend the office may access one-on-one counselling and a structured support group. SAFER also offers training, education, and professional consultation in the areas of suicide prevention, intervention, and postvention.

Youth in BC www.youthinbc.com

Crisis Intervention and Suicide Prevention Centre for BC
763 East Broadway Vancouver, BC V5T 1X8
Phone: 604.872.1811   **Fax:** 604.879.6216
604-872-3311 Crisis 24 hrs **or** 1-866-661-3311 Crisis 24 hrs also available

Offers live, one-on-one web-chat with trained volunteers, or support via email. A more anonymous, sometimes more comfortable option than traditional crisis telephone line services. For youth who need a safe, respectful place to find support and information, or just someone to listen without judgment and for parents and/or professionals who are looking for topic-specific information and resources for various youth-related issues.

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URLs for Hyperlinked Resources

A Guide for Early Responders Supporting Survivors Bereaved by Suicide
http://suicideprevention.ca/wp-content/uploads/2014/05/Early-Responder-Final.pdf

Aboriginal Resource Toolkit:
Inuit, Aboriginal, First Nations, Metis Suicide Prevention Resource Toolkit.
http://suicideinfo.ca/LinkClick.aspx?fileticket=MVIyGo2V4YY%3d&tabid=563

Adolescent Suicide Prevention Program Manual:
A Public Health Model for Native American Communities
www.sprc.org/sites/sprc.org/files/library/AdolescentSP_ProgramManuaPH_ModelNA_
Communities.pdf

After a Suicide: A Practical and Personal Guide for Suicide Survivors
www.klinic.mb.ca/docs/booklets/After_a_Suicide_-_A_Practical_and_Personal_Guuide_for_
Survivors.pdf

After a Suicide: A Toolkit for Schools
www.sprc.org/sites/sprc.org/files/library/AfteraSuicideToolkitforSchools.pdf?sid=35690

Applied Suicide Intervention Skills Training
www.livingworks.net/programs/asist/

BC Freedom of Information and Protection of Privacy Act
www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/96165_00

BC Personal Information Protection Act
www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/00_03063_01#section18

CDC Recommendations for a Community Plan for the Prevention and
Containment of Suicide Clusters
www.cdc.gov/mmwr/preview/mmwrhtml/00001755.htm

Celebrating the Circle of Life, Coming back to Balance and Harmony: A guide to emotional
health in pregnancy and early motherhood for Aboriginal women and their families
www.perinatalservicesbc.ca/NR/rdonlyres/361F0C20-FDC5-499E-AC8D-D0F2A0494597/0/
Circle_of_Life_FINAL_CompleteGuide_March2013.pdf

Community Engagement Toolkit
www.nordikinstitute.com/wp-content/uploads/2012/11/Community-Engagement-Toolkit.-July-25.-2006.pdf

Community Strategic Planning Toolkit
www.nadf.org/upload/documents/community-strategic-planning-toolkit2005-with-appendices.pdf

Comprehensive and Sustainable Community Planning
http://fnbc.info/resource/comprehensive-and-sustainable-community-planning

Coping With Suicidal Thoughts
www.comh.ca/publications/resources/pub_cwst/CWST.pdf

Cultural Competency and Safety: A Guide for Health Care Administrators, Providers and Educators
www.naho.ca/documents/naho/publications/culturalCompetency.pdf

Cultural Safety: Peoples' Experiences with Colonization (Module 1)
http://web2.uvcs.uvic.ca/courses/csafety/mod1/notes.htm

Cultural Safety: Peoples' Experiences with Oppression (Module 2)
http://web2.uvcs.uvic.ca/courses/csafety/mod2/notes.htm

Cultural Safety: Peoples' Experiences of Colonization in Relation to Health Care (Module 3)
http://web2.uvcs.uvic.ca/courses/csafety/mod3/notes.htm

Darkness Calls
www.turtleisland.org/healing/abcomic1.pdf

Darkness Calls video in Gitxsan
www.youtube.com/playlist?list=PLAFACC4E6C54DCFED

Developing an Evaluation Plan
http://ctb.ku.edu/en/table-of-contents/evaluate/evaluation/evaluation-plan/main

Gay and Suicidal: Sexual and Gender Minorities and Suicide
http://suicideinfo.ca/LinkClick.aspx?fileticket=88I4gNh0i5c%3d&tabid=563

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Health Inequalities and Social Determinants of Aboriginal Peoples
www.nccah-ccnsa.ca/en/publications.aspx?sortcode=2.8.10&publication=46

Health Support Services for Former Indian Residential School Students
www.trc.ca/websites/trcinstitution/index.php?p=9

Hope and Healing: A Practical Guide for Survivors of Suicide
www.comh.ca/publications/resources/pub_hh/HopeandHealing.pdf

Indigenous Cultural Competency Training Programs
www.culturalcompetency.ca/

Justice Institute of British Columbia
www.jibc.ca/

Media Guidelines and Social Marketing
http://suicideprevention.ca/news-resources/media-guidelines-and-social-marketing/

Outline for Writing a Grant Application for Funding
http://ctb.ku.edu/en/writing-grant-application

Plus 65 At the End of the Day
http://suicideinfo.ca/LinkClick.aspx?fileticket=cmFwRL4DMJw%3d&tabid=563

Practice Guidelines for Working with Children and Youth at Risk for Suicide in Community Mental Health Settings
www.mcf.gov.bc.ca/suicide_prevention/pdf/practice_guidelines.pdf

Practice Guidelines for Working with Children and Youth at Risk for Suicide in Community Mental Health Settings - Quick Reference Guide
www.mcf.gov.bc.ca/suicide_prevention/pdf/suicide_pip_pg_quick_ref.pdf

Preventing Youth Suicide: A Guide for Practitioners
www.mcf.gov.bc.ca/suicide_prevention/pdf/pys_practitioners_guide.pdf

Program Evaluation Model - 9 step process
www.janetwall.net/attachments/File/9_Step_Evaluation_Model_Paper.pdf

Promising Strategies. Aboriginal Youth: A Manual of Promising Suicide Prevention Strategies
http://suicideinfo.ca/LinkClick.aspx?fileticket=xYw_rxl1F7w%3D&tabid=475

Qmunity Queer Competency Training
www.qmunity.ca/education/training/lgtb-awareness-training/

Secwepemc Nation Injury Surveillance & Prevention Program
http://threecornershealth.org/index.php/programs/injury-surveillance/

School-based suggestions to address suicide contagion
www.nasponline.org/resources/principals/Suicide_Clusters_NASSP_Sept_%2009.pdf

Suicide Prevention, Intervention and Postvention Initiative for BC
http://suicidepipinitiative.files.wordpress.com/2009/05/suicide-pip-initiative-full-report.pdf

Suicide Prevention and Mental Health Promotion in First Nations and Inuit Communities
www.mcgill.ca/files/tcpsych/Report9_Eng.pdf

Suicide Postvention Toolkit: A Guide for Secondary Schools
www.headspace.org.au/media/274777/hsp040%20postvention%20toolkit%20final.pdf

White Mountain Apache Suicide Surveillance System
www.ihs.gov/Provider/documents/2010_2019/PROV0113.pdf

Working With a Client Who is Suicidal: A Toolkit for Adult Mental Health and Addiction Services
www.health.gov.bc.ca/library/publications/year/2007/MHA_WorkingWithSuicidalClient.pdf

Working With the Suicidal Patient: A Guide for Health Professionals
www.comh.ca/publications/resources/pub_wwsp/WWSP.pdf

Appendix 2:
Health Research and Suicide

What does health research say about suicide among First Nations and Aboriginal People in BC?

Trends among First Nations and Aboriginal people in BC show that reported suicide and suicide attempts continue to be at a higher rate than reported suicide and suicide attempts by other residents in BC. This is particularly evident among First Nations and Aboriginal youth in BC.

A provincial report in 2007 found that in BC[64]:

- Between 1993 and 2006, the suicide death rate for the Status Indian population fell by half; however, the 2006 rate was still over twice the rate for other BC residents.

- Suicide deaths were the fourth highest cause of premature death (under age 75) in the Status Indian population, after circulatory disease, cancer, and motor vehicle accidents.

- Regional data for 2002–2006 show that Status Indian suicide rates were higher than the rates for other residents in Vancouver Coastal Health, Northern Health, Island Health, and BC as a whole.[65]

It is estimated that suicide accounts for more than a third of all deaths among young First Nations and Aboriginal people nationally.[66] Although this toolkit is designed to address the needs of all age groups, we also recognize that youth have specific and important needs in the area of suicide.[67] A survey conducted in 2008 showed that 11% of the surveyed First Nations and Aboriginal youth in BC reported making a suicide attempt in the past year[68], compared to only 5% in a larger cohort surveyed in the 2008 Adolescent Health Survey[69].

Nationally

- Suicide occurs roughly five to seven times more often among First Nations youth than non-Aboriginal youth in Canada; it is important to note that there is considerable variation between communities – some communities have not experienced a suicide in over twenty years while others have experienced losses more recently.

- Suicide and self-inflicted injuries are the leading causes of death for First Nations youth and adults up to 44 years of age.[70]

64 British Columbia. Provincial Health Officer (2009). Pathways to Health and Healing- 2nd Report on the Health and Well-being of Aboriginal People in British Columbia. Provincial Health Officer's Annual Report 2007. Victoria BC: Ministry of Healthy Living and Sport.

65 Fraser Health Authority. (2012). Fraser Region Aboriginal youth suicide prevention collaborative: Suicide prevention, intervention and postvention initiative. Retrieved on July 20, 2013. www.fraserhealth.ca/media/AH_suicide-prevention.pdf

66 White, J. & Jodoin, N. (2007). Aboriginal Youth: A manual of promising suicide prevention strategies. Retrieved from: http://suicideinfo.ca/LinkClick.aspx?fileticket=xYw_rxl1F7w%3D&tabid=475

67 Fraser Health Authority. (2012). Fraser Region Aboriginal youth suicide prevention collaborative: Suicide prevention, intervention and postvention initiative. Retrieved on July 20, 2013. www.fraserhealth.ca/media/AH_suicide-prevention.pdf

68 Tsuruda, S., Hoogeveen, C., Smith, A., Poon, C., Saewyc, E., & the McCreary Centre Society. (2012). Raven's Children III: Aboriginal youth health in BC. Vancouver, BC: McCreary Centre Society.

69 Smith, A., Stewart, D., Peled, M., Poon, C., Saewyc, E. and the McCreary Centre Society (2009). A Picture of Health: Highlights from the 2008 BC Adolescent Health Survey. Vancouver BC: McCreary Centre Society.

70 Health Canada (2013). Suicide Prevention. Retrieved Aug 21 2013 from: www.hc-sc.gc.ca/fniah-spnia/promotion/suicide/index-eng.php

What are the facts about suicide in Aboriginal and First Nations communities in Canada?

- Suicide and self-injury are the leading causes of death for First Nations people between the ages of 10-44.

- For First Nations males 15 to 24 years old, the suicide rate is 126 per 100,000 First Nations people, compared to 24 per 100,000 for the same age group among the general population.

- For First Nations women between 15 to 24 years old, the suicide rate is 25 per 100,000 First Nations people compared to only 5 per 100,000 for non-Aboriginal women.

- Statistics show that 60 per cent of all Aboriginal people who attempt and die by suicide are intoxicated (alcohol) at the time, compared to 24 per cent of all non-boriginal people.

- Youth suicide has tripled in Canada over the past 40 years.

- Not all First Nations and Aboriginal communities experience youth suicide. BC researchers report that 90 per cent of the suicides take place in just 10 per cent of BC First Nations communities.[71]

71 Information sourced from the National Aboriginal Health Organization and the Honouring Life Network.
www.honouringlife.ca/youthCorner/suicideFacts/suicideFactSheet

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Appendix 3:
Planning Tools and Templates

Comprehensive Self-Care Reminder

The following checklist for areas of self-care is only a starting point. You can add areas of self-care that are helpful for you and then create a care plan to find ways to keep yourself well and safe.

Physical Self-Care

- ❑ Eat regularly (e.g. breakfast, lunch, and dinner)
- ❑ Eat healthy foods
- ❑ Exercise
- ❑ Get medical care when needed
- ❑ Take time off when sick
- ❑ Dance, swim, walk, run, play sports, sing, or do some other fun physical activity
- ❑ Get enough sleep

Psychological and Emotional Self-Care

- ❑ Take time to do something you truly enjoy
- ❑ Make time away from telephones, email, and the Internet
- ❑ Make time for self-reflection
- ❑ Notice your inner experience - listen to your thoughts, beliefs, and feelings
- ❑ Write in a journal
- ❑ Try to minimize stress in your life
- ❑ Say no to extra responsibilities sometimes
- ❑ Spend time with others whose company you enjoy
- ❑ Stay in contact with important people in your life
- ❑ Give yourself affirmations, praise yourself
- ❑ Love yourself
- ❑ Identify comforting activities, objects, people, places and seek them out
- ❑ Allow yourself to cry

Spiritual Self-Care

❑ Spend time in nature

❑ Find a spiritual connection or community

❑ Be open to inspiration

❑ Cherish your optimism and hope

❑ Identify what is meaningful to you and notice its place in your life

❑ Meditate

❑ Pray

❑ Sing

❑ Find things that make you laugh

Workplace or Professional Self-Care

❑ Take a break during the workday

❑ Take time to chat with co-workers

❑ Make time to complete tasks

❑ Identify projects or tasks that are exciting and rewarding

❑ Set limits with clients and colleagues

❑ Balance your workload so that no one day or part of a day is "too much"

❑ Arrange work space so it is comfortable and comforting

❑ Attend staff meetings

❑ Seek regular supervision or consultation

❑ Have a peer support group

❑ Have regular debriefing sessions either as teams or one-on-one

❑ Seek out additional training and educational opportunities

Coordinating Committee

Potential Members for Our Committee	Potential Members for Our Committee
Youth/Youth Council	Public School
Elders (healthy)	Community Watchmen
Traditional healers	Survivors (healthy)
Cultural Workers	Parenting Program People
People in Health	Mental Wellness Counsellors
People in Child and Family	Recreation, Sport and Activity
People in Early Childhood Development	Police / RCMP
People in Education	Hospice, Victim Support
Emergency responders	Suicide Crisis Workers
Chief, Council & Band Office	Other(s) – "go-getters"

Draft Agenda for First Coordinating Committee Meeting

Meeting Date/Time:		Location:	
Meeting Invitees:			
Agenda Item	**Description**		**Item Lead**
1. Welcome and review agenda	- Opening prayer - Introductions of members		
2. Meeting purpose	- Kick-off (1st) meeting for the _____ Community Suicide PIP Coordinating committee.		
3. Name the committee	- Discuss and brainstorm what to call your committee. It doesn't need to include the word suicide. You may want to use an uplifting word.		
4. Develop Terms of Reference	- See example Terms of Reference on the next page. - Be sure that the goal is to develop your PIP Plan and then overseeing its implementation and review.		
5. Review membership	- Consider inviting others to help you plan - use the template on the previous page to give you ideas.		
6. Determine roles	- **Chair(s):** Attends and facilitates meetings, helps resolve conflicts, seeks ideas from others on major decisions, acts as spokesperson for matters agreed to by the group, and approves things that the group clearly gives them power to do. You may want a Co-Chair who can act if this person is away. - **Members:** attend meetings, do any pre-reading and preparation for meetings, and often given tasks to take away to do for the group within their own organizations. - **Coordinator:** Takes the minutes and sends out for approval; organizes the agendas with the Chair and members and sends these out before the meeting; organizes any catering (if there is a budget) and meeting room; does tasks for the committee which may include some typing or letter writing, may also coordinate a project.		
7. Determine meeting frequency	- Agree on how often you will meet and develop a schedule so people know in advance. You can use a calendar and send it out to members with the dates on it – or use Outlook to invite people to meetings so that it is locked into their Outlook calendars.		
8. Next steps	- Determine next steps - book your ***planning meeting*** to start assessing your community needs and existing resources. You may wish to hold a planning meeting to develop your committee's work-plan (see examples). - Closing prayer		

HOPE HELP HEALING

Confidentiality Agreement

During my association with the [Name of Committee], I will have access to information and material relating to clients, employees and other individuals of the [Name of Health Provider or Community], which is of a private and confidential nature.

I agree to respect the confidentiality of matters dealt with in the course of my time spent on the [Name of Committee] and I shall respect the privacy and dignity of the [Name of Health Provider or Community]'s clients or members, employees, and all associated individuals. I agree that the terms outlined in this agreement will remain in force even if I cease to have an association with the [Name of Committee].

I understand that during my association with the [Name of Committee], I may be sharing information and databases with other committee members, employees of [Name of Health Provider or Community] or other individuals or health professionals, and I will protect all information to ensure full confidentiality. This obligation applies to information in any form (e.g. written, electronic or oral).

I agree to respect the following rules regarding the treatment of confidential information:

- I will only access confidential information that I need to know to perform my job duties or to meet my responsibilities with the [Name of Committee].

- I will not search for or access any client or employee information for any reason not related to the performance of my duties.

- Where I am sharing information and databases with other committee members or employees, I will abide by my responsibilities to ensure the confidentiality of information for clients of the [Name of Health Provider or Community].

- I will not engage in discussions about confidential information in public areas.

- I will keep all confidential and/or personal health information to which I have access secure from unauthorized access, use, disclosure, copying, modification or disposal and I will follow all steps required to do so.

- I will immediately report the fact that confidential information in my possession has been

  stolen or lost as well as any other violations of the above rules to the [Name of Committee] Chairperson without threat of penalty for doing so.

- I understand that the [Name of Committee] may conduct regular audits to ensure confiden-

  tial information is protected against unauthorized access, use, disclosure, copying, modification or disposal.

I have read this Agreement. I understand and agree that if I fail to comply with the conditions outlined in this agreement, I may be subject to corrective action, up to and including termination of my position, or any similar action as determined by the [Name of Committee].

Name _____ Role _____
(please print)

Signature _____ Date _____

Budget Template for the Coordinating Committee

SOURCES OF INCOME

1. Income Source   **2. Amount**

TOTAL:

PROJECT EXPENSES

3. Expense (Cost)   **4. Amount**

TOTAL:

Community Information Gathering Template

Information and Tasks	Lead Person	By When	Notes

HOPE HELP HEALING

Existing Program and Resources
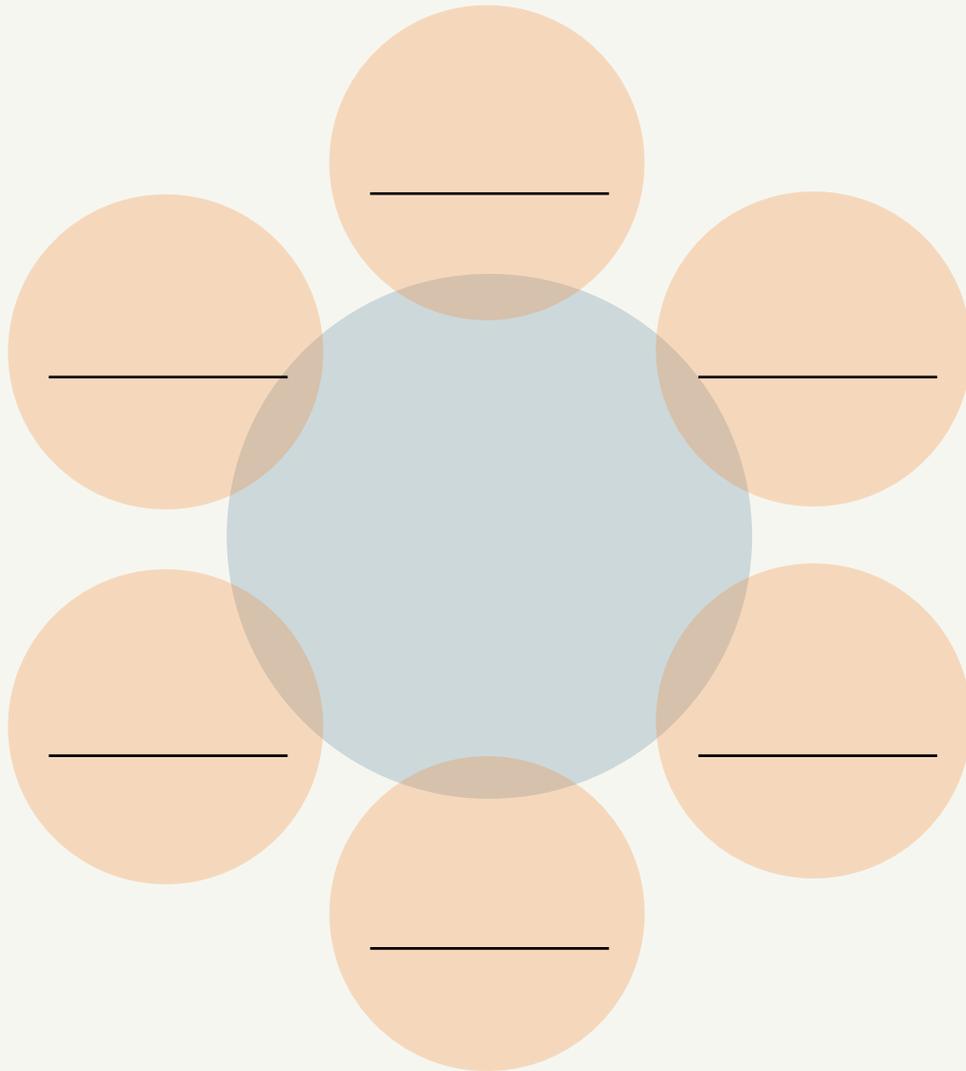
Issues and Needs Prioritization

Need/Issue Suicide PIP	Resource	Category	Steps of Action	Actions by Whom/When	
What gaps need to be addressed to reach the desired PIP goal (s)?	List any existing resource you can start from.	1 2 3	What actions/ tasks are needed to address the gap(s)? What resources?	Who is responsible for addressing the gap?	When will you complete this work?

Workplan (Who Does What)

	Community Worker	Committee Chair or members	Community Members	Leadership
Pre-Planning Activities				
5. Create a Coordinating Committee.				
6. Committee members secured.				

7. Kick off meeting held
  d. Terms of Reference developed - draft and final
  e. Work plan developed
  f. Budget developed.				

8. Tell the community about the planning work - each community will need to decide what process they will follow based on their resources and whether the community is ready to engage.				
Assessment Activites				
5. Engage your community members about suicide.				
6. Develop a community information gathering template e.g., identify what information is needed and who will get it, and by when.				
7. Analyze the information and identify gaps. Remember to include section four's information here about PIP gaps.				
8. Hold a gaps planning meeting with the committee - prioritize gaps.				
Write Your Plan Activities				
2. Write your PIP draft plan.				
5. Develop evaluation plan, measures, reporting timing, data sources - link with Evaluation #1.				
6. Consult on your draft PIP plan.				
7. Get your PIP approved.				
Act (doing) Activities				
4. Develop a work plan for all tasks.				
5. Develop a budget for all tasks.				
6. Monitor and report on PIP plan implementation activities.				
Reflect (Evaluation) Activities				
2. Do your evaluation planning.				

Community Engagement Preparation Checklist

❑ Has your budget been approved and funding confirmed for the engagement meetings? How do you access that funding (what forms need to be filled out)?

❑ Has an appropriate venue been chosen?

❑ How long is the meeting? Does your booking allow enough time to go in and set up and to tidy up afterwards?

❑ Does the venue have enough seats for your expected numbers?

❑ What marketing, promotion and/or invitations are needed for your audience?

❑ Who from the Coordinating Committee will support and present at each meeting?

❑ Have facilitators been selected or are you facilitating?

❑ Have you organized who is taking the notes? Are you using tape recorders or cameras (and do you need a waiver to use the images of the audience?)

❑ Have meeting materials been prepared? Handouts been copied?

❑ Do you need to purchase, rent or borrow any supplies - projectors, flip charts, stationary, etc.?

❑ Will you have access to Internet service if you need it (WIFI)?

❑ Has consideration been given to how the meeting will open and close? Perhaps with an Elder's prayer and who will do this? Do you have a gift of acknowledgement for the Elder?

❑ Have caterers been organized and specific times been given? Will they supply eating utensils, plates and clean up afterwards?

HOPE HELP HEALING

Work Plan Tasks for Actions

Suicide PIP Implementation Work-plan					
Prevention					
Item	**Activity Description**	**Responsibility**	**Start Date**	**End Date**	**Notes**
Intervention					
Postvention					

Status Report

Suicide PIP Planning Status Reporting Template			
Start Date and End Date		**Project Sponsors**	
Planning Leads		**Team Members**	
Project Purpose			
Deliverables:	**Target Date**	**1st Delivery Date**	**Comments**
Ongoing	**Dates**		**Comments**
Current Status	**Key Activities**		

Appendix 4

Appendix 4: **Tripartite Suicide Prevention, Intervention and PostventionWorking Group Members**

Dr. Naomi Dove, Public Health Physician, Health Promotion & Disease Prevention - First Nations Health Authority

Nicole Hetu, Health Planner, Mental Wellness and Substance Use - First Nations Health Authority

Hertha Holland, Senior Project Coordinator, Strategic Services - First Nations Health Authority

Allison Twiss, Senior Health Planner - First Nations Health Authority

Haike Muller, Strategic Policy Research Analyst - First Nations Health Authority

Carole Patrick, Senior Mental Health Advisor - First Nations Health Authority

Blake Stitilis, Planner, Policy & Planning - First Nations Health Authority

Rebecca Sovdi,Program Manager, Healthy Living & Chronic Disease - First Nations Health Authority

Shannon Stone, Mental Health Program Consultant (NAYSPS) - First Nations Health Authority

Sarah Williams, Senior Advisor, Health Services - First Nations Health Authority

Ian Knipe, Aboriginal Health Lead, Health Authority Representative – Island Health Authority

Leslie Bonshor, Aboriginal Health Lead, Health Authority Representative – Fraser Health Authority

Agnes Snow, Aboriginal Health Lead, Health Authority Representative – Northern Health Authority

Hilary McGregor, Lead, Knowledge Translation and Community Engagement Aboriginal Health – Northern Health Authority

Brad Anderson, Aboriginal Health Lead, Health Authority Representative – Interior Health Authority

Diana Day, Leader, Aboriginal Community Development/Engagement, Health Authority Representative – Vancouver Coastal Health Authority

Peter Vlahos, Aboriginal Health Lead, Health Authority Representative – Vancouver Coastal Health Authority

Nancy Laliberte, Lead, Aboriginal Health, Health Authority Representative – Provincial Health Services Agency

Leslie Varley, Aboriginal Health Lead, Health Authority Representative – Provincial Health Services Agency

Dena Carroll, Director, Aboriginal Policy, Provincial Representative

– Ministry of Children and Family Development

Deborah Saari, Director, Child and Youth Mental Health Policy, Provincial Representative
– Ministry of Children and Family Development

Sandy Wiens, Executive Director, Child Welfare & Child and Youth Mental Health Policy,
Provincial Representative – Ministry of Children and Family Development

Warren O'Brian, Executive Director, Communicable Disease Prevention,
Harm Reduction and Mental Health Promotion, Provincial Representative – Ministry of Health

Stephen Smith, Director, Mental Health Promotion and Prevention of Mental Illness,
Provincial Representative – Ministry of Health

Rachel Mason, Manager, Health Actions, Aboriginal Health Directorate, Provincial Representative
– Ministry of Health

Tracy Smythe, Manager, Partnerships & Community Renewal Division, Provincial Representative
– Ministry of Aboriginal Relations and Reconciliation

David Stevenson, Executive Director, Partnerships and Community Renewal Division,
Provincial Representative – Ministry of Aboriginal Relations and Reconciliation

Jeannette MacInnis, Director of Health, BC Association of Aboriginal Friendship Centres

Tanya Davoren, Director of Health, Métis Nation BC

HOPE HELP HEALING

Notes

Notes

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