

**YOUTH SUICIDE: INFORMATIONAL WORKSHOPS DESIGNED
FOR GATEKEEPERS: CAREGIVERS, SECONDARY SCHOOL
PERSONNEL, AND GRADUATE COUNSELLING STUDENTS**

by

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**PROJECT SUBMITTED IN PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF**

MASTER OF EDUCATION

In

The Faculty of Education

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SIMON FRASER UNIVERSITY

Summer 2008

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ABSTRACT

The project offers essential comprehension of suicide, gatekeeper intervention, and informational frameworks for workshops on youth suicide intervention suitable for caregivers, secondary school personnel, and graduate counselling students. The information is based on best practice research, common field practice concerns, and basic facilitation concerns. Each workshop is a full day of psycho-education, values exploration, and experiential intervention activities. Participants will learn about suicide warning signs, interviewing skills, gatekeeper intervention, postvention strategies, and needed community resources.

Keywords: gatekeeper, suicide intervention, youth, graduate counselling students, caregivers, secondary school personnel, Aboriginal, cultural sensitivity

Subject Terms:

Suicide refers to intentional and understood self-murder.

Prevention refers to all means socially and individually to stop suicides. Primary and secondary prevention may be referred to.

Suicide Intervention refers to intervening with a suicidal person, exploring reasons for wanting to die and if there maybe ways to resolve situations or feelings so that the person may achieve hope and opportunities to explore living instead of dying.

Postvention is actions to take to help others after a suicide occurs.

DEDICATION

I dedicate this work to my miracle Christmas born mother, Helen Selina Katherine (Dollery) Kesteven and to the families, friends, caregivers, counsellors and teachers of those young people who could not sustain their lives on mother earth, and chose self-murder.

ACKNOWLEDGEMENTS

O' Siem: Thank-you to Charlaine Avery-Cox, M.Ed, Alexander Duncan, Hon. B.A. and Michael Manley-Casimir, Ph.D. who have supported and encouraged me, especially in my intellectual endeavours and this work, in particular. Thanks to Virginia Peters, Manager of Health and Family Services, Sts'ailes, Chehalis First Nations who should be awarded an Honourary degree for her contribution to the well being of Aboriginal communities in the Fraser Valley. Thank-you Soteira Hortop, my supportive "Goddess" daughter, who in her second year of university offered her support.

Sadly, my supportive, ever proud mother, Helen Selina Katherine (Dollery) Kesteven died June 21, 2007, Aboriginal Day and my father Bruce Richard Kesteven predeceased her in April 1995, so they will never see these results. Nor will hypnotherapist "Steve" Wasyl S.Dawydiak, who taught me his own "brand of hypnotherapy" and insisted I never give up.

Thank-you Dr. John Frederick Anderson, a visionary supervisor who enjoys William Blake as I do, for providing your leading supervision. John would agree that the "fox condemns the trap, not itself," a saying of William Blake. Thank-you Dr. Jeff Sugarman. Thank-you so much Dr.Heeson Bai, Director of Graduate Studies, as you have "made a difference." Every one of you contributed to this work in your own way and without you, this work would never have found completion. My hands are held up to you, all my relations!

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INTRODUCTION

Suicide is a serious concern for youth (ages 13 to 19 years) in British Columbia. Suicide is defined as death from injury, poison, or suffocation where there is evidence (implicit or explicit) that the injury was self-inflicted and the decedent intended to kill himself (Ashworth, 2001, p. 13). An attempted suicide would be actions of self-harm, with or without resultant injury.

From the British Columbia Coroner's statistics (2005, p. 1) for the period of 1997 to 2004 there were 215 youth suicides (ages 13 to 19 years) with an average of 26.9 and a range of 15 to 37 per year. Suicide deaths increase with age; for example, in 2004, there were 27 youth suicides, 13 of them 18-year-olds—therefore, the older the youth, the greater the risk. Estimations suggest that for every death by suicide there were likely 50 to 100 attempts (Mental Health Evaluation & Community Consultation Unit (MHECCU), 2005, page iii). Generally, males are three times more likely to complete suicide than females, but more females than males make attempts; however, there are some suggestions this ratio gap may be inclined to close. There can be variation in this gender statistic in differing populations. Aboriginal communities, presenting higher risks than in the mainstream for both males and females, are at a high priority for gatekeeper interventions.

Since suicide is a risk for youth, suicide prevention response and understanding suicidal behaviour becomes a special concern for gatekeepers such as foster parent caregivers, school staff including school counsellors, and graduate counselling students, because of the high likelihood of encountering suicidal behaviour in the youth they serve. Youth is a time when the greatest number of people is readily available through the

school system and other programs such as the Ministry of Children and Family Development programs if they live in foster care. This means that this age group is under the most observation, supervision, and availability for intervention opportunities. The purpose of this project is to provide useful, long-standing training materials based on current research for caregivers, school personnel, and graduate counselling students (hereafter the “targeted groups”).

i.1 Method

Literature for this project is selected for currency (1999 and later) or landmark studies, best practice research, and the common, practical, relevant needs of the targeted groups for information useful to suicide intervention.

One difficulty with research into suicide is the determination of the combined factors leading to suicide. Prediction of suicide is problematic. A person with many vulnerability factors may never attempt suicide. People who knew the deceased may not be aware of, or may be unable to report, important factors. When the person is dead, it is difficult to verify whether separate co-occurring factors were relevant. Reports of suicide attempters may not always be a valid comparison to suicide completers, since they may differ in significant ways from those who die by suicide, although there is clearly overlap between attempters and those who eventually die in this way. Simplifying the workshops for targeted groups presents difficulties since suicide factors are diverse and complex as well as targeted groups for education being diverse, particularly in their view of suicide itself. Theoretical perspectives serve to both illuminate and complicate a view of suicidology. Another complexity is that in the sociological perspective certain groups are at a greater risk. For instance, Aboriginal people generally are at a greater risk, but certain

Aboriginal communities appear more at risk than others do and some show no more risk than non-Aboriginal populations. Teaching Aboriginal gatekeeper groups about suicide, facilitators encounter the grief and losses of the students' own lives, in sometimes overwhelming proportions, and this must be attended to in order to increase gatekeeper intervention capabilities. This is particularly so for Aboriginal gatekeepers because of the large size and community connectivity of families which extend over several reserves. Ethno-cultural considerations need to be part of facilitation of workshops for gatekeepers. Aboriginal cultural considerations are referred to in this context.

This need for education resulted in the development of the Community Crisis Assessment survey tool for whole communities (see *Acting on What We Know: Preventing Youth Suicide in First Nations, The Report of the Advisory Group on Suicide Prevention*, July, 2005,¹ pp. 155–170). Other individual assessment tools resources include a Ministry of Health project, written by Lynda Monk & Jori Samra (2007), titled *Working with the Client Who Is Suicidal: A Tool for Adult Mental Health and Addiction Services*. These resources may be reviewed by facilitators prior to workshops and then recommended to gatekeepers as resources. Suicide is far from strictly an isolated individual problem. One perspective is suicide is a resultant act manifesting out of genetic vulnerabilities and societal ills, which create mental, emotional, biological, and spiritual vulnerabilities. Suicide can be viewed from a range of “complex phenomenon emerging out of a dynamic interaction of biological, psychological, social, cultural, and spiritual factors” (Monk & Samra, 2007). Some research views suicide as a psychiatric problem of a particular individual and from that standpoint mental health assessment of

¹ No date of publication or authors is given in the Advisory Committee Report. However, references cited in the report were up to 2005.

all students seems advisable. Sociology views it as a social phenomena and the medical profession as a brain chemistry imbalance (depression, mental illness) created by a range of stressors, but treatable by a medication regime. For First Nation communities' cultural identity and cultural stressors are a vital aspect of mental health, and so the Advisory Group recommends funding for traditional healers as part of intervention and prevention (p. 13). There are also biological theories of suicide. For example, in Pfeffer (2000) she and colleagues found the "level of whole blood tryptophan, a precursor of serotonin was significantly lower in prepubertal child psychiatric inpatients with a recent history of suicide attempts than among normal children or prepubertal psychiatric inpatients with suicidal ideation" (p. 166). In Vohs and Baumeister (2000) researchers discussed neurochemical process dysfunctions and hormone contributions contributing to and linking together both violence and suicidal behaviour. Links between biological research and mental illness research into biological underpinnings help to bring these two theoretical viewpoints together. Prevention and intervention need to be addressed from all these perspectives.

What places a youth at imminent risk for suicide is a multi-factorial juxtaposition at some point in time brought about by the youth's current situational distress and the youth's capacity and coping ability for distress tolerance (Grossman & Kruesi, 2000; Shneidman, 1993). White (2005) acknowledged that:

On the surface, preventing youth suicide appears straightforward: identify the risk and protective factors, develop a program that addresses these factors, implement the program and evaluate the results. The reality is more complex. First, knowledge about risk factors is limited by what researchers determine is worthy of, and amenable to, investigation. Typically, researchers examine quantifiable items, such as personality traits, demographic characteristics, psychopathology symptoms, stressful or traumatizing life events, family functioning levels, and

school failure. Secondly, researchers studying suicide have a perspective defined by their disciplines, which provides only a “partial view” of the problem. (p. 8)

Thirdly, best practices dictate that to improve the effectiveness of programs, the programs need ongoing evaluation. However, White (2005) acknowledged program effectiveness means that programs must be “comprehensive and implemented across multiple domains, including family, school and community, as well as multiple sectors” (p. 8). White perceived difficulties with this as it is “often difficult in a service delivery context marked by budget constraints, increased demands for accountability, time shortages, and interdisciplinary and inter-sectoral tensions” (p. 8). White also saw that “positive program effects may not be seen for many years and given the complexities of risks and causes is difficult to attribute any changes in the suicide rate to a specific preventive intervention”. Fourthly, she reported there are ethical challenges in conducting suicide prevention studies. Ethically, known current information needs to be shared with targeted groups to both identify and suitably respond to anyone having suicidal ideation.

Clusters of risks/vulnerability factors sometimes considered as predictive are explained in more detail in the following sections. Many of these are precursors to the youth’s inability to cope with distressing situations; others would be current situational stressors, while some would be both.

i.2 Youth And Suicide

i.2.1 Incidence

An example of incidence-related factors is gender. Generally, males are known to die by suicide more frequently, yet this gender gap does not hold true for all populations. Hawton (2003) and Sachs-Ericsson (2000) point out that this gender specific factor may

be partially explained by the more lethal means generally chosen by males. Particular ethnic groups are at a higher risk. White (2005) indicates Aboriginal suicide rates are about “five to six times higher than non-Aboriginal youth, although variations in suicide rates across First Nations communities are common and many have low or non-existent rates of youth suicide” (p. 7). Aboriginal females may more often choose more lethal means than non-Aboriginals. Suicide completions also tend to be greater in number where it is more difficult to get people to hospital emergency quickly.

i.2.2 Vulnerability or Risk Factors

There are differences between vulnerability and precipitator. A precipitator of suicide is the immediate trigger that seems to be the immediate cause of the suicide action at a point in time, but vulnerabilities are the multi-dimensional context that places a person at greater risk of considering suicide as an option, and in this respect may be considered the ultimate cause of suicide. However, multiple losses (such as other suicides, death by other means, and relationship loss) may provide both a vulnerability to suicide and at some point be a precipitating or triggering factor either when a new loss occurs or when an anniversary date of a loss acts as a precipitator. At times, this may be difficult to categorize or definitely pinpoint for a particular suicide, especially as the person is not available to interview.

The Advisory Group (2005) prepared a booklet for The First Nations’ Centre called *Assessment and Planning Tool Kit for Suicide Prevention in First Nations Communities*. In the booklet, the National Health Organization refers to a research report called *Youth Suicide Prevention: A Framework for British Columbia*. Predisposing factors are those that set the stage for vulnerability to suicide. These include a history of

suicide, attempts by one or more family members, abuse /trauma history, illness/depression, contributing factors increasing existent risk such as substance abuse, poor coping skill set, few social supports, financial problems, precipitating factors (triggers), and protective factors such as good social supports, strong cultural ties, resiliency, and creative problem solving skills.

This report referred to all these as factors of influence that are seen to interact, and then diagrammed these with the individual at the centre of a circle, suggestive of the Medicine Wheel. The Medicine Wheel depicts balance of spiritual, physical, mental, and emotional aspects of a person, placing the individual at the center of the wheel. Within this research report, a Report of the Royal Commission on Aboriginal Peoples identifies four important inter-related factors for understanding youth suicidal behaviour. These are socioeconomic (poverty, housing, lack of community infrastructure), psychobiological (mental illness, Fetal alcohol spectrum disorder), life history or situational (isolation, grief, abuses), and cultural stress, defined as “rapid cultural change, loss of culture, loss of language and urbanization” (p. 3).

i.2.2.1 Youth

Jennifer White (January, 2005) prepared a research report for the British Columbia Ministry of Children and Family Development, called Preventing Suicide in Youth: Taking Action with Imperfect Knowledge, outlining risk factors for youth suicide and preventive factors. Risk factors listed are grouped as follows: “1. mood disorders, substance use disorders, conduct disorder and concurrent disorders; 2. previous history of suicidal behaviour; 3. family history of suicide or physical abuse; 4. current life stressors; 5. exposure to sensationalized media reports of other’s suicidal behaviours; and 6. access

to lethal means for suicide” (p. 5). Various researchers organize these factors differently, or leave out specific items. In this paper, risk factors that increase vulnerability to suicide, specific to the youth, are grouped into five clusters. They are beliefs, substance abuse and health, coping abilities, and criminality.

i.2.2.1.1 Beliefs

Several types of belief can influence vulnerability. One of these is about the after-life. Some examples include the idea of reunion with loved ones, going to a better place after death where pain experienced in this life is absent, or as a way to punish others and escape from persecutors (Maltzberger, 1992). Religious belief in some cases is found to be protective, but not in other cases. Depending upon the individual’s perspective it may not be. A religious belief that suicide is wrong is protective, but believing that one has committed a terrible sin may increase vulnerability. The belief that one may go to heaven and join loved ones may increase suicidal ideation (Shea, 1999). Religious influence on personal beliefs about suicide may be declining (Bagley & Ramsay, 1997). Different religions have different effects. While suicide is condemned in the Muslim religion, the Buddhist stance is considered ambiguous, and in Hinduism, under certain circumstances, suicide is considered acceptable. Christian groups are not homogeneous and differ regarding beliefs about the issues of suicide (Murthy, 2000).

In general, what a youth believes about his situation and what problem solving or coping abilities he lacks may increase vulnerability to a suicide attempt. Ability to cope is generally lower in traumatized individuals who have already had their coping abilities overwhelmed. Several generations of Aboriginal peoples were forced to attend residential school where many were severely traumatized. The generational effects of residential

school for Aboriginal peoples contribute to making these populations generally more vulnerable. There are mitigating factors that defy this generalization though, when specific individuals or different reserve communities are considered. The “religious” environment of these schools turned many away from the protective factors the Christian religion might have offered them.

Contagion, which is a “process by which one suicide may facilitate another” (White & Jodoin, 1998, p. 275), can result from beliefs. For example, clusters of suicide sometimes occur when a famous person completes suicide with media publicity as it provides a justification for a vulnerable person to take this final step (Robbins, 2000). The Internet has increased the sharing of suicidal ideas, means, and resources. Some sites offer instructions on how to commit suicide, as well there are many sites offering help to those feeling suicidal (Schmidtke & Shaller, 2000). Bagley and Ramsey’s (1997) findings demonstrate an increase in youth finding suicide as an acceptable solution, whereas older people’s attitudes generally reflect the opposite. Both contagion and suicide pacts may be somewhat more likely in a ‘closely knit’ family community such as is the case on Aboriginal reserves. Worldwide areas that generally are accepting of suicide could make it easier for a vulnerable youth to make use of this option, whereas societies that consider this wrong may be somewhat protective of this vulnerable population.

Hopelessness and depression are commonly present in suicidal ideation. However, hopelessness in adolescents was not related to suicidal actions in boys and only moderately related to suicide behaviours in girls when depression was controlled for in some research trials (Cole, 1989, in Abramson, Alloy, Hogan, Whitehouse, Gibb, Hankin & Cornette, 2000). Hopelessness served as a significant predictor only when it was

analysed separately from survival and coping beliefs (Weishaar, 2000). Prior suicidal expressions/attempts and self-harm are predictive behaviours of future suicidal behaviours, even twenty years later according to Bagley and Ramsay (1997). This may be because of long-term beliefs regarding suicide as well as maladaptive coping skills.

In summary, how a youth thinks about suicide may increase his vulnerability to act, regardless of what affected the youth's beliefs to think about this means of dealing with his inner conflicts.

i.2.2.1.2 Substance abuse and mental health

Substance abuse disorders are among the most common correlates for youth and suicide (Riskind, Long, Williams & White, 2000). Some personal characteristics may be the consequence of drinking, or in many cases predisposing factors to drinking, since suicidology studies have pinpointed impulsivity, low frustration tolerance, sensation seeking, high negative affect/anxiety, high aggressiveness, and more anti-social deviance, as increasing vulnerability to suicide (Verona & Patrick, 2000). Robbins (1998) lists impulsivity in his psychological profile of suicidal youth. Impulsivity has been found to influence the ability to problem solve (Goldblatt & Silverman, 2000). Some researchers have found several drugs associated with suicide risk including cocaine (Goldblatt & Silverman), LSD (Shea, 1999), and alcohol (Appleby, 2000). However, some drugs, such as marijuana and sedative hypnotics, were not associated according to some researchers (Goldblatt & Silverman). Aboriginal youth populations are at a heightened risk of substance abuse and related harms, as well as for other mental health disorders compared to non-Aboriginal youth (McIntyre, 2001).

The strongest predictor for suicide in any diagnostic groups is depression (Lester, 2000; MHECCU, 2005; and Tousignant, 2004). Tousignant adds schizophrenia and bipolar disorder as commonly present factors. Anxiety has also been implicated in suicide (Riskind et al, 2000). Goldblatt & Silverman (2000) conclude that suicide risk is significantly higher in psychotic (delusional) versus non-delusional depression. Davis (1995) found that the top pre-attempt symptoms were anxiety, dysphoric mood, initial and middle insomnia, fatigue, suicidal ideation, feelings of worthlessness, loss of interest/pleasure, and difficulty thinking/concentrating. Suicidal, sexually abused youth exhibited a variety of mental health conditions such as post-traumatic stress; depression; anxiety; dissociation; and somatic, conduct and emotional disorders (Bagley, Bolitho & Bertrand, 1997). Para-suicidal behaviour (self-harming), with or without suicidal intent, is most common among individuals with borderline personality disorder (Linehan, 2000) and impulsivity is a symptom of borderline personality (Robbins, 1998). Verkes and Cowen (2000) report that low serotonin levels may predispose people to psychotic processes and suicidal behaviour. This is the crux of their argument for the use of psychotropic drug treatment for the prevention of suicide. An increase in energy coming out of depression augments the risk of suicide (Verona & Patrick, 2000). Co-morbidity of an affective disorder, schizophrenia, alcohol dependence, and personality disorder increase the lethal risk (Appleby, 2000).

The onset of mental illness and one-year post discharge are times of greater risk for suicide. A one month post discharged person is at one hundredfold greater risk than the general population (Hawton & van Heeringen, 2000). Refusal of care and leaving treatment with little follow-up are both risk factors in psychiatric patients

(Appleby, 2000). Certain psychotropic drugs (Selective Serotonin Reuptake Inhibitors (SSRIs) in particular) are linked to higher reported rates of suicide attempts compared to other anti-depressants (Shea, 1999). Controversy around this has likely prevented their use when they might be useful.

A completed suicide is more probable in geographic areas where medical help is less available (Bagley & Ramsey, 1997). What too frequently occurs is an ambulance cannot get to the injured person fast enough, so the chance of the person dying is greater. Many British Columbia Aboriginal reserves are semi-isolated or isolated with transportation issues a common feature. Transportation issues play a large part in many difficulties these reserves face, contributing to individual feelings of hopelessness in social assistance dependence. Jobs that are within reach may be strictly band employment positions, which are limited both in numbers and in scope of possibilities. Again, these factors predispose a person to suicide attempting.

Prior self-harming increases the risk of suicide. Joiner (2000) indicates, "Multiple attempters are at chronically elevated risk for suicidality, even despite sharp post-crisis improvements" (p. 5). According to Joiner, negative events shown as relating to the intensity of suicidal crisis among never and first time attempters and duration of suicidal crisis was related to negative events in eventual multiple attempters. These findings accord with both the mental health of the individual and their coping abilities.

Aside from health problems defined as mental illness, other health factors such as epilepsy, Acquired Immune Deficiency Syndrome (AIDS), diabetes, and serotonergic dysfunction also increase suicide risk (Grossman & Kruesi, 2000). Diabetes alone exists in epidemic proportions in Aboriginal communities.

i.2.2.1.3 Coping abilities

Some researchers found problem-solving deficits associated with suicidal behaviour (Cantanzaro, 2000). Cantanzaro offers deductive evidence that problem solving and mood regulation are linked in several ways. For example, problem solving can be interrupted by negative mood, and mood regulation is a problem solving skill. Suicide may be viewed by the deficit problem-solving individual as a problem solving solution. Furthermore, not being able to resolve issues leads to poor lifestyle and feelings of shame, guilt, and hopelessness. A number of researchers showed a connection between the combination of shame and depression in children and suicidal ideation (e.g. White & Jodoin, 2004). Robbins (1998) discusses a study of adolescent girls who attempted suicide and found that suicide attempters had fewer problem solving skills compared to non-attempters regardless of psychiatric status. Suicide attempters generated fewer solutions to stressful problems. Kral and Dyck (1995) report hospitalized children experiencing suicidal ideation are less able to think of alternatives to their problems than hospitalized non-suicidal children are.

Perfectionism, rigid thinking, distorted cognitions, and poor self-regulation of negative thought and moods are examples of problematic coping. Perfectionism, defined here as high expectations of oneself combined with a perceived failure to meet this unrealistic standard, was found to be part of the composite psychological profile of suicidal youth (Robbins, 1998). Cognitive distortions for suicidal youth include delusions (false beliefs) and rigidity of thought (things must be a particular way or there is no other way out except escape through death), demonstrating a deficit in coping skills and offering no alternate ways to cope (Lester, 2000). Weishaar (2000) refines this further

suggesting cognitive rigidity in suicidal clients might be accompanied frequently by a difficulty in tolerating problem solving processes. Vohs and Baumeister (2000) offered evidence that self-regulation, or the ability to control impulses and desires, presents as a limited resource for suicidal individuals.

i.2.2.1.4 Criminality

Verona & Patrick (2000) described a cluster of vulnerabilities to suicide associated with criminality. These vulnerabilities included impulsivity, mental illness, antisocial personality disorder, violence, aggressiveness, poor coping skills, chaotic family history, substance misuse, social alienation, school/employment difficulties, and Fetal Alcohol Syndrome/Effect. Situational risk factors such as legal (i.e., incarceration) and disciplinary problems increased the risk (Grossman & Kruesi, 2000). Generally, there was a higher risk of suicide among those exhibiting criminal behaviour (Verona & Patrick, 2000), not surprising since this description of vulnerabilities dovetails with suicidal vulnerabilities as well.

i.2.2.2 Family

i.2.2.2.1 Abuse (victims of sexual/physical abuse and perpetrators)

Robbins (2000) discussed evidence of links between suicide attempting by adolescent girls and sexual abuse. Bagley and Young (1997) reviewed a number of empirical studies linking sexual abuse and suicidal behaviours. Separation from a parent increased risk, as studies show biological parents less likely to abuse the child sexually than boyfriends and stepfathers. In a study of 750 men and 750 women with childhood sexual abuse histories, 30.8% of males made suicidal gestures and 41.2% of females made suicidal gestures. In an Albertan high school study, 13.2% of 53 girls who

experienced frequent, undesired sexual contact made greater than two suicidal gestures or attempts in the six months prior to the study (Bagley, Bolitho & Bertrand, 1997). Among 18 boys who experienced sexual assault, 33.3% were suicidal. Estimates of those who are sexually abused and suicidal are considered underreported, so it is unknown how many young people took their own lives taking sexual abuse secrets with them. Clusters of vulnerabilities for risk of suicide attached to sexual abuse include: post-traumatic stress disorder, anxiety, depression, chaotic family history (many abused by family and/or family friends), difficulties with intimacy in relationships, physical problems, shameful pregnancies, poor self esteem, shame and guilt for events beyond their control (Robbins, 2000). Bagley and Young (1997) discovered that perpetrators of sexual abuse were often victims of sexual abuse in their childhood, and that there was a high rate of suicide for perpetrators. Sexual abuse by priests in Aboriginal Residential schools affected older students who would sometimes abuse younger students and so the problem was too frequently a young person being burdened with both unhealthy situational behaviours and then returning to the community with this serious behavioural problem. Generational abuses became all too common along with guilty family secrets and humiliating incest pregnancies that “everyone knew about” but a silenced community could not discuss openly. Adelson (2005) reports almost a quarter of victims (female) of assault are seven years old and under, and that Aboriginal communities are at a higher risk for abuses of all types. Abortion when resorted to has extra burdens of spiritual beliefs that are in conflict with this action. The person who aborts a child risks both social and spiritual negativities (Olsen, 2005), leaving the person with greater inner turmoil.

Bagley and Young (1997) explained that victims of physical abuse possess many of the same vulnerabilities for suicide that sexual abuse victims have, such as: post-traumatic stress disorder, anxiety, depression, panic attacks, chaotic family history, physical problems, and poor self-esteem. They also pointed to poor self-esteem correlating strongly with suicidal ideas and feelings. In conclusions from summarizing a mental health study they emphasized that the role of childhood sexual abuse creates “aetiological factoring diminished self-esteem, depression, suicidal ideas and suicidal behaviour” (p. 157). When a young person experiences sexual assault, physical and emotional abuse, there appears to be a longer-term effect on mental health.

Perpetrators of physical violence were found likely to have a neurobiological vulnerability of low serotonin levels in the brain according to research by Vohs and Baumeister (2000). This predisposed the person to low impulse control and violent tendencies towards others or self. Earlier research found correlations between violence and suicidal behaviour prior to brain chemistry knowledge available to researchers now (Fish-Murray, 1993).

i.2.2.2.2 Ethnicity/immigration

Pfeffer (2000) discussed differences in suicide rates amongst different racial and socio-cultural groups. Shiang (2000) explains that cultural systems affect the moral standpoint (beliefs) a person directs their daily activities from, and so culture can affect the reason why a person decides to commit suicide. Tousignant (1995) sees suicide as a cultural schema or a “goal-schema linking the action of suicidal behaviour or suicide completion with culturally reasoned motivation” (p. 204).

White and Jodoin (2004) explored the high incidence of Aboriginal suicide. In this population there are clusters of vulnerabilities related to accumulative historical abuses such as the physical and sexual abuses in Residential school and losses of culture and language, and this abuse underlies their employment and education limitations, subsequent substance abuse, poor self-esteem, increased mental illness, and all the other vulnerabilities understood as resulting from generational abuse.

Shiang (2000) explained that culture shock and language barriers stress the individual and may make him or her vulnerable. Generational differences when parents move to a new country affect their young children in numerous confusing ways that may keep them torn between two cultures and differing moral standpoints. Bagley and Ramsay (1997) discussed a Canadian study showing recent migration as one of the predictors of suicidal ideation and behaviour. In Aboriginal cultures, this immigrant phenomenon took place, although there was no recognized migration from another country. Children returned home from Residential schools no longer knowledgeable about their language or culture, creating generational differences of an unhealthy sort. Parents, given the hurts their families suffered, were now reluctant to pass on their traditions and again much was lost, affecting the identity, self-esteem, and strengths of culture and community.

i.2.2.2.3 Family break-up

Robbins (1998) reflected that overt family conflict in the background of suicide attempters differentiated them from psychiatric comparison groups. Youth prone to suicidal problems often belonged to families that do not work very well. Parent-youth relations were often conflicted, parents had behavioural problems of their own, and there

was often little emotional support within the family. Early childhood loss and separation factored frequently into the personal history of those who commit suicide, although this research observation could be confounded by the large numbers of divorced parents in present society, according to Owens and Booth (2003).

Grossman and Kruesi (2000) reiterated family risk factors including psychiatric disorders, father absence, family discord, family abuse, violence, and marital conflict. All of these factors contributed to family break-up. Bagley and Ramsay (1997) offered empirical evidence that separation from a parent prior to age sixteen and separation from the mother during any teenage year was associated with suicidal ideation and action.

Relationship break-ups may influence vulnerable individuals to attempt suicide. Abramson et al (2000) found twice as many single as married people commit suicide and that divorced and widowed individuals were at much greater risk. Bagley and Ramsay (1997) presented evidence of separation from a spouse or boy/girlfriend within the last month before suicide as a significant factor. Break-ups and arguments with significant others may be factors blamed as the “cause” of suicide by invested, grieving bystanders. However, those caring for the survivors of a loved one’s suicide must consider they may not want to look at the whole picture of other factors in the person’s back ground that led to a vulnerability to respond to relationship break-up and arguments in this violent way. This particular factor lends itself easily to pointing fingers at others and blaming, something that needs to be worked with therapeutically in postvention.

i.2.2.3 Social

i.2.2.3.1 School

Robbins (2000) explored the problem of some youth not fitting well into the school environment and seeming “out of step.” When this happens to a youth, maladaptive behaviour patterns, including suicidal behaviour, may occur. Bagley and Ramsay (1997) linked secondary school dropout rates and unemployment amongst those who die by suicide. The youth who completed suicide most probably quit school and was unemployed prior to his death. This does not mean that these youth are less intelligent than other youth. Studies demonstrate suicidal psychiatrically hospitalized young people, with active suicidal thinking, exhibited both more verbal skill and higher I.Q. scores than non-suicidal psychiatric peers did, according to Leenaars (1993). It is ironic that a bright, sensitive young person may be more at risk. Schools provide a significant social environment where opportunities for conflict with teachers and other students abound. Again, break-ups and arguments with significant others may be blamed as the “cause” of suicide by invested bystanders. This particular element may manifest itself in survivors pointing fingers at others and blaming, something that needs to be worked with in postvention, both with the family and perhaps with some school staff and other students. The social environments of schools need to be evaluated for negative impact possibilities on vulnerable youth. Supportive school environments may be preventive. In the case of Aboriginal students, bringing Elders to teach Aboriginal wisdom in the school, providing education on Aboriginal culture to all students and encouraging Aboriginal communities to share ceremonies in the school may all contribute to social suicide prevention as these improve and create a positive school climate for these students. An example in British Columbia where a reserve school was created and there are few school problems, little isolation and more understanding and education about culture is Chehalis Community

School. Bill Dietrich, the principal indicates there are very few problems in this school, and the school is known for creating a positive and cultural environment. The school respects and is flexible around the needs for ceremony and learning about culture. Language is being revived through this school. The youth are proud to be Chehalis and often wear items with the Chehalis sasquatch logo.

i.2.2.3.2 Community isolation and peer relationships

Feelings of isolation from peers may increase risk as individuals who isolated themselves were more likely at greater risk, according to Owen and Booth (2003). Relationship losses, such as an intimate relationship break-up, were considered as a trigger to suicide, as well as relationship losses being a vulnerability factor. This is general knowledge in suicidology. Whether the person withdraws from peers and relationships as they consider suicide or the person is rejected from relationships, it is clear the isolated person is vulnerable.

i.2.2.3.3 Sexual orientation

Nelson (1994, cited in Ashworth, 2001) found substance abuse, suicidality and homelessness affected a higher number of gay, lesbian, bisexual, and transgendered adolescents compared to the population norms. Shea (1999) explained homosexuals were more vulnerable to suicide as adolescents because of verbal abuse and bullying from peers, individual family members rejection, and their own difficulties accepting their sexual preference. Homosexuality was considered a psychiatric problem in recent history. Professionals were not always supportive of homosexuals. Bagley and Tremblay (1997) carried out a stratified random sample study in 1997 of 750 young men in Calgary, Alberta (Dorais and Lajeunesse, 2004); 12.7% of the sample that were homosexual and

bisexual young men accounted for 62.5% of the suicide attempters (p. 11). “Coming out” was found to be a high-risk time. These researchers thought sexual orientation did not cause the vulnerability but that homophobic environments added many of the vulnerabilities). Coming out at a younger age appeared to increase vulnerability of suicide attempting and that risk decreased with waiting to an older age to “come out” (Bagley & Tremblay, 1997).

i.2.2.4 Precipitating Events (Examples of Triggers)

i.2.2.4.1 Relationship factors

Social rejection can be humiliating as well as isolating. Loss of an intimate relationship was reported as a frequent trigger (Advisory Committee, 2005). Factors increasing risk in a vulnerable individual were a humiliating event in relation to others, such as personal failure, loss of status (including loss of an intimate relationship), and incarceration. Incarceration was seen as both personal failure and a humiliating event which created relationship loss and isolation from significant others. Unfortunately, the behaviours of a poorly coping person may tend to lead to frequent social rejection.

Contagion (copycat, suicide pacts, premeditation) was another relationship factor, defined by White & Jodoin (1998) as “a process by which one suicide may facilitate another” (p. 275). In a suicide pact, one or more youth may strengthen each other’s resolve. In copycat suicides a youth’s idol/hero who commits suicide may encourage suicidality and premeditation over a period of time in which the idea is focused upon thereby increasing the likelihood of a follow through action.

i.2.2.4.2 Abuse (sexual, physical, and bullying)

Abuse situational factors increase risk and may precipitate/trigger a suicidal event (Bagley, Bolitho & Bertrand, 1997). Abuse includes humiliation factors, detrimental to self-esteem, making it difficult for a young person to cope and tend to be socially isolating. Humiliation, whatever its origins, is seen as particularly important by the individuals studied. Many scenarios fall under this category including physical abuse of a girlfriend, perhaps leading to relationship loss and the above circular problem of humiliation and reduced self-esteem. The abuser feels humiliation over the relationship loss as this lessens his perceived social status. The abused girlfriend also suffers humiliation and self esteem issues, perhaps feeling at some level deserving of the abuse or embarrassed for others to know of the abuse.

i.2.2.4.3 Protective factors

National Aboriginal Health Organization (2003) described protective factors as “conditions that reduce the risk of suicide” (p. 4). Some examples given were optimistic outlook, resiliency, willing to find help, having a good role model, having access to an empathetic adult, and strong, positive cultural ties. Jennifer White (2005) noted:

Protective factors against suicide are less well established but are thought to include:

1. individual coping and problem-solving skills,
2. strong family support and involvement,
3. interpersonal competence,
4. positive school climate,
5. strong community and cultural ties.
6. having a child to care for

Protective factors for First Nations youth include living in communities that have high levels of ‘cultural continuity’ as defined by involvement in land claims actions, a recognized level of self-government, involvement in cultural activities, and control over education, police/fire and health services (p. 5).

In non-Aboriginal youth, it may mean marginalized youth becoming part of any positive group where feelings of belonging grow.

i.3 Prevention

Research on suicidology led to useful information on proposed prevention strategies. Interestingly, Maris (1993) defined “Suicidology” as a “science of self-destructive behaviours, thoughts, and feelings” (p. 4) and did not include the idea of prevention strategies in the definition. Prevention work for the helping professions has connected closely with the study of suicide.

Workshops may cover prevention, intervention, and postvention. Primary prevention targets youth “before the fact” (White & Jodoin, 1998) or “increase(s) protective factors in suicide prevention among the general population” (National Aboriginal Health Organization (2003, p. 5). In other cases it may focus on a specific, targeted population such as youth in school to offer useful instruction that is seen as preventive when no known specific problem is known. Intervention (also known as secondary prevention) consists of strategies aimed at identified “at risk” youth and postvention focuses on people who have recently been exposed to a suicide.

i.3.1 Prevention and suicide methods

In terms of practical individual prevention, the removal of lethal means from the youth’s environment increases safety and may prevent an attempt. Evidence in the literature suggests when a chosen lethal method becomes unavailable the individual does not simply choose another method, and therefore removal of the means to commit suicide can reduce the number of suicides occurring (Grossman & Kruesi, 2000). Firearms, hanging, and overdoses top the lethal methods available in our society, although some

use carbon monoxide in a sealed vehicle, drowning, and jumping from a high place. In hospitals, prevention relies on no access to lethal means and increased monitoring (Grossman & Kruesi, 2000). Hanging is very difficult to prevent as almost anything may be used to hang oneself and within fifteen minutes rescue is not possible. Alcohol often is a factor in suicide. Removal of guns and alcohol from homes would be a practical intervention along with vigilant parental supervision. Problems with limiting access to guns are hunting lifestyles in many parts of Canada, including British Columbia. Hunting lifestyles are common in Aboriginal communities, another factor accounting for greater opportunities for suicide in those populations.

i.4 Training Interveners

There are a number of factors to consider when training interveners/gatekeepers including resources, screening tools, targeted interveners, adult learners, cultural beliefs and field best practices. The factors reviewed here consider some resources to use beyond this paper, the teaching methods useful for adult learners, and needs for ethno-cultural groups, in this case Aboriginal, Coast Salish, and intervener screening tools. Since this particular slant is being adopted, some of the research and papers are selected from the perspective of adult learners and First Nations including Coast Salish writers. Care has been taken to choose professional field writers who made use of known sound research for manuals reviewed. Partially resulting from the choice of practical goals of writing a manual, manuals were reviewed and at times referred to, rather than strictly adhering to first hand research. White & Jodain (1998, 2008) present a manual that covering mainstream information needs as well as First Nation's cultural needs and at the same

time is based on best practice research. Therefore, this manual was reviewed closely, although there are numerous other resources for training people to intervene.

White and Jodoin (1998, 2004) wrote *Promising Strategies, Aboriginal Youth: A manual of promising suicide prevention strategies* and *“Before-the-fact” interventions: A manual of best practices in youth suicide prevention*, which provide complex and extensive information. The purpose of this project is to distil the essentials of the field for workshops for the targeted groups (adults, Aboriginals, caregivers, school personnel, and graduate students learning counselling). ASIST (Applied Suicide Intervention Skills Training) involves teaching material by ASIST facilitators, trained by the ASIST program, at considerable cost. Generally cost is a barrier to training enough people in these skills so although this program is mentioned, it is not given in depth. It is recommended as a follow-up for anyone interested by these workshops and is currently quite popular in the helping professions in British Columbia. Also, having received ASIST training, I perceive the competence level for intervention it provides as similar to ASK screening tool (using C.P.R. Current Suicide Plan, Prior Suicidal behaviour and Resources) taught to foster parents, but ASIST has the added advantages of a take home manual of information provided to participants after training and a first aid style card for one’s wallet. This identifies a person who received training and may help some individuals to feel good about the training they have received, but in does little more than any other workshop certificate. The public domain, long-term use of ASK by Ministry personnel and contracted workers makes it a useful beginning introduction to a quick method of assessment of a potentially suicidal person and the workshops are partially based upon it. ASK focuses perhaps overly on determining the level of risk, using a series

of useful criteria; however, this can set the stage for a dangerous scenario where the assessor sees the risk level as low and does not take the situation seriously enough. Levels of risk can change rapidly and this must be made clear in workshop discussions. Since the majority of those people experiencing suicidal ideation never commit suicide, which is comforting, it is possible for a person to become somewhat “laissez faire” about responding to suicidal thoughts. It is important to strike a balance of not over reacting and not under responding. It should be known that the foremost experts in assessing for suicide risk are not consistently accurate, and to some extent one never knows how accurate the assessment is unless the person commits suicide, which assessing is designed to intervene in!

i.5 Effective Prevention Programs

According to Grossman and Kruesi (2000, p. 176), in 1992 the Center for Disease Control and Prevention surveyed youth suicide prevention programs that were considered to be exemplary and put together a guide describing the “rationale and evidence for the effectiveness of various strategies.” Eight prevention strategies were cited and programs using them were described. The eight strategies listed consist of: school gatekeeper training, community gatekeeper training, general suicide education, screening programs, peer support programs, crisis centers, telephone hot lines, and means restriction intervention. These formed two divisions: the identification and referral of youth to resources (mental health) and addressing known or suspected risk factors for adolescent suicide. The Center for Disease Control recommended programs that would target children under 15 years for prevention (Grossman & Kruesi, 2000).

At all community, professional, and personal levels there exist levels of responding to the problem of youth suicides. Berman and Jobes (1993), cited in Grossman and Kruesi (2000), developed a conceptual model of prevention strategies, which included primary prevention (examples: gun safety training, school drop out prevention, early detection), secondary prevention (examples: gatekeeper/caregiver training, restriction of means, outpatient treatment), and tertiary prevention (examples: juvenile justice programs, substance abuse treatment, medications).

Identifying cultural frameworks presents a vital consideration in suicide prevention since operating from an understanding of an individual's beliefs and culture when considering suicide facilitates helping him.

This applies when presenting the workshops as well. Facilitators "in tune" with ethno-cultural perspectives will naturally understand and make information relevant for participants (Shiang, 2000). Ramsay, Tanney, Harrington, and Franssen (1997) wrote a chapter titled "The United Nations Guidelines for the Formulation and Implementation of National Strategies: Prevention of Suicide," found in Bagley and Ramsay (1997). Some of their main points were:

1. Employ a bio-psycho-social framework to understanding suicide prevention.
2. "No single discipline or level of social organization can be solely responsible or effective in suicide prevention. Thus individuals in many roles and at all levels of community and society have expertise in making unique as well as co-operative efforts to prevent suicidal behaviour" (p. 236).
3. Since the "meanings and antecedents of suicide vary between cultures", prevention strategies need to be "nation specific" (p. 236).

4. Psychological autopsy should be done for every child/youth suicide.
5. Support services always made available to family and friends, especially since about 5% of young suicides happen in a short period following the suicide death of a relative or friend (cluster suicide).

In other works, White and Jodoin (1998) presented a well-rounded picture of what would maximize success in a suicide prevention program. The ingredients they prescribed include:

1. Focus on both risk and protective factors.
2. Work with both the children and all the environments the children are affected by on an ongoing basis.
3. Emphasize Life skills such as critical thinking, problem solving, coping, communication, stress management, and various social skills.
4. Multilevel programs and agencies with different strategies in a variety of settings such as school, family, and community and a number of different partner agencies involvements such as schools, churches, police, parent groups, and youth groups and others can help programs to be successful.
5. Since schools offer an efficient and systematic way to promote the well-being of children and youth, bring services to schools and involve school staff to increase the likelihood of program success.
6. Peer influence when used in a positive role (tutors, trained support helpers) has proven helpful. Parents who are successfully involved as “co-therapists” and given helpful roles prove to be assets in prevention.

7. Early interventions and planned interventions timed for stressful transition periods, such as changing schools, are likely to prevent problem growth and limit problems from the start.
8. Program workers of all types need to be trained for good standards of help to be possible. There needs to be good on-going supervision, support, and coaching for trained staff.
9. Program evaluation/monitoring helps programs improve and offers models to others that have evidence of efficacy.

All of the above indicates the need for a practical, multi-pronged safety network for youth. Identifying and referring youth to overworked Mental Health child psychologists is not practical because there are not enough child psychologists available in the system and youth may not always be willing to see them. When youth do see them, the available time they offer is limited, and not ideal for the general needs of youth for relationship. Non-Aboriginals more often receive counselling employment because of educational qualifications. This will change over time, but is a current reality. This frequently may result in the counsellors youth encounter having only a shallow understanding of the cultural framework and connect poorly with the youth. Even with some cultural understanding, it may not be sufficient to assess successfully the acculturation level of the youth. Collaborating with a skilled and culturally knowledgeable Aboriginal person or qualifying natural helpers in Aboriginal communities may be advisable. Cultural exchange placements would benefit the level of understanding these counsellors have. In Coast Salish areas, time spent in the longhouse during winter dancing would benefit counsellor competency, but not all long houses

would welcome their presence. Accessing wise Elders or Aboriginal Healers and acculturated youth respects may need to be part of the safety plan.

According to program results reviewed in Robbins (2000), student educational prevention programs often resulted in an increase in student awareness of items such as suicide warning signs, but had little effect on students' willingness to seek professional help or advise a friend to call a hotline if thinking about committing suicide. Youth predominately seek out other youth. Robbins (2000) suggested training peers in helping peers would be a creative way of working on this problem and noted that there have been some useful programs created that include this concept, but this has not been taken advantage of sufficiently. Many years have passed since a peer-counselling program was offered at the University of Victoria in the 1980s. Mentorship programs designed to have older youth mentor younger ones is an option in mainstream, lower mainland British Columbia communities, but is not available in many places or on reserve. Robbins (2000) noted limited and fragmentary studies exist evaluating the effectiveness of programs designed to prevent youth suicide. However, he indicated a combination of several strategies offers the greatest likelihood of success, citing: gatekeeper training, screening programs, and establishing a hotline. In British Columbia, there is a hotline "1800SUICIDE" which may be useful both for clients and for professionals. Universities may have their own crisis lines such as Simon Fraser University's Nightline. There is also mainstream crisis lines and a Native crisis line on Vancouver Island. Crisis lines have limitations though, especially when manned by unpaid volunteers who may not make it to their shift on the line.

Although basic training available does look at brief assessment, low, medium, and high-risk levels, this topic is still usually limited in the field, to a half-day or one-day seminar. Risk is a vital topic as there are suicidal individuals who are disinclined to admit to their final decision to die, so intent are they upon doing so. Still others, who may claim quite honestly one moment to have abandoned their intentions, may change their decision under certain circumstances.

A good example of an efficient, short workshop for foster parents was created for the Ministry of Children and Family Development (MCFD). The material that the MCFD requires covered is given to a contracted professional, who presents the material, or invites a guest speaker to cover the material (C. Doyle, personal communication, March 30, 2005). Topics the three-hour workshop covers are warning signs of suicide, risk factors, assessment, and interventions. A useful part of the presentation is the “Ask” assessment.

The first step in assessing immediate risk is to ask the youth if they have been thinking of ending their life and about any suicide plans. Next, if the person has chosen a method to die, assess how lethal that method is and if the youth has access to that method. Learning intended time frames and locations may be helpful. The interviewer tries to discover what the reasons are for wanting to die, looking for factors that augment the risk level, as well as reasons for not wanting to die which are protective factors lowering the risk level. If the youth honestly dialogues with the interviewer, quite a bit of useful information will be shared that can help the interviewer decide how risky the situation is at that point in time and suggest ways to intervene (such as removing firearms from the youth’s access, locking up medications, household poisons, and/or keys to the

car). Usually there are preferred methods of dying, and knowing these can be useful in intervening. The focus of the discussion with the youth can augment the youth's protective factors against attempting and diminish the looming factors that increase the likelihood of an attempt. If the youth has 'hope,' there are alternative ways to deal with his circumstances, protection against a suicide attempt increases.

The level of immediate risk helps to determine if the youth needs to be in emergency and given the brief protection of a hospital commitment. It is clear the youth should not be left alone but be supervised. Once the interviewer has gleaned this kind of information, intervention is possible and the information should be passed on to the youth's social worker, doctor, parents, school counsellor and so on, in order to protect the youth. The youth can be referred to a mental health professional, but will still need a safety plan that includes those who can contact the youth more frequently. The more helpful people who know that the youth needs protection, the safer the youth may be.

A mental health professional can check regularly the youth's stability and progress and assess factors that may affect safety. Some agencies' policy/protocol direct the youth be taken to emergency regardless of risk level. "Playing it safe" is a good plan generally, however once the hospital assessment is done and the youth released, a safety plan is still needed that involves other people. Hospitals have many resources and when a psychiatric unit is needed to stabilize a person experiencing psychosis, for example, this may be the only good choice possible.

The workshop participants practice the intervention and assessment tools taught during the workshops and the participants test themselves for knowledge acquisition. One concern is that brief assessment is taught to non-helping professionals. For example,

foster parents are not counsellors, so they may or may not have the communication skills of someone in the helping profession. This creates a burden of being expected to implement an assessment tool to prevent youth suicide. This ASK model and the information given are useful, but it is a lot of information in a short period of time, and with little helping skills training given to these substitute parents of children. Ongoing training for foster parents would be supportive and skill building. In addition, levels of risk can change rapidly. Suicide prevention is a difficult area, even for a seasoned professional, so effective training for foster parents is important.

i.6 Effective Prevention Strategies and Prevention Program Characteristics

White (2005) outlined several key components in an overall approach to prevention of youth suicide within B.C. Comprehensive strategies undertaken at the local level that capitalize on the existing resources and strengths of the community are considered the most promising. Four general categories of action should direct our activities in youth suicide prevention: 1. promote competencies and capacities, 2. reduce risks, 3. improve early detection of those at risk, and 4. minimize contagion. These actions need to be implemented across an array of prevention settings including families, schools, and communities. Most advisable is to strategically combine approaches that target high-risk groups with those that are aimed at reducing risks and promote protective factors at the population-level. Intervene with youth and “their social environments” (p. 6). An extensive review from Elias (1997), Silverman & Felner (1995) was distilled into basic points cited in Kalafat 2000.

These points consist of:

1. conceptually and empirically grounded goals and objectives;

2. clearly articulated and packaged components, including appropriate instructional principles;
3. sufficient duration;
4. comprehensive in that it addresses all levels of target organization;
5. ecological and addresses the multiple contexts in which participants interact;
6. conforms to the culture/values of the target participants and organization;
7. implements with fidelity; and
8. institutionalizes over a sufficient period to show effects.

Kalafat (2000) referred to a report published in 1994 by the Institute of Medicine regarding prevention methodology. This included the following:

1. Universal interventions: These interventions would be directed to a population as a whole rather than to subsections of it. Examples include: (a) teaching coping skills to an entire population, and (b) enhancing the supportiveness and ability of populations such as they would be able to respond better to a troubled youth.
2. Selective interventions: These interventions are targeted at subpopulations such as students in critical transitions, such as when youth enter high school and may be stressed by the transition.
3. Indicated interventions: These would be interventions targeting individuals, who have been identified/screened as needing intervention.

Effective program evaluation is an important aspect of making sure a program is having a useful impact, to sift out what does not work well and to enhance what does. Evaluation is not as simple as asking whether the program works or not. Kalafat (2000) clarified that in order to evaluate summary results; several evaluation points must be

considered. Considering evaluation, a pilot program should be considered differently than a mature program, as a pilot program just being established has not had sufficient time to make useful adjustments. In considering implementation, no program will be implemented with complete fidelity, as programs need to be flexible to consider various environmental differences. To assess distal outcomes or epidemiological impact in prevention programs, the program must be disseminated and institutionalised over a sufficient period.

Besides carrying out formative and implementation evaluations, Kalafat suggested multilevel outcome evaluations be carried out that can assess participants reactions to the program, the acquisition of the skills and information of the program, application of, and impacts associated with these. At the date of publication Kalafat indicated no school prevention program has done all of these evaluations. According to Kalafat some second-generation suicide prevention programs showed promise when other students were trained as peer helpers. Reasons for this adjustment given by Kalafat were that suicidal youths confide in other youths rather than adults, disturbed youth prefer peer supports, youths do not feel that school adult staff respect confidentiality, school based adults were considered insensitive to current youth culture and their difficulties, and the organizational aspects of schools prevent youth from getting to know helpful adults. Note that legal considerations for reporting to social workers and ethically sharing information about youths contribute to barriers preventing youth from confiding in adults! Youth know that adults report some things.

Presenters using the workshops described in this project are advised to evaluate effectiveness during and following the presentation and adjust the materials as necessary.

Facilitators should be able to discuss broader aspects of suicide prevention in order to advocate for curriculum such as teaching coping skills in schools, having peer support programs, and other services recommended as best practice information increases.

Suicide prevention should involve parents groups such as parents' school advisory groups and training should be offered to various community groups that interact with youth or groups that youth are found to seek out to belong. For example, sports coaches could receive training.

i.7 Professional Roles In Suicide Prevention

Although both large and small communities need to respond to a crisis quickly and in an organized and effective manner, smaller communities face the added challenge of fewer resources, but have the advantage of resource staff being more likely to know each other to network effectively. Both types of communities need to coordinate services and have viable plans in place.

However, if school staff does not have the understanding and training to identify “at-risk” students, or respond adequately, the best plans cannot be put into effect. All school staff (teachers, principals, teaching assistants, secretaries, janitors, and librarians) needs training because a student may have a relationship with one of these staff and not a counsellor who may never have seen him or her. In turn, the school counsellor may read the school protocol and refer the student on to mental health services, to which the student refuses to go. Protocol and service divisions may inadvertently contribute to inaccessibility of services for this youth. Teachers can be nervous about dealing with something they do not consider part of their expertise, as well as having issues with large

classes to teach, rather than focusing on an individual. However, knowledgeable teachers can create useful school prevention curriculum and prevention strategies as well as identify an at risk student.

Although hospitalization is the usual means open to imminent high-risk individuals, Esposito, Cosiglio, and Petone (1987) cited in Robbins (2000) found evidence hospitalization is not especially effective in preventing suicide. Robbins noted that the emergency room might be a fast entry into the health care system but also a fast exit. He stated that the majority of youth who attempted suicide, were left to their families for care. He quoted researchers who found in their studies that, after the initial treatment, 80% of the suicidal patients were discharged prior to any anti-depressant medication assisting with depression. Robbins (2000) discussed various problems with this. One was that medication for depression takes time to have an effect and amelioration of a depressive state does not necessarily guarantee that the risk of suicidal behaviour is over. In some patients, “the risk of suicidal behaviour may intensify as their depressed mood lifts and energy level returns” (Robbins, 1998, p. 105). They may have increased energy to carry out a suicide plan.

Some empirical support exists for intensive follow-up, case management, telephone contacts, and home visits for increasing treatment compliance with lower risk individuals, according to Rudd (2000). Rudd presented empirical evidence that improving access to emergency service reduced further attempting and service demands in the case of first time attempters. Short-term cognitive behavioural therapy integrated with problem solving was found useful in the reduction of suicidal ideation, depression, and hopelessness of a period up to a year, but not as useful over longer periods. Rudd found

that longer-term treatment was needed to reduce suicide attempting and that specific skill deficits need to be targeted to do this. Skill deficits mentioned include emotion regulation, poor distress tolerance (impulsivity), anger management, interpersonal assertiveness, relationships, and self-image disturbances (i.e., personality disorders). Some of these skills can be taught naturally through teachers, youth support workers or school counsellors. A calm, supportive, non-reactive, non-judgmental worker can do this over a long time period, while establishing a close, helpful person for the individual to come to in times of distress. Unfortunately, too often short-term government funding for youth programs undermines possibilities for long-term work by someone who establishes good rapport with an individual.

Sometimes service providers may feel frustration and think they did what they could do, but that the system is failing the youth. Noting that intervention training and information should be provided to a broader range of people involved with youth, as well as the professional protocols to allow this to occur, the project aims to provide a background understanding for the identified people most able to intervene “at risk” youth by providing the following:

1. Typical profiles of at-risk youth;
2. Practical assessment tools for three gatekeeper groups;
3. Research information about factors contributing to suicide risk;
4. Postvention information; and
5. Research information about effective prevention program characteristics.

The teaching intention is to increase the sensitivity of new helping professionals, caregivers, and teachers to risk factors for consideration, to consider the

similarities/differences between “triggers” and “risk factors” in completing suicide, and thereby increase their understanding of potential suicide factors. For instance, teachers may give workshops incorporating substance abuse as a risky lifestyle, or as part of assessing safety and use of cars for new drivers’ training, as these are areas of high risk for youth disability or death, whether intentional or accidental. The workshops are designed to inform target groups in a manner suitable and helpful to them. Other workshops may be developed from these workshop frameworks for other people who can be of help.

i.8 Postvention

Postvention must be contemplated because of the grief involved, and because when someone commits suicide, others become at risk of repeating the same behaviour. A volunteer task force formed by the Canadian Mental Health Association (CMHA) in 1981 came to similar conclusions, stating that “a comprehensive and coordinated approach to suicide must be developed within a three-tier framework of prevention, intervention and postvention services” (in Bagley & Ramsay, 1997, p. 204).

Suicide bereavement similarities and differences between “normal” bereavement and suicide bereavement warrant consideration. Survivors inquire “Why?” and “Who or what is to blame?” Sometimes experiencing guilt over insignificant negative interactions with the deceased, they feel anger. Cleiren and Diekstra (1995) suggested that a dynamic interaction between the magnitude of loss, the strength and availability of instrumental resources and the strength and characteristics of adaptation resources influence the consequences of bereavement. The results of a literature review by these authors found that “bereavement after different modes of death is marked more by similarities than by

differences.” They stated “virtually all studies” showed when differences occurred, it was not the intensity of the shock of the death that is so different, but rather differences related to themes of “rumination” and “preoccupation.” The authors referred to four psychological dimensions by which each type of death can be assessed. These were:

1. Expectedness (versus unexpected): a natural death in old age is expected; a violent sudden death is not;
2. Naturalness (versus unnatural): a car accident is not natural;
3. Violence (level of violence: low versus high): self-poisoning seems lower in violence than shooting oneself;
4. Perpetration (who caused the death?): another person versus self.

Cleirena and Diekstra (1995) concluded expectedness versus unexpectedness of death impacts little. Losing hope for a person’s recovery appears a useful adaptation to the loss. Unnatural death may involve long-term adjustment. Police/coroner investigations into the case of unnatural death involved greater stress for survivors. They found post-traumatic stress frequently occurs when a family member or friend discovered a mutilated suicide body. Since the perpetrator of a suicide death is the victim, survivors can be plagued with questions about why and where to place the responsibility for the death. The role of the survivor in relationship to the deceased was a major factor in the impact of the death. Workshop trainers should discuss checking both for the roles of the deceased for how this may affect survivors. They need to examine possible blaming survivors might do, what the basis of the blame might be (guilt for their own helplessness regarding the death is common), and consider how to dispel simplistic and unhealthy notions of guilt for “causing” the suicide death.

The literature generally emphasizes a child's death as the most devastating loss (Cleirena & Diekstar, 1995). Within kinship losses, including loss of a spouse, women appeared to suffer "more loss reactions and health complaints than do men" (p. 16). These authors discussed the impacts in terms of loss of roles in relation to the deceased. Some difference was noted in the emotional relationship patterns with the suicide victim as opposed to other bereaved. They stated that suicide survivors perceive the relationship with the suicide deceased as being "less intimate, less satisfactory, and more ambivalent," whereas they viewed the deceased as having been more dependent upon them. The pre-loss relationship was often one of "frustrated, self-protecting emotional withdrawal from the unpredictable and /or difficult psycho-emotional situation, with less frequent contacts with the later deceased" (p. 17).

Cleirena and Diekstra identified other survivor affects. The distancing effect may have been protective of survivors. This was seen with suicide victims having a long psychiatric history, seen as incurably ill, where the survivors have withdrawn from a caretaker or helper role. Loss of social resources was another aspect of how survivors were impacted. Survivors may have been stigmatized and/or blamed for the suicide. Siblings may be affected because they unhealthily identify their own lives and situation too closely with that of the deceased. Their trust in a safe world may be changed. Supportive individuation work around these identifications may benefit this sibling. This may be even more deeply needed work in the case of Aboriginal families, as family groups are such strong identifiers. An example of this is the general remarks made and observed frequently in Fraser Valley Aboriginals' communities, such as: "He's a Paul or she's a Leon," given as a cause of an individual's behaviour or personal characteristics.

Cleirena and Diekstra explored evidence that lower socio-economic individuals with low level education and a low level of skills tend to be impacted with more “depression, boredom, and loneliness” (p. 22) both for bereaved and controls. The ability of the bereaved to adapt the loss into their “assumptive world (attribution activity), that is to develop an image of what has happened, the reasons for what happened, and evaluate the damage” (p. 23) determined largely the degree of impact on the survivor.

Cleirena and Diekstra (1995) found empirical evidence that angry reactions to the loss produce longer, more problematic adaptation and dysfunctional reaction. In some individuals, guilt (anger towards self) may also be related to problems of functioning after the suicide. Perhaps the most serious impact on survivors is problematic grieving in a bereaved survivor who responds to “the strong model-function of this mode of death as a form of problem solving or as an adaptation strategy” (p. 29). Shneidman (1993) raised concerns some survivors later die from disorders arising from self-neglect and abuse such as alcoholism, malnutrition, or disregard for taking their medications.

“I believe the person who commits suicide puts his psychological skeleton in the survivor’s emotional closet” (Shneidman, in Kamerman, 1993, p. 346). When community helpers are faced with a postvention situation, multiplied in complexity because of system glitches or delays, this results in increased stress for survivors (Hoff, 1983, in Renaud, 1995). The “psychological skeleton” in a sense is augmented by this. Pre-existing protocol is essential to deal with these situations smoothly and helpers need to be prepared to facilitate this smoothness in crisis intervention for the sake of survivors and the increased risk of those close to the deceased. Protocol regarding postvention should

be updated and improved regularly and as situations dictate. Protocol must adapt to changing knowledge and new knowledge of best practices.

Robbins (2000) paraphrased the American Suicide Foundations' advice to survivors:

1. Maintain contact with other people, particularly during the months following the suicide.
2. When you are ready, share your feelings of loss and pain with your family and friends.
3. Think of what the children may be going through. Remind them that they are still loved.
4. Anniversaries and holidays are likely to be particularly painful. Plan anniversary dates and holidays ahead to meet your emotional needs and those of your family.
5. You may feel guilt for a time before you can accept the fact that you were limited in what you could do and were not to blame.
6. Avoid the temptation to focus at length on trying to understand the suicide. Do not make an obsession out of it.
7. Healing yourself means not only going on with your life, but in time, resuming the capacity to enjoy life.
8. The survivors of suicide need support. Trusted listeners can help. A support group is an option to consider.
9. Counselling with a mental health specialist or a member of the clergy can also help you through these difficult times.

Lists such as these can be useful for survivors to read when there is no one available to talk with (p. 134).

Cleiren's and Diekstra's (1995) literature review presented some important ideas for professionals in intervening with the bereaved including:

1. Rebuilding of instrumental and adaptation skills in the bereaved may be more useful than a support group.
2. Check for vulnerability in the bereaved such as seeing suicide death as a mode of problem solving.
3. Anger or self-blame can be a sign for problematic and prolonged grieving.
4. Roles in regards to the deceased will affect how the death of the youth impacts the survivor (example: the death of the child is most devastating for a parent and death of a sibling with similarities in circumstances to the deceased increases the sibling's vulnerability).
5. Extent of resources, perhaps especially social resources, affects impact.
6. Attribution styles and coping skills affect impact.
7. Questions regarding who and what are responsible for the death need be explored.
8. Survivors who discovered the body need to be assessed for posttraumatic stress.

Considerable ranges in how people experience bereavement exist. Range is influenced by multiple factors. Besides how the person died, bereavement is affected by the kind of kinship lost, how old the person was when they died, gender, and the culture of the bereaved (Cleiren, 1993; Cleiren et al., 1996; Seguin et al., 1995a, 1995b, cited in Clark & Goldney, 2000).

Empirical evidence exists that support groups can reduce depression and anxiety, as well as helping to resolve many other factors. Renaud (1995) and Farberow (1996) referred to a review of survivor groups led by him in 1992. One group called Survivors after Suicide Program in particular stood out. This group involved an evaluation of survivors and found encouraging positive outcome measures results from the group. Briefly described, the Los Angeles Suicide Prevention program had a closed-end approach, just once per week sessions with mixed kinship in the group. Especially noteworthy is that both a facilitator and a survivor-facilitator led sessions. This latter fact seemed to produce many positives from the group feedback, most finding this helpful. Consumer facilitated group approach has been found useful in mood disorder groups as well. Clark and Goldney (2000) reviewed studies, controlled trials, and offer some points from one study:

1. In one study of a 10-week group, the participants rated the program as beneficial, but the outcome scores on mental health and grief issues did not suggest benefits in this area (Murphy et al., 1998, in Clark & Goldney, 2000).
2. Changes in the study scores showed the most benefit to very distressed mothers; fathers appeared to be “worse off” (p. 481) along with those originally less stressed.
3. Gender differences, role differences and individual grieving styles would need to be considered. What is helpful for one family member may not be for another and family discord may augment over this, complicating a family member’s grief if this is not understood and carefully dealt with. In many ways, grief after

suicide is no different from other sudden deaths in terms of the grief expressions.

4. The primary difference is the problem of a youth intending to die and who may be blamed for this. Family break up can result from this discord.

Another treatment consideration is whether to do family therapy or not. Farberow (1996) recommends that if there are signs of “scapegoat, blaming, isolation, and disturbed behaviour, especially with children” (p. 343), then family therapy together is indicated. A parent of an adolescent suicide victim, experiencing unresolved grieving who enters counselling a few years later, “contrary to expectation of an exploration of past and current concerns regarding the deceased, may regress and in a sense become “an expendable child in conflict with his/her parents” (Samy, 1995, p. 40). Ambivalence towards the child may have influenced the child to feel psychologically abandoned, but the ambivalence with the death of the child remains unresolved. His review of literature leads to a discussion that “messages of hatred, incestuous activity or dynamics, and death fantasies toward the child are common manifestations of repressed parental ambivalence” (p. 42). Family violence is a common factor in the background of adolescent suicide in Samy’s review of the literature.

Although in general, bereavement from a suicide does not differ from other bereavements, intensity may be greater, and there are some differences noted by Farberow (1996). These consist of:

1. the voluntary nature of suicide (“the fact that the decedent chose to die, to leave behind all loved ones, to sever irreparably all ties with family and friends, to deliver an unanswerable message, and to deprive the survivors of any

opportunity to help or to change his mind, make the fact of suicide very hard to reconcile”) (p. 338);

2. reactions that survivors are often left with (guilt, wondering why, stigma, now seeing suicide as an option for problem solving, difficulties in relationship trust, feeling abandoned, and repressed, unconscious or unrepressed anger or social pressure not to be angry at a dead person); and
3. Hauser (1987) in Farberow (1996) point out that unconscious anger may lead to “scapegoating”, blaming, and distancing that can create terrible rifts in families.

Dunne (1987) discussed in Farberow (1996) indicates some symptoms, similar to post-traumatic stress in children, may be found in survivors. An abbreviation of this list of symptoms is:

1. various cognitive-perceptual problems may occur (perceptual difficulties about what actually took place, overgeneralizations, losses of memory details, confusion over event sequences and other distortions);
2. children may sense they will die young or think they will not live beyond a particular period of time;
3. developmental regression may take place;
4. posttraumatic acting out of events, nightmares, dreams regarding event;
5. suicidal ideation/fantasy and possible contagion (preoccupation with death);
6. flashbacks; and
7. taking on roles left by the deceased (example: a parent suicides and a child assumes parent’s responsibilities (p. 339-40).

i.8.1 Impact on a Helping Professional/Caregiver

In these roles, guilt and self-blame can be extra powerful issues (Tanney, 1995). After a suicide, helping professionals and caregivers may be reluctant to work with or be close to someone with suicidal ideation. Tanney states there is an “experience of injury to both personal and professional beliefs about self” (p. 109), while normal responses of grieving are present also. Institutions or agency reviews of the suicide are usually for that agency and not particularly helpful to the caregiver or professional helper (Tanney, 1995). When encountering other individuals at risk a therapist may be at risk of employing a number of defensive mechanisms such as:

1. indifference, boredom, or inattentiveness;
2. projection;
3. reaction formation (i.e., behaviour may be seen in such things as hasty decisions regarding hospitalization; and
4. suppression or denial (negating suicidal potential in the at risk person) (p. 116).

Caregivers may need professional help to integrate their experience, may need supervision around working with other at risk people, and may be advised to limit the number of at risk people working with at one time (Tanney, 1995).

Jacobs and Klein (1993) refer to Maltsberger (1992) regarding what has been found helpful to professionals when a patient commits suicide. What Maltsberger suggests is:

1. doing a psychological autopsy (psychological autopsies may be useful legally as well). Litman (1965), referred to in Jacobs & Klein (1993), found reviewing the

case and presenting it to a colleague as a way for a therapist to work through the pain); and

2. holding support groups, professional meetings including meetings with experienced supervisors.

Caregivers could benefit from similar processes. Child protection agencies should have plans for foster parents who experience these situations, as well as safety plans for at risk youth. The plan would involve a number of helpers, taking the full burden of providing safety from one or two people.

i.8.1.1 Organization of Workshops

The workshops will cover precipitators, triggers, warning signs, vulnerabilities, and brief risk assessment of relevant contributing factors to suicidal behaviours, incidence, vulnerabilities, and nature of suicide. What to do and not to do, and suicide practices around confidentiality and resources will be covered. Each workshop will be adapted to the gatekeeper groups of caregivers, secondary school teachers and graduate students of counselling.

Facilitators should note that the vulnerabilities category includes:

1. family history;
2. relationship status and issues;
3. sexual preference;
4. psychological illness and therapy;
5. physical illness or disability;
6. history of criminal behaviour;
7. history of violence;

8. evidence of being the victim of sexual and/or physical abuse;
9. perpetrator of sexual and/or physical abuse;
10. substance abuse history, substances present at death;
11. suicide or natural death of someone close to the victim;
12. cognitive rigidity and deficient coping abilities.

The categorical nature of suicide includes evidence of suicidal ideation. Examples of evidence may include if the victim told someone of the intention, the presence of suicidal notes and their nature, the method of suicide, whom the victim was found by, and if there was a suicide pact or dual suicide. Anything that did not fit into these categories but appeared of importance is referred to as part of the literature review and general discussion.

CHAPTER 1: WORKSHOP FOR CAREGIVERS

The primary purpose of the caregiver workshop is to educate foster parents, but it can also include parents, grandparents, aunts, and uncles, or another caregiver who provides support for the youth.

1.1 Learning Objectives

The learning objectives are to:

1. increase caregivers' awareness of the background of those who make suicide attempts or complete suicide;
2. increase caregivers' knowledge of warning signs for youth;
3. increase caregivers' ability to assess risk;
4. increase caregivers' knowledge of resources and access to them;
5. make clear the responsibility of the caregiver and foster parent obligations; and
6. explore beliefs and values that may affect caregivers' ability to enact suicide prevention skills.

Generally, the objective targets giving the caregiver a better understanding of the topic, helping the caregiver to understand their own viewpoints and the helpfulness or unhelpfulness of those views, and tools and resources to best access appropriate help for the young person.

1.2 Presenter Preparation

To prepare for the workshop, the presenter should complete the following:

1. Read all preceding chapters on youth suicide, not only the ones referring to caregivers.

2. Review agenda in terms of time allotted and audience. If possible, offer caregivers an additional day to discuss, review and express feelings. Emotional processing may be needed.
3. Research the history of suicide for caregivers attending. Sensitivity to participants is vital. Sometimes people who have experienced a suicide attempt or completion and have processed this can have something helpful to share and be willing to do this.
4. Prepare sufficient handouts for the participants and overhead transparent sheets. Power point presentations are helpful for a professional presentation. Save presentation on CD-ROMS or flash drives and upload presentation prior to the workshop. (This saves time and keeps transitions smooth.) Power point is not necessary for small group workshops, but is helpful. If handouts are prepared in a thoughtful way such as having a booklet prepared for the workshop presentation, points can be followed either on the projection screen or in their handouts in the booklet. A nicely prepared booklet of information and local resources would rival the ASIST handbook given to workshop participants in a simpler format.
5. Preview short videos that fit with your audience ethno-culturally and role wise as much as possible. If purchasing a video for this purpose, know that many companies allow previewing and it is unwise to purchase from those that do not. Short videos that offer information or scenarios to use in discussion are best, may increase audience assimilation of information and provide a break from your voice for the audience.

1.3 Materials

1. Flip chart, paper, markers, extra pens, paper for those unprepared for the workshop. It should be possible for participants to avoid taking notes if your handouts and booklet form is well ordered and a good reminder of the workshop, however some people like to take notes as part of absorbing the information.
2. Overhead projector and overheads of handouts. Or, for audio-visual and computer set: projection screen, white board, overhead projector, TV/VHS player, LCD projector, Macintosh Powerbook with internal CD-ROM drive and Microsoft Office Suite Pro including PowerPoint, set of speakers. Video/DVD may be needed for the video you plan to show.
3. Handouts in booklet format:
 - a. Caregivers' Workshop Agenda, Appendix A.
 - b. Confidentiality Contract, Appendix B.
 - c. Youth Suicide Awareness Quiz, Appendix C.
 - d. Warning Signs, Triggers & Vulnerabilities, Appendix D.
 - e. Myths, Appendix E.
 - f. What to Do and What Not to Do, Appendix F.
 - g. Ask Model, Appendix G.
 - h. Suicide Case Studies, Appendix H.
 - i. Blank Local Suicide Resources, Appendix I.
 - j. Workshop Evaluation, Appendix J.
4. Some "lighten up" exercise or items (e.g., life savers candy with handouts).

5. DVD or video.
6. Snacks and beverages for the participants for arrival and 2 breaks.

The handouts become useful reference guides for future difficulties and become a tangible resource in the event of encountering a youth showing signs of risk.

1.4 Procedures

The purpose of the introduction is to inform the audience ethically of the expertise of the presenter in order to help participants understand reasons for their workshop involvement and to provide an environment in which participants feel able to engage safely in the workshop processes and to ensure participants' legitimate concerns are addressed. At the same time, consideration must be given to the fact these are adult learners. Adult learners appreciate an exchange of expertise and this assists the learning process. The older participants are, the greater the probability they have experiences regarding suicide, making the workshop real and relevant to them. Engaging adult learners may depend upon honouring their knowledge and experience-their expertise. This may be especially true for Aboriginal groups. These experiences with suicide have affected their lives and their emotional presentation and must be acknowledged, respected and validated. Know their experience in advance if possible. Caution and sensitivity are needed. Especially if presenting to Aboriginal caregivers a holistic approach with images used to explain helps. Medicine Wheel explanations are always useful, but thinking of other images to help explain will quicken the understanding of a sad topic. For example, a tree could be drawn showing the roots below the ground. The roots could represent the beginnings of the child's life, which may become vulnerable to suicide. At the roots might be genetic predispositions to mental illness or other physical illnesses, fetal alcohol

effect, neurological brain defects and all the other items giving the child a poor start in life. The trunk could grow twisted and weak emotionally, physically mentally or spiritually because of this and a poor environment (family problems, unhealthy school environment) growing into where there are few trees nearby to offer positive encouragement and support. The branches would be off shoots of all this including low self esteem, depression, substance use, relationship failures, school failures and these things could be divided onto branches representing mental, spiritual, physical and emotional aspects of an individual out of balance and vulnerable.

The first part of this presentation offers a brainstorm activity to cover values related to perspectives on suicide, cultural views, personal attitudes (judgment and prejudice) towards suicide and emotional reactions that may interfere with the target trainees intervening successfully.

The second section of this presentation involves group brainstorming to stimulate active learning of warning signs and triggers they are aware of from their own experiences. This brainstorming activity encourages and respects the expertise of the adult learners. Facilitators can add items participants have not thought about and give out the warning signs and triggers handout at the conclusion of the presentation. The discussion should focus on what kinds of warning signs, triggers, and vulnerability factors a caregiver most likely will discover in the child's home environment. Warning signs are defined as observable behaviours compared and contrasted with vulnerability factors, which consist of information about the youth's background. Triggers are defined as events that prompt an already vulnerable individual to make a suicide attempt. Some questions to stimulate discussion are:

1. What kinds of warning signs, vulnerability factors, and triggers are caregivers likely to become aware of in the home setting?
2. If a parent or foster parent may only become aware of a small portion of the warning signs, how do you think a caregiver ought to treat any warning signs?
3. What can a caregiver do when he/she sees a warning sign?

The discussion continues after the break and the purpose is to identify caregiver responsibilities and identify barriers for caregivers assessing for suicide. Situational examples include but are not limited to other children in the family being present, finding time to have a serious discussion with the youth, and the caregivers' own values and feelings or experience with suicide. Caregivers are the first line of help to identify a suicidal youth and help him/her to connect to the needed resources. Caregivers should review the Ministry of Children and Families Development's protocol regarding reporting suicidal youth to the social worker. Caregivers also need to know what to do when other supports are not readily available. Some of these alternatives normally suggested include family monitoring, removing methods of suicide, not leaving the individual alone, and engaging friends and family to assist in supporting the suicidal youth. For safety reasons, if there is any suspicion of suicidal ideation caregivers are recommended to seek assessment at a hospital that has psychiatric resources, where medication may be considered and further assessment done. A child psychologist appointment may be arranged through the Ministry of Children and Families Development's social workers. The youth's doctor needs to be contacted and consulted.

The purpose of the second half of the presentation, after the lunch break, is to introduce a basic assessment method, through facilitator demonstration and then give

opportunities to practice this assessment model. The ending of the group focuses on closure and workshop evaluation. Part of the closure needs to include filling in any identified information gaps for participants. When these are identified, facilitators should include this information in subsequent workshops.

Participants should be encouraged to question or express concerns pertinent to their experiences. A scaling question may be utilized to measure how confident they feel they could be to help an at risk youth, using the workshop's information.

CHAPTER 2: WORKSHOP FOR SECONDARY SCHOOL TEACHERS

Secondary school teachers “gate keep” in schools as the first line of contact with youth. The primary objective of this workshop for secondary school teachers consists of providing sufficient knowledge to enable teachers to understand and intervene with suicidal youth. This workshop would also be of benefit for school administrators, teaching assistants, and school counsellors. In addition to this basic intervention, a discussion should be held about prevention tactics in the school such as incorporating problem solving and coping skills into programs and developing peer based programs if this has not been done in the school already. Many schools over time have developed peer counsellors, peer tutors and have older youth teaching in the classroom. Others have involved youth in mentorship programs. Many schools have a Native liaison worker. It would be helpful to elicit from the teachers what has been done in the school they teach in and how they may be part of the schools suicide intervention strategies. Workshops need to be adapted to individual school situations.

2.1 Learning Objectives

Learning objectives building the capacity of teachers to accomplish the workshop’s primary objective include:

1. Increase knowledge of warning signs for youth.
2. Increase teachers’ ability to assess and refer at risk youth.
3. Build skills to increase confidence to act as a gatekeeper.
4. Emphasize teachers’ responsibility as a gatekeeper.

5. Encourage teachers to explore their beliefs and values around their role in suicide prevention.

2.2 Presenter Preparation

In preparation, facilitators should:

1. read all preceding chapters on youth suicide, not only the ones referring to teachers;
2. review agenda in terms of time allotted and audience; arrange a joint meeting with school personnel (principal, vice-principals, and school counsellors) to review expectations, registration, school suicide protocol, and history of suicide attempts in the local school or neighbourhood. Give Resource Fill-In Handout to the school counsellor to input local numbers; and
3. prepare enough booklet handouts for the participants and overhead sheets, or PowerPoint presentation materials and equipment readiness.

2.3 Materials

Basic materials the facilitator would use are:

1. flip chart, paper, markers; extra pens, paper for those unprepared for workshop;
2. overhead projector and overheads of handouts; power point equipment, DVD/video
3. handouts:
 - a. Caregivers Workshop Agenda, Appendix A;
 - b. Confidentiality Contract, Appendix B;
 - c. Youth Suicide Awareness Quiz, Appendix C;
 - d. Warning Signs, Triggers & Vulnerabilities, Appendix D;

- e. Myths, Appendix E;
 - f. What to Do and What Not to Do, Appendix F;
 - g. Ask Model, Appendix G;
 - h. Suicide Case Studies, Appendix H;
 - i. Blank Local Suicide Resources, Appendix I;
 - j. Workshop Evaluation, Appendix J;
 - k. Secondary School Teachers Suicide Awareness, Appendix K;
4. some “lighten up” exercise or items (e.g., life savers candy with handouts);
 5. brief DVD/video; and
 6. snacks and beverages arranged for the participants’ arrival and for two breaks.

Facilitators can use other resources and materials fitting the situation.

2.4 Procedures

2.4.1 Introduction

The introduction establishes the expertise and background of the presenter, such as education, research involvement in the topic, and experience regarding the topic. Other objectives encompass helping participants understand the reasons for their workshop involvement, and providing an environment in which they feel able to participate safely. Some teachers may feel uncomfortable with the topic and may prefer a counsellor “deal with it”. Be sensitive to this common discomfort. Some basic steps aiding accomplishing these objectives are for the facilitator to:

1. ensure their concerns are addressed. Confidentiality and respectful communication: rules to maintain participants’ safety today;
2. on the flip chart, list questions participants would like answered; and

3. explain that they can fill in the answers to the quiz as presented in the workshop.

Hand out the Confidentiality Contract and Youth Suicide Awareness Quiz.

The facilitator should lead a discussion on values related to perspectives on suicide, cultural views, personal attitudes (judgment & prejudice) towards suicide and emotional reactions. Make clear that these factors and past experience can affect effectiveness in intervening and outcomes in making decisions regarding “at risk” youth.

2.4.2 Warning Signs, Triggers, Vulnerability Factors and Myths

This section promotes active thinking of the kinds of warning signs and triggers secondary school teachers notice. During the brainstorm group activity have a participant write the responses on the flip chart. Add items they have not thought of and give out handout Warning Signs and Triggers. In the classroom, warning signs are observable behaviours contrasted with vulnerability factors, which are the youth’s background information. Triggers are events that influenced an already vulnerable individual to make a suicide attempt. Triggers are events that may leave survivors with blame and guilt.

Some questions for discussion are “If a teacher is only going to become aware of a small portion of the warning signs, how do you think a teacher ought to treat any warning signs?” “What can a teacher do when he/she sees a warning sign?” One example would be checking on the youth’s background information.

After warning signs and triggers brainstorm the kinds of vulnerability factors a teacher is most likely going to find, given the environment of the classroom setting. The handout to be given out is Vulnerabilities Factors and Myths.

2.5 Teachers as Gatekeepers

The goal is to identify teachers' responsibilities and barriers realistically as gatekeepers. The facilitator needs to discuss the teachers' knowledge of the local school suicide protocols, having relevant sections of it available for review.

What gets in the way for teachers in assessing suicide risk? Ask a participant to note answers on the flip chart as participants answer this question. Some examples:

1. Other classroom children present.
2. Time in class setting.
3. Internal (own values).
4. Historical (an individual teacher's own experience with suicide).
5. Teachers do not have expertise training in this area.
6. Cannot connect emotionally to someone wanting to die or just do not understand.

Teachers should know what to do when other supports are not readily available and this may be brainstormed. Some examples would be family monitoring, removing methods of suicide, not leave the child/youth alone, and engaging friends and family to assist in supporting the child/youth. Handing out the Local Resources Handout to fill in local numbers will save teachers valuable time when a situation arises. Note that occasionally a facilitator may encounter a group that just cannot understand how anyone could commit suicide, and those people just cannot connect to the act emotionally. If this is encountered, please ask permission of the participants to do a powerful emotional exercise to aid understanding and make it clear that no one need participate. One exercise that works is to have those experiencing this difficulty write on 3 tiny separate

pieces of paper the first, second and third most important thing to them, that would be devastating loss. With participants having shut eyes, have them crumple and throw into the center of the room the third most important paper and let the participants feel this loss, then the second and then the first most important are thrown in. Let the participants feel each loss and then discuss it. They will have a better sense of what a suicidal person may feel. Then tell them they can take everything back off the floor and feel the joy of retrieving what they felt lost. This is a good exercise but very powerful to help people who need to get in touch with their feelings to understand and have empathy for those with suicidal thoughts.

2.5.1 Intervention Model

The purpose of this module is to introduce basic risk assessment/intervention through facilitator demonstration and then providing participants with opportunities to practice gatekeeper brief assessment/intervention. A resource you may like to refer to for brief assessment may be found in a chart adapted from the Regional MCFD Risk Assessment form found in *Identifying and Assessing Suicide Risk*, table 5 – Risk Assessment Matrix. This chart lists primary criteria for assessing risk on one side of the table and across it describes factors indicating if this factor needs to be considered as mild, moderate or high, imminent risk. The factors listed are ideation, immediacy of plans, method, mood, level of emotional distress, protective factors, previous attempts, reasons to live or hope factor, symptoms of depression and other risk factors are clustered (family history of suicidal behaviour, suicidal friends, recent loss, substance misuse, school problems, criminality, mental health, impulsivity, negative family attitudes that do not take suicidality seriously) (Advisory Group, 2005). Probably the teachers could

brainstorm a close imitation of the chart, as they are relatively simple guidance markers. For example, ideation that is mild is described as: “periodic intense thoughts of death or not wanting to live that last a short while” while high, imminent ideation level is described as: “thoughts of death or wanting to die are very intense and seen as impossible to get rid of” (Advisory Group, 2005). Appendix D provides a similar chart. These factors are covered through the ASK model, but it is another way of explaining brief gatekeeper assessment. The facilitator hands out the ASK model format and explains as well as demonstrates with a participant. The participants practice first a written activity and then in a group role-playing activity with each other. The facilitator reviews what to do and what not to do.

Adapting to the classroom situation means the situations used should be realistic for the classroom setting. List classroom situations that are barriers to intervening that teachers brainstorm during the workshop and elicit their suggestions about what they could do to overcome these barriers or work around them. Simple things may be suggested such as dismissing a class first before speaking to the student. Use the flip chart again to brainstorm good role-play situations. Hand out the suicide practice case studies. Use these examples to role-play and identifying warning signs, risk factors, protective factors, and vulnerabilities. Once brief assessment is done, the teachers need to know various professionals and the guardians/parents need to be involved. Take the student to emergency, consult the family doctor, and facilitate a mental health appointment being made. The student should be connected with the school counsellor, who can be helpful in talking with parents, mental health, psychiatrist, family doctor and helping with safety planning. Safety plans are planned with the student and the parents,

and the student needs to be monitored for suicidality by all involved over the long term. Safety contracts can be part of the safety plan with a list of people the student identifies as their supports listed to contact whenever there are suicidal thoughts. Including a statement in the student's own words that generally says something about not making an attempt when feeling suicidal but instead contacting people on my phone list to talk with and informing my counsellor, may be the central portion of the contract. It should be signed, dated and witnessed. It can be a brief simple contract or whatever is felt relevant may be included. A list of what the student agrees to do can be in this contract. Higher risk individuals may be more resistant to doing a safety no suicide contract or safety plan. Safety plans can do much to keep even high risk clients safely treated on an outpatient basis when caregivers are prepared to provide around the clock supervision (Advisory Group, 2005). School protocol previewed by the facilitator will allow incorporation of it into the training. Protocol is not identical in all school districts or in other helping agencies.

2.5.2 Closing

The facilitator must provide closure and have participants fill out a workshop feedback evaluation form. The facilitator asks participants if they have more questions, or any concerns that have not been dealt with for them. It is useful for the facilitator to inquire if teachers feel confident that they could be helpful to an at risk child using the workshop's information. Issues that arise at this point should be added to subsequent workshops. Follow-up workshop should be offered within a six-month time frame in order to evaluate the outcomes of this workshop, offer guidance for any issues that arise after the initial workshop and to review what was previously learned. Evaluation forms

can now be provided to hand in for feedback on the workshop. A good practice would be to arrange a follow-up workshop within the following six months. This can provide review much like first Aid training regularly redone to remain certified. It also offers opportunity to evaluate the workshop done and to discuss anything that occurred after the workshop took place and how this was handled.

CHAPTER 3: WORKSHOP FOR GRADUATE COUNSELLING STUDENTS

3.1 Learning Objectives

The learning objectives encompass the following:

1. Increase knowledge of counsellor/graduate student responsibility (confidentiality and safety issues/ethics), suicide warning signs, vulnerability factors, and triggers for youth.
2. Increase counsellor/graduate student's skill and confidence to interview, assess, and refer at risk youth.
3. Encourage counsellors/graduate students to explore their beliefs and values around their role in suicide prevention.
4. Encourage counsellors and graduate counselling students to develop support and self-care systems for themselves.
5. Develop counsellor awareness of what to expect during the aftermath of a suicide, particularly grief, and what is useful for others and themselves, who have differing roles regarding the deceased.

3.2 Presenter Preparation

Presenters should:

1. read all preceding chapters on youth suicide, not only the ones referring to students;
2. be aware of changing interview styles to suit individual clients (e.g., borderline personality, an individual experiencing psychosis, and so on). do additional

reading about the intervention needs for various clients, some of which is suggested in the introductory section;

3. review agenda in terms of time allotted and audience;
4. meet with those requesting the workshop to review expectations;
5. prepare enough handouts for the participants and overhead sheets;

3.3 Materials

Preparatory materials suggested are:

1. flip chart, flip chart paper, markers, extra pens, lined paper;
2. overhead projector and overheads of handouts; Power point presentation equipment, audio video equipment
3. handouts:
 - a. Caregivers Workshop Agenda, Appendix A;
 - b. Confidentiality Contract, Appendix B;
 - c. Youth Suicide Awareness Quiz, Appendix C;
 - d. Warning Signs, Triggers & Vulnerabilities, Appendix D;
 - e. Myths, Appendix E;
 - f. What to Do and What Not to Do, Appendix F;
 - g. Ask Model, Appendix G;
 - h. Suicide Case Studies, Appendix H;
 - i. Blank Local Suicide Resources, Appendix I;
 - j. Workshop Evaluation, Appendix J;
 - k. Sample Agency Confidentiality Agreement, Appendix L;
 - l. Graduate Student Interventions Handout, Appendix M;

4. some “lighten up” exercise or items e.g. giving out Life Savers candies with handouts;
5. snacks and beverages for the arriving participants and 2 break times.
6. DVD/video.

3.4 Presentation

3.4.1 Introduction

The purpose of the introduction is to ethically inform the audience of the expertise of the presenter, in order to help participants understand reasons for their workshop involvement, and to provide an environment in which participants feel able to safely engage in the workshop processes and to ensure participants’ legitimate concerns are addressed.

1. Clarify the professional and experiential background of the presenter.
2. Confidentiality and respectful communication rules to maintain participants’ safety today.
3. On the flip chart, list questions participants would like answered.
4. Explain that they can fill in the answers to the quiz as presented in the workshop.
5. Give out the Handout of the Confidentiality Contract and Youth Suicide Awareness Quiz. Lead discussion on values related to perspectives on suicide, cultural views, personal attitudes (judgment and prejudice) towards suicide and emotional reactions.

Lead the group in a brainstorming of warning signs and triggers. Have a participant write responses on the flip chart. Add items they have not thought of and give out handout.

Follow this with brainstorming vulnerabilities and myths. Discuss briefly any questions around these factors. Hand out Warning Signs and Triggers, Vulnerability Factors and Myths.

Use questions to stimulate discussion (example: “Will a suicidal client tell you they are thinking about suicide?” Discuss why or why not.) Note topics for discussion may vary considerably dependent on the level of expertise in the group and expectations for the workshop. If these discussions are done in breakout groups, the information they produce may be taken away and screened, added to, and feedback informational handouts may be sent back to the class.

Make the discussion relevant to graduate students and adult learners by asking useful questions (example: “What barriers do you think a counsellor might encounter in interviewing a client to assess a client’s risk?”) Ask them to consider gender differences, adolescent versus adult differences, motivational differences, ethno-cultural differences, situational and environmental factors, physical condition, sexual preferences, and psychological condition.

Other questions to consider are: “What could you do to intervene with a client considering suicide?” “What kinds of directions could you give to others to protect the suicidal person from themselves?” (Some examples are family monitoring, teacher monitoring, removing methods, not leaving individual alone, friends involved and monitoring.) “How might it affect your ability to work with suicidal clients, when one of your client’s dies from suicide?” “How do you prepare yourself for this?” “What should you realistically be responsible for as a counsellor?” Hand out sample Agency Confidentiality Agreement.

3.4.2 Gatekeeper Assessment Model

The facilitator explains and demonstrates the ASK and if trained in ASIST (Applied Suicide Intervention Skills Training) may integrate these assessment/intervention tools with a participant, using whenever possible counselling techniques such as those suggested by Shea (1999). Two demonstrations should be done. First, show the ASK and ASIST model in transparent order. The second demonstration should be shown as clearly tailored to a specific client group (e.g., adolescent, borderline personality, person experiencing psychosis) and should be set up to be in a specific setting (e.g., hospital emergency, counsellor's office, school). Although covering necessary information there would be an observably different characteristic to interview flow.

Give out the Handout "What to do and What Not to Do".

Using the Suicide Case Studies, participants will practice the essence of ASK and ASIST models with each other and an observer in the group (a triad with roles of counsellor, suicidal person, observer). They will then role play a second and a third time, changing roles and will try out the interviewing of a specific client group of their choosing or a client group that the facilitator secretly gives to the "client".

Observers will observe: what warning signs and vulnerabilities were heard, what aspects of the ASK and ASIST model they heard covered, what counselling skills appeared useful, what intervention methods were put in place by the counsellor, what adaptations were made to the individual client and the situation. They will be told if they are interested in the ASIST model they should be trained specifically in that by an ASIST facilitator. However, the demonstration given distills the important elements of the

models and is given as a practical introduction to allow them to see the similar practical elements necessary in basic suicide intervention.

Graduate students will eventually take assessment and treatment planning much farther than a gatekeeper role. Inform them hospitalization is a best practice if the individual is psychotic, suicide threats are escalating and the person is at risk to self-harm or harm others and also when the client needs close medication monitoring on psychosis drugs particularly with a history of overdose (Ashworth, 2001). Counselling students need to know that assessment by a psychiatrist is recommended both for medication considerations and a mental status exam which is administered to determine underlying psychopathologies (with Axis I or II diagnosis) for treatment planning. In the case of Axis I clusters (depression, hopelessness, loneliness) brief problem solving interventions were found to be a best practice (Rudd, 1999 in Ashworth, 2001). Currently, Dialectical behavioural Therapy (DBT) is recommended for personality disorders as randomized outcome studies indicate DBT compared to regular treatment appears encouraging (Ashworth, 2001).

3.4.3 Closure and Evaluation

Ask participants if they have more questions or any concerns not dealt with and refer to a list of questions (save on the flip chart from the workshop's introduction) they requested answered. Ask if they feel confident, they could be helpful to an at-risk youth using the workshop's information. Give out evaluation forms to hand in for feedback on the workshop. If possible arrange to do a follow up workshop within six months time to review and discuss what was helpful in the interim and what more they may require.

SUMMARY

The intent of this project is to provide a framework of gatekeeper youth suicide awareness, intervention and postvention workshops to three targeted groups: caregivers, secondary school teachers, and graduate counselling students, and to increase understanding of the need for continued education of other groups connected with youth. Other target groups should be provided with workshops like these with subtle adjustments made. Especially recommended is a peer gatekeeper workshop as youth tend to access peers for help more often than they seek adult helpers as youth are inclined to talk to other youth for help.

The workshops are brief daylong events, easily presented to these target groups. This is for expediency, but a two-day workshop is usually better to help deal with the backgrounds of those involved in the workshop. It may be especially important that graduate students submit to a longer process as they are the ones who are to help others on an ongoing professional basis and must not carry issues that interfere with this work. While they do not provide extensive training, they do provide a basic understanding and a means for each gatekeeper group to take reasonable actions to help suicidal at-risk youth.

Much more work needs to be done to further what assistance every person who contacts a suicidal youth can do to help. More work needs to be done for gatekeepers to provide helpful cultural contexts, using the basis of the culture's beliefs and wisdom, to support coping skills and faith that there is meaning and hope for everyone. Within the context of their situational roles, it is hoped newer research and assessment tools may be used with these workshops in future presentations. Mostly, it is hoped that others will feel free to make use of these workshops to help gatekeepers help youth.

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APPENDICES

APPENDIX A: WORKSHOP AGENDAS

A.1 Care Givers Agenda

Table A.1

Time Lines	Activity	Hand Outs
10 Minutes	Introduction: <ul style="list-style-type: none"> • Background of presenter • Confidentiality and respectful communication • Participant questions • Youth Suicide Quiz 	Confidentiality Contract Youth Suicide Awareness Quiz
15 Minutes	Group Activity: <ul style="list-style-type: none"> • Values 	
15 Minutes	Group Activity: <ul style="list-style-type: none"> • Warning Signs & Trigger 	Warning Signs and Triggers
15 Minutes	Group Activity: <ul style="list-style-type: none"> • Brainstorm for vulnerability factors. 	Vulnerability Factors and Myths
35 Minutes	Discussion: <ul style="list-style-type: none"> • Warning Signs in the Home • Possibilities to intervene 	What to Do and What Not to Do
15 Minutes	Break	
90 Minutes	Discussion: <ul style="list-style-type: none"> • Caregiver Barriers to intervening • Local Resources 	Resource Fill-in List
60 Minutes	Lunch	
90 Minutes	Presentation: <ul style="list-style-type: none"> • ASK Group Activity: <ul style="list-style-type: none"> • Practice ASK • Brainstorm and discuss adapting to home situation. 	ASK Model Case Studies
15 Minutes	Break	
60 Minutes	Continued Practice	Youth Suicide
30 Minutes	Closing Discussion: <ul style="list-style-type: none"> • Questions, Concerns Evaluation	Workshop Evaluation

A.2 Agenda for Secondary School Teachers

Table A.2

Time Lines	Activity	Hand Outs
10 Minutes	Introduction	Confidentiality Contract Youth Suicide Awareness Quiz
15 Minutes	Discussion: <ul style="list-style-type: none"> • Values, cultural views, personal attitudes and emotional reactions 	
15 Minutes	Group Activity: <ul style="list-style-type: none"> • Brainstorm Warning Signs and Triggers 	Warning Signs and Triggers
15 Minutes	Group activity: <ul style="list-style-type: none"> • Brainstorm for vulnerability factors 	Vulnerability Factors and Myths
35 minutes	Discussion: <ul style="list-style-type: none"> • Teacher's classroom experiences 	
15 Minutes	Break	
90 Minutes	Presentation: <ul style="list-style-type: none"> • Teachers as Gate Keepers 	Resource Fill-In
60 Minutes	Lunch	
90 Minutes	Presentation: <ul style="list-style-type: none"> • ASK Model Group activity: <ul style="list-style-type: none"> • Practice ASK model Discussion: <ul style="list-style-type: none"> • Adapting to classroom 	What to Do and Not to Do ASK Model
15 Minutes	Break	
60 Minutes	Continue Role Play	Case Studies
30 Minutes	Closing Discussion: <ul style="list-style-type: none"> • Questions, Concerns Evaluation	Workshop Evaluation

A.3 Agenda for Graduate Students

Table A.3

Time Lines	Activity	Hand Outs
10 Minutes	Introduction	Confidentiality Contract Youth Suicide Awareness Quiz
15 Minutes	Discussion: <ul style="list-style-type: none"> • Values, cultural views, personal attitudes and emotional reactions 	Myths
15 Minutes	Group Activity: <ul style="list-style-type: none"> • Brainstorm Warning Signs and Triggers 	
15 Minutes	Group activity: <ul style="list-style-type: none"> • Brainstorm for vulnerability factors 	Warning Signs, Triggers & Vulnerabilities
35 minutes	Discussion: <ul style="list-style-type: none"> • Graduate student counselling experiences 	
15 Minutes	Break	
90 Minutes	Presentation: <ul style="list-style-type: none"> • Special considerations for graduate students 	Resource Fill-In Agency Confidentiality Graduate Student Handout
60 Minutes	Lunch	
90 Minutes	Presentation: <ul style="list-style-type: none"> • ASK Model Group activity: <ul style="list-style-type: none"> • Practice ASK model Discussion: <ul style="list-style-type: none"> • Counsellor considerations in applying ASK 	What to Do and Not to Do ASK Model
15 Minutes	Break	
60 Minutes	Continue Role Play	Case Studies
30 Minutes	Closing Discussion: <ul style="list-style-type: none"> • Questions, Concerns Evaluation	Workshop Evaluation

APPENDIX B: CONFIDENTIALITY CONTRACT

Suicide Prevention Workshop

To be completed at the beginning of the workshop.

By signing below, I confirm my understanding and agreement to the following:

- I understand that if I share personal information in this workshop, the facilitator cannot guarantee that the other participants will keep this information confidential, so I must share to my comfort level or consider not giving personal information.
- I agree to keep others personal information safe by not sharing personal information about others outside of this workshop.
- I understand that this agreement is made to help everyone feel safe discussing this sensitive topic and agree this is important.

Print Name: _____

Signature: _____

Date: _____

APPENDIX C: YOUTH SUICIDE AWARENESS QUIZ

To be completed during the workshop.

1. What are five vulnerability/risk factors for youth suicide?
2. What are five warning signs?
3. What are two common triggers?
4. What are two myths about suicide?
5. What is the ASK method? Explain.
6. What is the CASE method?
7. What resources can be accessed to help suicidal youth in your area?
8. How would you help yourself if a young person you knew or who was in your care suicided?
9. Do you feel confident you could intervene to help a suicidal youth after learning information in this workshop? Explain what was helpful to you.

APPENDIX D: WARNINGS SIGNS, TRIGGERS & VULNERABILITIES

D.1 Warning Signs

Table D.1

CHANGES IN BEHAVIOR

Normally, active people may become withdrawn; cautious individuals may start taking unusual risks. Any significant change may be cause for special concern.

PROBLEMS IN SCHOOL

A dramatic drop in grades, falling asleep in class, emotional outburst or other behaviour that's uncharacteristic of a particular student may be cause for concern.

THEMES OF DEATH

A desire to end one's life may show up in the person's artwork, poetry, essays, listening to heavy metal music, or preoccupation with an occult group or activity.

A PREVIOUS SUICIDE ATTEMPT

A significant number of young people who commit suicide have attempted suicide before.

SUBSTANCE ABUSE

Alcohol and other drug abuse appear to be significantly linked to increased risk-taking and suicide attempts among young people.

ISOLATION

Isolation is indicated by the person withdrawing, self-deprecation, feelings of helplessness/hopelessness or depression and no longer engaging in daily activities.

DAILY FUNCTIONING

Youth's daily routines are impaired, self-care decline.

DISORIENTATION

The youth is not correctly oriented to time and place.

SIGNS OF DEPRESSION

These may include changes in eating and sleeping habits, anxiety, restlessness, fatigue, feelings of hopelessness and guilt, and loss of interest in usual activities. Alcohol and drug abuse are common ways for people to medicate themselves from depressive feelings.

VERBAL STATEMENTS

Comments such as "you'd be better off without me" or "I wish I were dead" should always be taken seriously.

GIVING AWAY POSSESSIONS

Someone who has decided to commit suicide may give away personal possessions: skateboard, favourite articles of clothing, etc.

POOR COPING SKILLS

The inability to see many options for solving problems and lacking confidence in a brighter future makes young people vulnerable.

OTHER

These may include physical complaints, frequent accidents, hyperactivity, aggressiveness, sexual promiscuity, or prolonged grief after a loss.

DISORGANIZATION

The youth's thinking and reasoning are clouded and confused.

HOSTILITY

The youth may display a high level of hostility that is different from their usual behaviour.

D.2 Vulnerability or Risk Factors (not predictive)

Shea (1999) presents two acronyms to facilitate recall of risk factors. The first one was published by Patterson, Dohn, Bird, & Patterson in 1983 and referred to as “The Sad Persons Scale”. Here it is, beside Shea’s (1999) addition to it: “The No Hope Scale”.

<u>S</u> ex	<u>N</u> o framework for meaning
<u>A</u> ge	<u>O</u> vert change to clinical condition
<u>D</u> epression	<u>H</u> ostile interpersonal environment
<u>P</u> revious Attempt	<u>O</u> t of hospital recently
<u>E</u> thanol Abuse	<u>P</u> redisposing personality factors
<u>R</u> ational thought loss	<u>E</u> xcuses for dying to help others
<u>S</u> ocial supports lacking	
<u>O</u> rganized plan	
<u>N</u> o spouse	
<u>S</u> ickness	

Table D.2

Risk Factors			
	High	Medium	Low
Method	Well thought out	Some plans	Unclear
Time	Immediately	Within a few hours	In the future
Location	At location	May be at place	Unplanned
Details	Well thought out	Some specifics	Vague
Availability of Means	In hand/has used	Have close by	Will have to get
Possibility of Rescue	Unlikely	Difficult	Likely
Impulsivity	High	Moderate	Low
Final Arrangements	Will, note, favourite items given away	Few	None
Previous Suicide Attempts	Multiple attempts of high lethality	One or more moderate lethality	None/low lethality
Alcohol/Drug Use	Often – Abuse pattern of binges	Frequently to excess	None/infrequent
Overall Depression	Current	In past	No history

Table D.3

Triggers & Vulnerabilities			
	Severe	Moderate	Mild
Anxiety	High (panic state)	Moderate	Mild
Support Network	One/none available	Few available	Several available
Attitude Toward Help	Refuses help	Hesitant	Accepts help
Current Resources	Few or none	Some	Several
Alcohol/Drug Use Today	Yes	Yes	No
Recent Losses	Just realized loss	Within recent months	None or not recent
Lifestyle	Chaotic	Disintegrating	Moderately unstable
Attitude Toward Suicide	Welcome, positive	Ambivalent	Negative, Fearful
Conception of Death	Not an end to consciousness – Fantasies of being invisible at funeral, Etc.	Unclear	An end to consciousness
Physical Health	Chronic health problems	A few problems	Good health
Hallucinations Advocating self harm	Present, persistent and irresistible	Vague or present but no need to obey	Absent
Anniversary of Loss	Within a week	Near	Absent
Suicide in Family	Present in parent of same sex. One or more suicides by significant others	Present. Self destructive tendencies in role models	Absent
Recently highly publicized suicide or suicide in peer group	Present in friend or person identified with	Present	Absent
Perfectionism	Current	In past	No history

APPENDIX E: MYTHS

E.1 Examples of Myths (there are many others)

1. It is not true that a person who threatens suicide will not commit suicide.
2. It is not true that talking with a person about suicide will trigger suicide.
3. It is not true that a person who has attempted several times unsuccessfully will never complete suicide. Often many attempts are made prior to suicide.
4. It is not true that a person talking about suicide under the influence of alcohol is not seriously at risk. They are at greater risk.
5. It is not true that suicide cannot be prevented.
6. It is not true that a person will always tell you if they have suicidal intentions. Someone with serious intent may hide this from you to avoid being stopped.
7. It is not true that a person threatens suicide strictly to get attention. Normally a serious problem hides behind serious “attention-getting” behaviour that really does need attention. It is usually a cry for help.

E.2 Dispelling Myths

1. Asking about suicide will not give a client suicidal ideas. (Shea, 1999)
2. Information about suicide is common knowledge. Films, Internet, songs, media and movies all discuss suicide. (Shea, 1999)
3. It is difficult to commit suicide, not easy to do. (Shea, 1999)
4. A client will not necessarily give off hints that they are at risk. Shea (1999) In fact in the period just prior to most suicides, the individual is not likely to have had contact with a helping professional. (Jacobs & Klein, 1993)
5. If a client says answers no to a question regarding having thoughts of killing oneself, it is not enough to ask only once when many risk factors are present. (Shea, 1999)
6. Although a client may have many risk factors and not be currently suicidal, a client who has many risk factors, but denies any thoughts of suicide, could be dangerously hiding information. Clients with psychotic processes may present well during an assessment, when faced with things they may fear such as involuntary hospitalization. Delirium also fluctuates in intensity, so the client could pass a cognitive exam and seem fine. It can be helpful to have information from others who know the individual well. (Shea, 1999)

APPENDIX F: WHAT TO DO AND WHAT NOT TO DO

Do understand that your responsibility is to make a safety net for this person. Do your best to take preventative measures and involve those professionals and family who can help to prevent attempts. Note that Aboriginals on reserve probably have a large family that could help. Also, if they are spiritually involved in Smokehouse season, Smokehouse leaders, cultural workers and Elders may be vital to the safety net. A reputable First Nation Healer may be needed.

Do not impose your values on the person. Do not say things like, “you have everything to live for, you are young, and why would you want to do that?”

Do not judge the person, whatever they may say.

Do encourage hope, by indicating realistically that there may be ways to improve things for the person. Do not make false promises. Make plans together to get some help.

Do not get caught up in the hopeless feelings associated with overwhelming situations and the powerful “catchy” emotions of a feeling hopeless and depressed person.

Do not leave the suicidal person alone, no matter what they say. Be aware that suicidal thinking can come, go, come back and so on. In general, moments of impulsive desire to make an attempt will pass, but the impulsive desire may return with lonely, depressed moments or new negative events that trigger mood changes. Frequently, when a person is actively suicidal, agency protocols indicate taking the person to emergency for evaluation.

Do not keep this serious matter to yourself, no matter what the person says. Do not make promises to keep this to yourself. The person’s doctor needs to know, caregivers need to know and if a social worker is involved, that person needs to know. People who know can assist in keeping the person safe and in helping him.

Do be careful of your words. Be aware that people around the youth need to understand that “reverse psychology” is not advisable. No one should ever challenge the youth to “go ahead and do it”.

Do find out all the details you can. Know that the more you find out about the youth’s suicidal planning, reasoning for wanting to make an attempt, and means to do it, the greater the chance is the youth can be intervened with and the action avoided.

Do talk about it. Talking will not trigger an attempt and can help prevent it. Checking in with the person regularly/frequently to see where their feelings and thoughts around attempting, is helpful in prevention.

Do look for ways to improve any situation that may have triggered the suicidal ideation. For example, if the youth quarrelled with a parent, perhaps some mediation between them would assist. Offers of ongoing counselling for the youth and parent may be advisable. If the youth is using drugs, “detoxification” and/or drug and alcohol counselling may benefit them.

Do see the youth is assessed not just by you, but also by Mental Health, or a psychiatrist.

It is important to discover possible underlying disorders, and taking the youth to emergency may be necessary for immediate evaluation of safety needs.

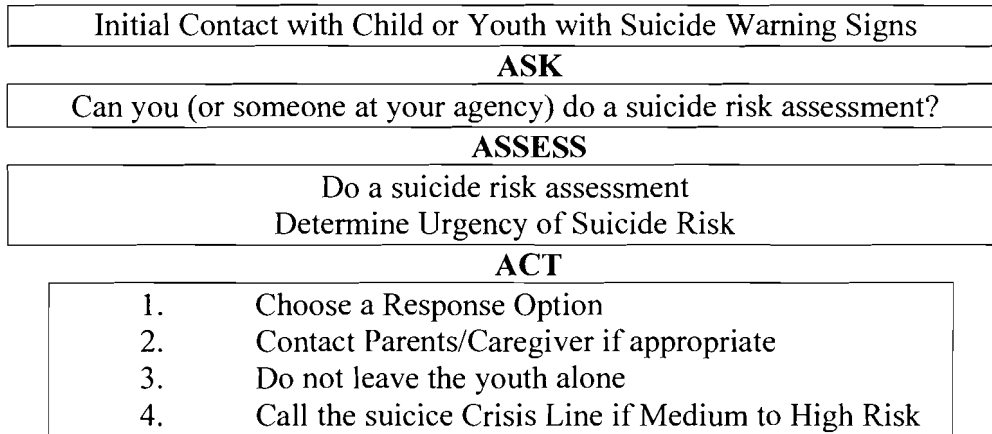
Do have any means of attempting removed from the youth's home and regular environment. This includes medications, alcohol, poisons, rope, guns (not enough to lock them in a cabinet, remove them and other weapons such as knives), and access to car exhaust in an enclosed area. Yes, they may find access to such things elsewhere, but if it is not handy, the urge to attempt may pass without incident. Monitoring by others can help with the problem of other access places.

Table F.1

SUICIDAL YOUTH: HOW TO HELP	SUICIDAL CRISIS: HOW TO HELP
<p>Recognize the Clues to Suicide Signs of hopelessness and helplessness Suicide threats or warnings Changes in behaviour Symptoms of deep depression</p> <p>Trust Your Own Judgement Act on your own beliefs about danger Do not allow others to lead you to ignore signals</p> <p>Tell Others Share your concern with those who can help Do not worry about breaking a confidence</p> <p>Stay with a Suicidal Person Do not leave the youth alone if you believe the danger is immediate Stay with the youth until help arrives or the crisis passes</p> <p>Listen Intelligently Listen and sympathize Assure the youth that there are other alternatives</p> <p>Urge Professional Help Put pressure on to seek help from a professional Encourage continuing with therapy even though it becomes a difficult process for the youth</p> <p>Be Supportive Show that <i>you</i> care Help the youth to feel worthwhile again</p>	<p>Suicidal crises usually last only a short time.</p> <p>The goals of crisis intervention are: Get the youth through the crisis without harm Convey a sense of hope Increase the perception of alternatives Identify and mobilize resources</p> <p><u>Step 1: Assess the suicidal risk factors</u> The greater the ability to describe plans of suicide, the greater is the risk.</p> <p><u>Step 2: Listen</u> Really, listen and hear; be empathetic.</p> <p><u>Step 3: Evaluate the seriousness of the youth's feelings</u> It is possible for a youth to be extremely upset but not suicidal – or to appear only mildly upset and yet be suicidal.</p> <p><u>Step 4: Take every comment and feeling seriously</u> Do not discount any of the youth's concerns.</p> <p><u>Step 5: Begin to broaden the youth's perspective of his or her past and present situation</u></p> <p><u>Step 6: Be positive in your outlook of the future.</u></p> <p><u>Step 7: Help the youth to increase his perception of alternatives to suicide.</u></p> <p><u>Step 8: Act to make concrete plans to resolve the problem.</u></p> <p><u>Step 9: Evaluate available resources</u> Help the youth to identify and mobilize supportive resources.</p> <p><u>Step 10: Do not hesitate to get help.</u></p>

APPENDIX G: ASK MODEL

Table G.1



Low Risk Assessed	Medium Risk Assessed	High Risk Assessed
<ul style="list-style-type: none"> • Suicide ideation • Does not have clear plan or means • Feels hopeless/helpless but has support in place • No self or family history of suicide 	<ul style="list-style-type: none"> • Suicide intention • May have plan or means • Perceived support • Future support 	<ul style="list-style-type: none"> • Suicide intention • Has self or family history of suicide • Has plan and/or means • Has no perceived supports • Perception of loss, isolation or aloneness
↓	↓	↓
Low Risk Response	Medium Risk Response	High Risk Response
<ul style="list-style-type: none"> • Ensure safety • Notify parents/guardian as required • Call Crisis Line if a consultation is required <p style="text-align: center;">In addition:</p> <p>Teachers/Counsellors</p> <ul style="list-style-type: none"> • Notify supervisor • Document carefully • Coordinate follow-up services (mental health, alcohol and drug services, school counsellor, etc.) 	<ul style="list-style-type: none"> • Ensure safety • Notify parent/guardian • Contact Crisis Line • Ask parent/guardian to contact the family doctor <p style="text-align: center;">In addition:</p> <p>Teachers/Counsellors</p> <ul style="list-style-type: none"> • Notify your supervisor • Document carefully • Notify supervisor • Coordinate follow-up services 	<ul style="list-style-type: none"> • Ensure safety. Do not leave alone • Contact Emergency Services (911) or transport to Hospital • Notify parent/guardian • Ask parent/guardian to contact Family Doctor <p style="text-align: center;">In addition:</p> <p>Teachers/Counsellors</p> <ul style="list-style-type: none"> • Contact Crisis Line • Document carefully • Notify your supervisor • Provide Follow

ASKING THE QUESTION – OUTLINE
(See SAMPLE STATEMENTS next page)

1. The Question:

- Ask directly and openly about suicide
- Be aware of your tone, timing, and relationship
- Rephrase the question throughout the interview:
- There will be generally two responses to this question
 - If “no” this is the response, be sure to discuss a suicide safety plan in case the person becomes suicidal in the future, or in case, they do not feel comfortable discussing their real feelings. *Continue on to #6*
 - “Yes” or “Maybe”: If this is the response *continue on to #2*

2. Maintaining Rapport:

- An open-ended question invitation to gather more information and to validate is most useful and gives permission to speak freely, which reduces anxiety around stigma and secrecy.

3. Current Stressors:

- Empathize by paraphrasing and by maintaining good eye contact and an attentive listening posture.
- Explore current stressors and events.
- Explore symptoms such as substance misuse, constriction of thought, feeling, or behaviour, inability to communicate, perceptions and distortions, sleeping and eating irregularities, and changes in mood and energy

4. History:

- Determine the lethality level of any prior attempts, what intervention interfered or did the youth self-rescue?
- Current intervention strategies may depend on this information; e.g. If it helped to see a counsellor in the past, would they attempt to re-establish contact?

5. Urgency:

- Explore if the youth has lethal means and/or a date to commit suicide.
- Get a sense of their impulse control; e.g. are they able to tolerate these painful feelings for a while until they can get connected or counselling?

6. Safety:

- Develop intervention strategies based on their current risk level.
- Reinforce their current skills and capacities to cope.
- Make referrals for follow-up; e.g. G.P., crisis centres, hospitals, emergency, community agency, support group, Cultural Worker, Elder etc.

SAFER Vancouver 1998

1. The Question:

- “Has it been so bad that you’ve thought of suicide?”
- “. . . and that makes you feel like _____.”
i.e. (a) ending your life

i.e. (b) killing yourself

1. If the answer is “no” explain the reason for asking and then ask:

“If you were to become suicidal, what would you do to help yourself?”

Continue on to #6 on previous page.

2. If “Yes” or “Maybe”: *Continue on to #2*

2. Maintaining Rapport:

- “Tell me about it.”
- It sounds like you’re in a lot of pain. Can you tell me more about that?”

3. Current Stressors:

- “What has brought these feelings up now?”
- “Has there been a recent loss or trauma?”
- “It sounds like that was very important to you.”
- “I sense you’re really overwhelmed.”
- “What’s happening with substance use?”

4. History:

- “Have you felt like this before?”
- “Have you harmed yourself in the past?”
- “What happened?”

5. Urgency:

- “Have you actually thought so far along that you have made a plan to kill yourself?”
- “Have you thought about how you’d do it?”
- “Have you picked a date?”

6. Safety:

- “Who do you feel you can really talk to?”
- “What would help?”
- “Let’s make a plan for you to feel safer.”

SAFER Vancouver, BC 1998

APPENDIX H: SUICIDE CASE STUDIES

Profile 'A' "Mark"

Mark is 19 and Caucasian. He was born in B.C. Mark was recently fired from his restaurant job, because of problems associated with alcohol consumption. He did not finish grade 12 as he spent the last year at school drinking with his friends. His parents tired of his behaviour told him to shape up or find a new place to live at the end of the month. Mark made a suicide attempt three months earlier (wrist slashing), when his girlfriend threatened to leave him. A friend hung himself about year before this event. Friends thought he seemed very depressed. He refused the professional help offered. Recently, she split up with him and he went to a party where his girlfriend showed up with a new boyfriend. At the party, Mark drank a great deal and threatened to kill himself, but those at the party thought it was just the alcohol talking and did not take these threats seriously. Mark's dad has a hunting rifle locked in a gun cabinet in his home.

Profile 'B' "Bonnie"

Bonnie is 18 and Caucasian, born in B.C. Bonnie left school in grade 10. Sexual abuse occurred at a young age at the hands of a babysitter, but additionally, the father of a friend repeatedly raped her throughout her teenage years. She has a history of depression and drug abuse. She works as a hairdresser. Her father committed suicide when she was about 4 years old. Recently, she had a violent fight with her boyfriend who beat her severely. She started drinking more than usual during the past month.

Profile 'C' "Charlie"

Charlie is a 21 year old Aboriginal, born and living on a British Columbian reserve. He left school in grade 8. His parents attended residential school, where they were abused, and both have histories of alcohol abuse, sexual abuse and family violence. Two weeks ago, he slashed his wrists under the influence of alcohol, after his girlfriend rejected him. Charlie commonly takes excessive risks. He drives too fast, once leaping out of a moving car. He tends to get into bar fights. He was abusive with his girlfriend.

Profile 'D' "Gerry"

Gerry is a 22-year-old Japanese Canadian university student, who recently was refused entrance into an educational programme his parents wanted him to get into. He was not allowed in, because although most of his grades were "A's", the stiff competition kept him out of the program. Gerry is described by friends as sensitive, quiet and liked. He is considered a hard worker who studies while others go to the pub. He was not known to drink excessively or to use drugs. He wrote a note to his parents saying he was sorry for disappointing everyone, and gave a detailed description of how he felt about letting his parents down when he had to get into that educational program by not doing well enough.

Profile 'E' "Jennifer"

Jennifer is a 21-year-old single mother with a 2-year-old child. She has seen her doctor about feeling depressed and he has given her a prescription for antidepressants. She has told some close friends that some days she just wants to die. She doesn't think she will ever have a boyfriend who will be serious about her because it is so difficult to date with having a young child. She tells her friends she feels trapped. Jennifer has thought many times about overdosing on any medication in her medicine cabinet. She has some T-3's, antidepressants and Valium. She reassured her friends she wouldn't kill herself because of her child.

Profile 'F' "Janice"

Janice is 15 years old, Caucasian, grade 10 student. Her grades are average. She swallowed some Tylenols at a party recently after seeing her ex boyfriend with someone else. She uses pot, smokes cigarettes and occasionally gets drunk. On more than one occasion in a fight with her mother she screamed, "You'd be happier if I were dead!" Her poetry in English class sometimes focuses on death and dying. She told her best friend once that she has considered killing herself. She can't think of the best way to do it as most of the means seem too "gross" to her and told her friend that is what has stopped her so far. Janice often seems moody, going from high, ecstatic moods to angry and then to sad.

Profile 'G' "Erin"

Erin is 16 and in grade 11. Her grades are satisfactory. Recently, Erin has been telling people she is probably going to change schools, although her parents have no intention of moving. She gave her favourite piece of jewellery away to her best friend and has been giving away other favourite possessions. She seems in a good mood lately, though her teacher thought she seemed very down for a few months prior. She seems calm, collected. When asked if everything is okay, she just smiles and says everything is "fine". Erin has a secret life her parents would not approve of and she told the school counsellor about a month ago. Erin is a lesbian and afraid to tell people. Her parents want her to find a date for a school dance and wonder why she isn't more interested in dates.

Profile 'H' "Royette"

Royette is 15, in grade 10. Royette lives on a reserve of about 400 residents. Her parents and grandparents went to residential school in British Columbia. Her stepfather went to residential school too. He is quite a bit older than her mother is. Royette has 5 brothers and 1 half sister. Two of these are under school age and Royette baby-sits often. This is her second year in grade 10. She used to be a very good student, but her grades have dropped since involved with male youth. When she was 6 years old, a social worker investigated her for possible sexual abuse victimization. Nothing was ever proven. However, her mom and dad split up when she was 8 because the violent fighting became too much for her mother to stand and mother did not want to lose her children. Her father drank a lot. The rumour is that her older brother deals drugs on the reserve. Royette gets into a lot of fights in school. The principal has threatened to "kick her out". She loves sports and is good at soccer. The sports coach wonders why she did not show up for the last practice, as this is so unlike her. Last practice she was in a

fight with someone she says stole her boyfriend. She went drinking after that. In art class, she keeps drawing an owl with a dead mouse.

Profile 'I' "Hoop"

"Hoop" (everyone calls him that), is in grade 11. He just moved back to a reserve. His family lived off reserve for the past three years. He is a "good" youth with good grades, no major problems observable. He was beat up yesterday and someone referred to his parents as "apples". He is not happy to be living on reserve, but his parents are happy to get a house there, they have waited a long time for this. He does not seem to be making friends and his grades have dropped. He could fail some subjects. He hides in his room and stays on the computer. His sister, Jess seems to defend him a lot lately. She is close to her brother and only a year older. He says he wants to go live with his grandparents on his dad's reserve, but this is not going to happen. Jess found out he stole a printer from the school and wants him to return it. Finally, she told a school counsellor and now there is a big deal being made about this. He skipped school several times after this. Jess is worried about her brother and thinks he is depressed, but he will not get any help. Both his parents have high expectations of him. He carries an important name and is expected to carry himself well.

APPENDIX I: BLANK LOCAL SUICIDE RESOURCES

I.1 Resources for Everyone

Mental Health in your area _____

Ministry for Children and Families _____

Community Services in your area _____

Crisis Line 1-877-820-7444 Native Crisis Line

Crisis Response Team _____

SAFER, Suicide Attempt Follow-up Education and Research, Greater Vancouver Mental Health Services, 300-2425 Quebec St., Vancouver, V5T 4L6, 604-879-9251, 604-792-6575.

Suicide Information and Education Centre (SIEC), 201-1615-10th Avenue S.W., Calgary, Alberta, T3C 0J7, 403-245-3900/fax: 345-0299, siec@nucleus.com, www.siec.ca. found in

I.2 Resources for Parents

- B.C. Council for Families, 204-2590 Granville Street, Vancouver, V6H 3H1, 604-660-0675/1-800-663-5638/fax: 732-4813, bccf@istar.ca, www.bccf.bc.ca. Found in White & Jodoin, June 1998, 68.

I.3 Resources for Teachers

- Peer Resources, 1052 Davie St., Victoria, V8S 4E3, 1-800-367-3700 /fax: 595-3504 rearr@islandnet.com/~rearr/peer.html (peer, mentor and coach systems, publication of the Peer Counsellor and training manuals)
- BC Healthy Schools, c/o Ministry for Children and Families Regional Operating Agencies or 3rd floor, 737 Courtney Street, Victoria, 250-356-2489/fax: 356-0580 (program for helping students make healthy decisions).
- The British Columbia Government Publications Centre, www.publications.gov.bc.ca, 250-387-6409
- Curriculum and Resources Branch, Ministry of Education, P.O. Box 9152, STN GOV'T, Victoria, B.C. V8W 9H1, 250-356-2317/Fax; 356-2316, EducationCurriculum@gems.gov.bc.ca, www.educ.gov.bc.ca/curriculum/welcome.htm.

- B.C.T.F. Lesson Aids Service, British Columbia Teachers' Federation, 100-550 West 6th Avenue, Vancouver, V5Z4P2, 604-871-2283, 1-800-663-9163, /ax: 871-2294, [lacatalogue@bctf.bc.ca/Lesson](mailto:la catalogue@bctf.bc.ca/Lesson), www.bctf.bc.ca/LessonAids/LessonAids.html. Found in White & Jodoin, June 1998, 39.

I.4 Resources for Counsellors

- Mental Health Evaluation and Community Consultation Unit (MHECCU)
- Psychological Assessment Resources (PAR). P.O. Box 998, Odessa, FL33549, U.S.A., 1-800-331-TEST (for Suicidal Ideation Questionnaire).
- www.crisiscentre.bc.ca/distress/links.php offers a complete B.C. resource list and good online help for youth as well as postvention for grieving parents.

I.5 Resources for Adolescents

- 1800SUICIDE is for all ages. This resource can monitor anyone at all hours, if that request is made with the helper and youth. They also have 24 hour helpers available to talk to a suicidal person. Port Alberni has a First Nations crisis line that will also check on and monitor a suicidal person. Kuu-Uu 1800-588-8717
- Facilitator needs to check for the number of After hours response for adolescents. This is not available all night, but is available quite late. They will come out to where the youth is to talk with them to avert a crisis.
- Kids Help Phone 1800-668-6868 or website www.kidshelpphone.ca The on line helpers use brief solution focused therapy. The helpers do no trace calls even if the risk seems imminent. If the youth does not want to talk on the phone, the web site has a write in format. 24 hour access and provides a policy of confidentiality for the youth to decide if he wants to talk to a helpline person or not.
- Crisis Intervention and Suicide Prevention Centre of B.C. at www.crisiscentre.bc.ca/distress/links.php. This centre offers links and lists to all B.C. It has postvention as well as intervention help with an online chat at www.youthinbc.com.
- www.mentalhealthcanada.ca
- www.metanoia.org/suicide/ Site helps adolescents deal with peers who are suicidal. Model consists of TLR (talk, listen and respond to your friends) and gives directions (LIFE model: Listen, Insist on Honesty, Feelings: Share them, Extend a helping hand)

I.6 Resources for Agencies

- Social Planning and Research Council of B.C. (SPARC), 106-2182 West 12th Avenue, Vancouver, B.C., V6K 2N4, 604-718-7733/fax: 736-8697, www.esrin.esa.it:8080/handy/postcard/uk_sparc.html (Community development materials)

- British Columbia Children's Commission, 4th floor, 1019 Wharf Street, Victoria, V8W 9J1, 250-356-0831/fax 356-0837. www.childservices.gov.bc.ca found in White & Jodoin, June 1998, 226. (reports useful changes in policy or practice to prevent deaths, reviews all children's deaths)
- The McCreary Centre Society, 401 North Esmond Avenue, Burnaby, V5C 1S4, 604-291-1996/fax: 291-7308, mccreary@lightspeed.bc.ca, www.mcs.bc.ca. (research, information community participation projects and published The BC Youth Health Action Handbook (1996).
- Canadian Mental Health Association, 1200-1111 Melville Street, Vancouver, V6E 3V6, 604-688-3234/fax: 688-3236. Publication: Working with Young People: A Guide to Youth Participation in Decision Making (1995).
- American Association of Suicidology (AAS) Suite 310-4201 Connecticut Avenue, N.W. Washington, D.C., U.S.A., 20008, 202-237-2280/ax: 202-237-2282. Useful publication: Media Guidelines and Guidelines for Interviews.

APPENDIX J: WORKSHOP EVALUATION

Did this workshop satisfy your needs to carry out suicide intervention? Please explain.

What did you find useful to you in the workshop? What had little use?

Would you like a follow up workshop within 6 months to a) review what you have learned; b) add more information, (mention what information you would like added) or, c) develop further interview skills?

Would you recommend this workshop to others? Ask the questions: Why or why not? Rate the workshop on a scale of 1 to 10 with one being the worst workshop and ten the best in regards to information. Rate the workshops again in regards to useful practice. Rate the facilitator in regards to presentation.

Further comments on what you liked about the workshop and how further workshops could be improved would be appreciated.

APPENDIX K: SECONDARY SCHOOL TEACHERS SUICIDE AWARENESS

K.1 Introduction

Questions about Suicide:

What do you know about suicide?

What are your values around suicide?

Suicide Vulnerabilities or Risk Factors

Warning Signs a Teacher Might See

Possible Triggers in a Vulnerable Youth

What to do or say. Don't do or say.

Do not leave a suicidal youth alone.

K.2 The Role of Schools in Gate Keeping

“School gatekeepers are particularly well positioned to identify and intervene early with at-risk/exposed youth” (Grossman & Kruesi, 2000), however, few school personnel have useful training to be able to do this, and how often is it in fact done? This area needs increased attention. In discussing Alberta’s high suicide rate among adolescents, Pettifor et al, 1983 found in Bagley & Ramsay (1997) report that “the school personnel either did not notice or did not report any concerns about the youth who later committed suicide. The reported school referrals were mainly for poor academic performance rather than suspected emotional problems. “Difficulties, for youth at school, may be an area needing to be assessed more closely” (p. 14) b The Center for Disease Control recommends three strategies, which are caregivers training to recognize danger, means restriction to reduce risk and postvention activities to respond to loss when it does occur. (Grossman & Kruesi, 2000) Schools in Canada have procedural policies to follow, but training in identification and prevention activities still needs work. In the United States, a program was set up for schools, put on a CD-ROM and mailed to 27,000 principals. There was an attempt made to assess the impact by mailing out a brief questionnaire 6 months later, but the response rate was very low (3%), and worse it was found the program was seldom passed on to gatekeepers such as school counsellors (Grossman & Kruesi, 2000). There may be numerous problems for schools in acting as gatekeepers, and here are some suggestions of problems schools may encounter:

1. Schools are busy places and heavy demands for education are difficult enough.
2. School counsellors are not always seen by high risk students.
3. Students as a body are not usually screened for problems, as various ethical concerns and dilemmas can crop up in this regard.
4. Government programs dealing youth are generally under funded, poorly run or not well integrated into the school system.
5. Schools in Canada have cut backs in funding and personnel in recent years.
6. School personnel who are not comfortable with this topic are not predisposed to take part in training voluntarily offered.

7. Schools are influenced by various public and government agendas.

K.3 Screening for Suicide

ASK and ASIST Resume after Aug 2

ASK focuses on C.P.R. (C.P.R. stands for Current Suicide Plan, Prior Suicidal Behaviour/Attempts, and Resources: How to be a resource and seek other resources for the youth.) ASIST consists of six intervention tasks. First, explore (asking about the person's feelings about what happened to them. Secondly, Ask questions about if they are thinking about suicide. Always listen (for the reasons for dying and the reasons for living. Ask questions that help the person sort out their mixtures of feelings and ambiguity. Part of you feels suicide is your only solution, but another part of you would like to find another solution. Is this what is happening to you? Review risk factors or weigh the effect of risk factors with the offsetting factors and discuss the validity with the person. Agree (contract) to make a safe plan with the youth. Check to find out if the person really agrees. State what the person agrees to do and what you will do to prevent the immediate risk of self-harm. Then, check if the resources and safety plan are carried out. Agree about when and how to check back with each other (Ramsey, Tanney, Lang & Kinzel, 2004). ASK and ASIST can be integrated as models.

School personnel can tell parents simple instructions informing them of the following:

1. If known or suspecting the youth is at risk, tell the caregiver (parent, foster parent, guardian social worker)
2. Tell the parents about restricting means. Examples: Remove guns from the home, lock up kitchen knives, remove rope, lock up or remove lethal medications, remove alcohol access from the home, car restrictions (cars have been used for suicide).
3. Tell parents about resources, and give referrals. Both the youth and the parents will need assistance. Have the youth fully assessed for suicide risk by a professional. The youth's doctor should be informed. If there is imminent risk or any doubt about the risk, the youth needs to be taken to emergency.
4. Tell the parents to monitor the youth, not to leave them at home alone. A suicidal youth should not be left alone. Note that it takes within 15 minutes to die by hanging.

The most essential things to do are to screen and identify at risk youth, access resources and the more the better, restrict means and monitor the youth. Monitoring the youth may require a number of supportive resources. You may want to brainstorm with the parents and the youth in this regard. Know that there are no reliable tools to predict absolutely, if a particular youth will or will not commit suicide (Grossman & Kruesi, 2000).

What can a teacher do within the context of a regular classroom setting?

1. In almost any subject, the teaching of problem solving and coping skills to teach students how to think or alternatives rather than rote learning is very essential. There has been generally an increase in this thinking among teachers, but

further pushing this skill learning aspect can truly assist an individual in not running out of options and looking for alternatives instead of believing suicide is the only solution.

2. Encourage programs and activities that will assist in identifying at risk youth.
3. Integrate and invite suicide awareness and prevention programs into the school and classroom. Caution: Jenkins & Singh (2000) remark that there is evidence increasing the awareness of suicide may have negative consequences of increasing the acceptability of suicide, depending on presentation. The topic can be distressing to some (Shaffer & Gould, 2000). Mood disorders most associated with risk cannot be changed by a teaching process, so screening for these in the school might be more effective (Shaffer & Gould). Programmes promoting awareness of depression, reducing the stigma of mental illness and promoting peer support is seen as a useful. Also sometimes, it seems most useful to provide programming and training “to mature adults such as parents, school psychologists, and counsellors”. (Shaffer & Gould, 2000, p. 645)
4. Notice when youth do not seem to be doing well. Notice their artwork and writings. If there is a theme of death or self-harm, prepare yourself to do the ASK screening tool with that student. Take the time and act on it.
5. Learn more about suicide prevention yourself.
6. Invite the school counsellors, substance abuse counsellors and youth workers into the classroom and especially to fun activities, so the youth get to know more resources, and are more likely to access them.
7. Encourage peer-counselling programs in your school. Prevention programs the have incorporated peer counselling appear to be more effective. (Kalafat, 2000) Best Practice information available in British Columbia strongly suggests this. (White & Jodoin, June 1998) They also suggest good resources for doing this, which is Peer Resources in Victoria (1-800-567-3700, www.islandnet.com). The kit for doing a program is available from them. They caution about keeping peer supports within the range of academic and developmental issues and that peers need to involve adult counsellors for serious problem.
8. Find a way to encourage more extracurricular activities so more adults that are helpful can be involved in more youths’ lives. In general, in schools, youth do not see adults as accessible to talk with about these topics and have difficulty getting to know adults. (Kalafat, 2000)
9. Acting classes have room for exploring important themes in adolescent lives. Encourage this.
10. Discourage the suspension of youth for using banned substances. Find alternatives, such as the youth attending psycho educational sessions on substance abuse, perhaps within the school.
11. Find ways to talk about important topics freely and openly in the school setting. Encouraging responsible media or creating media that does not glamorize suicide, does not give details of methods employed, provides commentary by peers and youth workers of help that is available for depression and other youth concerns, promoting positive self-image and influencing youth culture in positive ways would be helpful (Jenkins & Singh, 2000). Responsible communication regarding media when a suicide takes place is needed.

12. Reducing access to means of suicide any way found possible.
13. For a school wide screening tool White & Jodoin (June 1998) recommend contacting Dr. William Reynolds, U.B.C. (Department of Educational and Special Education) for the Suicidal Ideation Questionnaire screening process. (822-8229/Reynolds&unixg.ubc.ca)

Indirect ways of preventing suicide can be helpful such as improving adolescents overall life circumstances through family education programs, teaching conflict management, coping skills, social skills and so on. Best practice information given by White & Jodoin (June 1998) emphasize the protective role a school can have if the school climate is a healthy one. Teaching how to get along in this world by good modeling as well as programming that incorporate healthy living into all coursework would be beneficial. As a role model to youth, consider they all watch what you do.

K.4 After A Suicide

According to the Dougy Centre (2000) found in S.I.E.C. Alert Publication, (May, 2004) those students who are impacted by the suicide need to comprehend that they are not alone and there are supports for them, to find ways to manage the resulting anxiety and to talk about the reasons a person suicides. A major problem in schools is copycat suicidal behaviour or contagion.

After a suicide, impacted students may do various self-harm activities. Some examples are games like Russian roulette, dare games to do “at risk” behaviours, and self-mutilation. Students may now hear frequent suicidal threats and school counsellors may be over whelmed. Most schools have protocols to deal with sudden deaths of students. If the protocol seems lacking, contacting the Centre for Suicide Prevention in Calgary, as they offer useful protocols.

In terms of memorials, suicide deaths should not be given special status. According to The Dougy Center 2000 (found in SIEC Alert, May, 2004) if memorials are given after other deaths then one could be given. Other authors, including the National Association of School Psychologists (SIEC Alert, May, 2004) do not agree and indicate in general whole school memorials may “communicate suicide as an appropriate or desired response to vulnerable youth and are therefore not recommended” (p. 1). The S.I.E.C. Alert does not recommend plaques, memorial trees and similar tangible memorials. Callahan et al (1999) & Oates (1993) suggest not glamorizing suicide through these rituals, but it is better to encourage the students in projects to help the living (S.I.E.C. Alert, May, 2004).

K.5 Healthy School Climate

Why is this important? White & Jodoin (June 1998) point out in their information on best practices that we should be concerned about school climate because:

1. Environments shape behaviour and the way people feel.
2. Schools are so important in the lives of youth/children.
3. Unhealthy school climate has a negative impact and is related to suicide risk.

Further, these authors recommend school climate improvement initiatives, advising learning about the BC Healthy Schools Initiative such as (S.T.E.P.) The School Transition Environment Program that helps students transit from one school to another through specific steps. Information can be gained through BC Healthy Schools, Ministry of Children and Families Operating Agencies, 250-356-2489, Victoria. They list 10 characteristics of healthy schools as follows:

1. Goals and visions that are shared.
2. Both continuous academic and social growth.
3. Lots of communication involving opportunities for input.
4. Respect that is clearly mutual.
5. Trust levels that are high.
6. Both caring and acceptance.
7. Discipline that is both clearly defined and consistent.
8. Playfulness and humour.
9. Hardy sense of ritual and traditions.
10. An environment that is both pleasant and stimulating.

APPENDIX L: SAMPLE AGENCY CONFIDENTIALITY AGREEMENT

Therapeutic Counselling services at _____ are offered by therapists with Master's degrees in counselling psychology, psychology or social work. You are welcome to ask any questions regarding the professional qualifications of the therapist assigned to you. Our teams operate from a best practices model called the bio-psycho-social model, but the therapists have been trained in a wide variety of theoretical models and therapeutic interventions. Any information that we collect from you will be to provide service to you, but you have the right to ask questions regarding the collection of any information.

In counselling, therapists/counsellors may make suggestions to you to do things they believe will help you to make changes you want to make in your life. At all times, we respect your understanding of what works and is right for you at any particular time, so it is your right to refuse treatment or any suggestions, if they do not feel right for you. However, sometimes making changes is uncomfortable and old habits are hard to change, so you may want to try new things suggested to make your life better.

You have a right to confidentiality, informed consent, and ethical treatment, before and after service. If you ever have any questions about our work, you may contact the Clinical Supervisor _____ at _____. There are exceptions to confidentiality, when every therapist/counsellor has a legal or ethical responsibility to break confidentiality:

1. Suspected child abuse (physical, sexual, emotional or neglect).
2. Any threat or harm to yourself or others.
3. Court subpoena, WCB investigation.
4. If you attempt to drive a vehicle while impaired by alcohol or drugs.
5. It is normal practice for your therapist/counsellor to be able to discuss situations with their supervisor and team colleagues in order to provide good service standards.
6. Government funders and accrediting bodies may randomly view files to make sure standards are maintained. These reviewers have the same professional requirements around confidentiality as your counsellor.

For any other release of information, a signed release would be needed from you. Youth 14 years and older can consent to treatment without parental consent. Others require a guardian's consent.

You have a responsibility to be as honest as you can be and to practice the changes you agree to in your everyday life. You are asked to be on time for appointments, you make and if you cannot attend, to let your therapist know.

By signing below, I acknowledge I read and understood the above, had opportunity to ask questions, and consent to treatment and follow-up, for myself and any children under the age of fourteen.

Client signature

Date

Client signature

Date

Therapist/witness signature Date

APPENDIX M: GRADUATE STUDENT INTERVENTIONS HANDOUT

M.1 Some Suicide Facts

1. It is important to discuss directly the issue of suicide with the person exhibiting warning signs. This will not give the person the idea to commit suicide.
2. Females attempt more frequently, but males commit suicide more frequently
3. Males tend to try more lethal methods than females
4. Aboriginal suicide rates among both males and females is much higher than for mainstream populations
5. Generally, when screening for suicide risk, a person's resources is considered most important. However, if a person is experiencing psychotic processes such as command hallucinations, this may be the most important factor of all.
6. People are usually ambivalent about dying, but may see suicide as their only solution
7. If a person indicates they have been thinking of suicide, detailed information about any plan is vital information
8. After accidents suicide is the second common cause of death in youth
9. It is important to take any indications of suicide thinking seriously
10. Knowledge of a youth's suicidal thoughts needs to be shared with the youth's social worker and an assessment will need to be done by a professional now as you have done your part and used the screening tool ASK. This is not knowledge that can be kept confidential between the youth and yourself.

M.2 Attitude and Approach

Shea (1999) "Not all therapists and assessment clinicians do well with people contemplating suicide; those who do best exhibit an unmistakable trait. They approach the stress generated by a person's repeated contemplation of suicide with a surprising matter-of-fact calmness that is at the very crux of their success in both uncovering and transforming suicidal ideation. It is the calmness of knowledge. It is the calmness of experience." P. 18 Shea (1999) demonstrates the CASE (Chronological Assessment of Suicide Events) method of eliciting suicidal ideation. For any helping professional, his book offers details of an interview method that aids in a thorough understanding of the client being worked with. The information in the book would offer a good understanding of suicidal clients to a beginning graduate student encountering a suicidal person for the first time and give a seasoned professional another flexible method to approach the needs of someone contemplating ending their life.

Concerning therapy for adolescents, even more research needs to be done, since most studies are all age or adult population samples and the results may not generalize to adolescents (Hazell, 2000). Therefore, there is a need to consider that therapy that works for adults may not translate into being useful for working with this age group. Hazell (2000) offers, "adolescents may not respond to treatment strategies that have

demonstrated efficacy in adults” (p. 540). Hazell (2000) recommends that there should be a re-evaluation of services for adolescents in terms of improving efficacy and making the service more user-friendly. Some suggestions made by Hazell (2000) include:

1. Explore flexible working arrangements, as adolescents tend to attempt suicide outside most therapists working hours.
2. Resource create through training more community personnel, and giving them ongoing training and support in the recognition and management of suicidality. This has an advantage of being adaptable to local circumstances.
3. Offer 24 hour crisis lines
4. Provide conflict management, problem-solving therapy and cognitive therapy.

Ideas by Hazell (2000) to improve treatment adherence in known adolescent suicide attempters are summarized as:

1. Positive regard shown at time of triage.
2. Arrange a definite follow up appointment time at the assessment.
3. Follow up should be quickly afterwards (within days).
4. Reminder calls for appointments.
5. Twenty-four hour emergency backup for emergencies.
6. Advise staff to make” vigorous attempts to contact non-attenders” (p. 545).
7. Clear contracts about what the treatment will be.
8. Involve family and those close in the therapy.
9. Provide “continuity of clinician from hospital assessment to aftercare”. (545)

Perhaps it would be useful to study youth workers who regularly connect with adolescents. In personal conversation and casual observation, it is interesting to discover how youth workers access the adolescent world by feeding them, playing games with them, remembering their favourite coffee, listening to them, laughing with them, taking an interest in their interests, and standing up for them in the adult world, amongst many other things (Otanga, 2005). Perhaps adults learning more skills to connect with youth could ameliorate some of the problem with youth accessing peers instead of adults for assistance. Monitoring is another important factor, and people who spend time with the youth can assist with this. Youth workers are an excellent resource in this regard. However, the greatest monitoring should take place at home, as that is where most youth attempt suicide or suicide (Centers for Disease Control, 1995 in Hazell, 2000) and most of this happens in the evening or night (Silburn et al, 1999 in Hazell, 2000). Also, the attempt is often triggered by conflict in the home, besides other significant others in the young person’s life (Hazell, 2000).

Susan Blumenthal quoted in Robbins (1998) emphasizes the therapeutic alliance in managing suicidal adolescents:

“One of the most important factors in the management of the suicidal young person is the therapeutic alliance. The clinician provides supportive care by allowing the young person to ventilate painful feelings through discussions that help him or the youth discover alternatives, improve interpersonal relationships, and change negative thinking, refocusing on the future. This can be achieved by listening intently and emphatically to what the patient says, by asking pertinent questions that help the patient share suicidal feelings, and by providing hope.” (Robbins, 1998, p. 110) She emphasizes high levels of therapist availability and commitment (Robbins, 1998).

M.3 Suicidal Ideation

How probable is it that people thinking about suicide will kill themselves? “Arguably, the most startling irony of suicide is that so few people do it. This statement is not made facetiously. It is meant to highlight an often underemphasized, yet ultimately reassuring fact: Roughly less than one percent of people who have had suicidal ideation go on to kill themselves.” (Shea, 1999, p. 18) However, Goldney, Winefield, Tiggmann, & Winefield (1995) discuss a longitudinal study that showed that the impact of suicidal idea and its enduring morbidity persists over a long period of time (follow-ups over an 8-year period). Shea (1999) states that the aetiology of suicidal ideology is “deceptively simple” (p. 19) and states that suicide ideation comes from three factors: 1. situational “external stressors” 2. psychological “internal conflict” and 3. biological “neurobiological dysfunction” (p. 21) which can be caused by drug use for example. For the therapist, it is important to be able to discover suicidal thinking in order to intervene. Shea (1999) remarks that if “a clinician can spot a client who is acutely suicidal and provide an alternative solution that delays the act; there is a reasonable chance that the person will have a change of mind. But first, we have to be able to uncover the hidden suicidal ideations. Once they are uncovered, we have to be able to decide which suicidal ideation is the harbinger of immediate danger and which is not.” (p. 19) This has its difficulties, because an adolescent’s idea of something worthy of taking his own life, would not likely match with what an adult professional might think is such a powerful stressor. The individual’s perception is what determines whether the stressor is a trigger for that person to attempt suicide. Asking detailed questions around this can reveal a great deal. Spiritual beliefs may greatly affect the ideation around suicide. Shea (1999) suggests asking many questions around the person’s beliefs. It may be important to find out if they believe in an afterlife, and if so do they think they will join a loved one in heaven, or might they believe that suicide would be punishable and they would be sent to eternal damnation? Shea (1999) believes that shame and humiliation is a common trigger for adolescents. Shea (1999) emphasizes that monitoring of suicidal ideation needs to be checked at every session, until the client consistently has no further suicidal ideation and to do this no matter how well the therapy seems to be progressing. Of particular concern, according to Shea (1999) is suicidal ideation connected to psychotic thinking processes such as command hallucinations, feelings of alien control and religious preoccupation. Psychotic thinking processes can make a person high risk, who has no other risk factors and if the clinician is unaware of this thinking, he/she may rate the client as low risk. Active hospitalization may be needed in such cases.

M.4 Primary Prevention Concerns Regarding Suicidal Threats to Family Members and Friends

Family and friends run risks in dealing with suicidal youth. People responding to threats may respond inappropriately, or withdraw from the person if they do not have coaching as to what to do. According to Mishara (1995), they may:

1. think of themselves as a bad person if their friend or relative is considering suicide;
2. feel like a martyr having tried all they know to help and still the person is suicidal; they may deny the suicidality of the person;
3. take on the person's anguish;
4. feel like a traitor for telling on the suicidal person; they may feel the suicidal person is trying to manipulate them through suicidal threats or that the person just wants attention; and
5. they may become at risk themselves.

All these perspectives may trigger inappropriate reactions that do not help and may increase risk. People with suicidal relatives and friends need coaching on how to approach this. According to Mishara (1995) may also think thoughts such as:

1. I am the only one who can help them.
2. The suicidal person chose a poor confidant.
3. Suicidal people can't be expected to do chores such as dish washing.
4. If the suicidal person wants to be left alone, this should be respected. Of course, it is unwise to leave a suicidal person alone.
5. My own problems don't matter; I need to put the suicidal person first.
6. These thoughts are the result of family genetics.
7. If I discuss the suicidal thoughts with the person, I might find out things I don't want to.
8. I can't engage in any fun under these very serious circumstances. However, although a person should take threats seriously, it does not mean that the suicidal person cannot joke nor have fun with others.
9. I don't want to burden others with this situation can be another perspective and yet the person would benefit from talking with others about this difficult situation.

It is necessary to explore the friend's or relative's perspective and understanding of the circumstance and to give them suggestions that would be helpful. It would be useful if those around the suicidal person were trained in basic helpful communication skills, basic risk assessment, problem solving and conflict resolution skills, emergency procedures, what to expect if the person does commit suicide and in self-care. Include the youth's peers in training, as much as is useful and possible. Paul Robbin (1998) states his research with Roland Tanck showed that adolescents under stress normally turn to peers and family, not professionals. Professionals can support, provide aid, therapy, direction, training and many other useful things, but the front line of prevention is those people

closest to the adolescent! Jerry Hinbest (2001) in a best practices project report reports the following with regards to youth participation:

Youth are capable of and interested in taking on diverse roles critical to the success of suicide prevention efforts. Older students involved in delivering generic skill building or peer helping programs provide important energy, hands on interaction, and legitimacy for the ideas discussed. Such participation for previous participants reinforces learning, and provides practical application of skills. (v)

A strong note of caution is needed here. In the situation where the clients who will not stay in therapy and Robbins (1998) noted this as high, their families may be similar in terms of sticking to any family therapy. Piacentini and colleagues (in Robbins, 1998) asked patients and families to take part in family therapy that involved teaching problem solving for interpersonal conflicts and copying strategies for dealing with crisis around the suicidality of the patient. If two appointments were missed there was telephone follow up and a letter was sent saying if the next appointment was not kept then the file would be closed for “non-adherence (p. 108)” and if warranted at “medical neglect report would be made” which is rather strong wording. What effect did this have? Robbins (1998) notes that 42% of the cases were closed for non-adherence, and this percentage Robbins considered low compared to other reports.

M.5 Gatekeepers Who May be Helpful in Identifying a Youth at Risk

School personnel come immediately to mind, but other gatekeepers who could receive helpful screening training should also be considered according to King & Knox (2000), a partial list might include:

1. Runaway/homeless agencies.
2. Substance abuse service staff.
3. Street and outreach youth workers.
4. Protection services such as Ministry of Children and Families staff.
5. Law enforcement personnel.
6. Youth probation officers.
7. Youth advocates.
8. Nursing staff.
9. Youth recreation service staff.
10. Foster parents and parents in general.
11. Youth who want to be helpful.
12. Teachers, school custodians, principals, school office staff.
13. Church youth group staff.
14. Peer tutors .
15. Tutors.
16. Youth employment program staff.

This list is not exhaustive. Anyone who could be in touch with youth could be a target for education on the topic of screening and suicide prevention, especially youth given responsibilities and training.

M.6 Additional Notes on Using ASK and ASIST (Applied Suicide Intervention Skills Training)

It is useful to refer back to the ASK screening tool when thinking of pertinent risk factors, which is C.P.R. (Current Suicide Plan, Prior Suicidal Behaviour and Resources). Special notice regarding age is that generally it is true that suicide of a child under 12 is extremely rare. However, since this is so, children in this age bracket have seldom been studied with regards to suicidal ideation, especially since theories regarding children generally indicated their immaturity for feelings of depression and hopelessness and the means or understanding of self-destructive methods. (Pfeffer, C.R., 2000) Suicide attempting is found in greater numbers among prepubertal psychiatrically hospitalized children than other children in a community. (Pfeffer, C. 2000) Some findings about prepubertal suicidal children:

1. Fantasize they are expendable to their families and family adversity appears to be a common situation. (Sabbath, 1969 quoted in Pfeffer, 2000)
2. Psychopathologies were found (children with personality disorders, depression and psychotic children). (Pfeffer, 1982c, 1986 found in Pfeffer, 2000)
3. History of suicide attempt in prepubertal children predicts attempts in adolescence. (Pfeffer et al, 1991, 1993 in Pfeffer, 2000) Therefore, this is an important risk factor to consider for youth suicide attempts.
4. Prepubertal children attempting were found to have siblings or parents with higher rates of attempting. This suggests suicide behaviour “aggregates in families”. (Pfeffer, 2000)
5. “a constellation of psychiatric symptoms and disorders involving assaultiveness (sexual and physical), substance abuse disorders, and antisocial personality disorders has been identified among first-degree relatives of prepubertal suicidal patients”. (Pfeffer et al., 1997 found in Pfeffer, 2000)

This information is suggestive of the need for screening prepubertal children early, in order to prevent this progression towards self destructive and tormented lives. Youth suicide prevention could begin with increased care of the younger child.

M.7 Self-Harm

It seems useful to look at suicide in terms of a continuum. First, there are conditions that create the fertile soil for suicidal ideation, then there may be behaviours that are destructive such as substance use, risk taking, there may be some self-harm behaviour and so on. Jenkins & Singh (2000) contemplate the field and discuss that the “dichotomy drawn between suicide and deliberate self-harm is false and that considerable overlap exists between the two populations. In addition, there is increasing awareness of the high prevalence of a range of deliberate self-harm and risk taking behaviours other than

overdose, by young people. These behaviours are seen as precursors to formal suicide attempts” (p, 607). There is a tendency to be dismissive of self-harm behaviours and suicide attempting when the person repeats several times and lives. Negative attitudes towards these young people need to be examined, monitored and dealt with. These youth must be considered as high risk (Jenkins & Singh, 2000). Besides mental health measures, these young people need more than “brief crisis counselling that follows a first attempt, more sustained involvement, either with individuals or groups of patients” (Jenkins & Singh, 2000, p. 607).

M.8 Counselling Skills/Interventions

Brent & Kolko (1990) quoted in Myatt & Greenblatt (1993) suggest four basic treatment strategies and three levels of treatment. The four treatment strategies consist of:

1. Maintain a no-suicide contract. (This idea has generally fallen out of favour in the field, but in some cases, it may be useful and likely does no harm.)
2. Make sure there is 24-hour clinical back-up support.
3. Take steps to insure there is compliance.
4. Remove firearms from the residence of the youth (add to this any other item that could be lethal such as pills). Note that it is important to remove the firearms from the home, as a locked cabinet is not sufficient in terms of preventing their use. (Brent et al, 1988a in Jacobs & Klein, 1993)

The three levels of treatment suggested are:

1. Treat any underlying psychiatric disorders.
2. Remediate for social and problem solving deficits.
3. Provide the family with psycho education and conflict resolution/mediation skill training.

Pfeffer (1990) quoted in Myatt & Greenblatt (1993) suggests intervention strategies to decrease both suicidal intent and behaviour by:

1. using a psychotherapeutic-cognitive method of approach;
2. stabilizing the environment; and
3. using psycho-pharmacotherapy.

These are supposed to be used together. Some problems have arisen with the use of some medications for adolescents and the doctor involved should be cognizant of that and in some cases perhaps use of medication would be counterproductive. Individual consultative assessments should be done. Note that besides intervening by removing access to lethal means, all efforts should be made to limit access to alcohol. Removal of alcohol from the youth may be a suicide prevention intervention all by itself. An interesting fact is that suicide rates and violent deaths dropped dramatically in the former Soviet Union between 1984 and 1990 when there was strict limitation on the sale of alcohol and punishment for over drinking (Jenkins & Singh, 2000).

“My reality is constantly blurred by the mists of words.” (Oscar Wilde, quoted in Shea, 1999, p125) Especially in the case of the high-risk client, it may be difficult to discover the powerful suicide intent he hides. Shea (1999) emphasizes that validity is the “cornerstone” of doing a suicide assessment. Shea (1999) recommends six validity techniques for exploring sensitive information. These are:

1. Behavioural incident (asking for concrete examples, asking for details of events).
2. Shame attenuation (Shea’s example: don’t ask if the person is bad tempered and picks fights; instead if other men tend to pick fights with him, when he is just trying to have a good time.);.
3. Gentle assumption (make an assumption and ask a question based on it).
4. Symptom amplification (i.e. increase the amount of the symptom to such a high level (such as drinking), such that the client needs to down play it).
5. Denial of the specific (after a client has denied a generic question, ask more specifically a series of questions. For instance, ask about a series of specific drugs that may have been used instead of generally asking about drug taking).
6. The last one is normalization in which the interviewer lets the client know others have had the same experiences, or self-normalization in which the interviewer indicates this is how he/she would feel and experience the situation.

Hawton (2000) puts forward the following factors as signalling high suicidal intent of an attempt (summarized points):

1. Attempt done in isolation and timed so intervention/discovery is less likely to occur.
2. Other precautions to prevent discovery/intervention.
3. Death preparedness such as making a will.
4. Planning and preparation made for the act such as saving pills.
5. Communication of intent prior and extensive premeditation, also leaving a note.
6. Not contacting helpers after the act and later admitting suicidal intent. (p 523- but points reworded and summarized, found in Hawton & van Heeringen, 2000)

In the CASE approach Shea (1999) describes behavioural incident is used to interview about suicide events (broad term which includes death wishes, suicidal feelings, thoughts, gestures, attempts etc.) in sections of time in the following order: 1. Presenting suicidal actions and ideation, 2. Suicidal actions and ideation over past 8 weeks, 3. Prior/past suicidal actions and behaviours and 4. Immediate suicidal ideation, future plans for implementation. Each of these is explored in great chronological detail. The clinician asks about specific plans thought about, how far the client took those plans and how much time the client has spent on these plans. If the client’s plan includes a gun, the clinician will ask a series of questions. “Do you have a gun in your home? Have you ever taken it out? Have you ever loaded it?” and so on. The basic framework of the ASK screening tool could be used, but expanded upon CASE style to assess more deeply the client’s situation.

Shneidman (1993) reflects that the characteristics of suicide can be useful in saving a person's life and gives his idea of practical measures in a list, which is:

1. Stimulus (unbearable pain): Reduce the pain.
2. Stressor (frustrated needs): Fill the frustrated needs.
3. Purpose (to seek a solution): Provide a viable answer.
4. Goal (cessation of consciousness): Indicate alternatives.
5. Emotion (hopelessness-helplessness): Give transfusions of hope.
6. Internal attitude (ambivalence): Play for time.
7. Cognitive state (constriction): Increase the options.
8. Interpersonal act (communication of intention): Listen to the cry, and involve others.
9. Action (egression): Block the exit.
10. Consistency (with life-long patterns): Invoke previous positive patterns of successful coping. (Shneidman, 1993, pp. 154-5)

Considering many individuals who are suicidal have endured trauma, other kinds of therapy such as E.M.D.R., hypnotherapy, bodywork and art therapy may be considered useful. Fish-Murray (1993) discusses that if the person is verbal, talking and writing should be the focus of therapy, but if the person is "more visually and spatially adept, drawings should be used" (p. 78). In other cases, Fish-Murray (1993) suggests using the body to show responses through psychodrama, miming or re-enacting the trauma can be used to redirect the experience. Greenburg (1987) referred to in Fish-Murray (1993) indicates that using the medium useful to the client will transform the experiences much faster.

M.9 Self-Harm

Dialectical behaviour therapy showed some promising results in a trial in Seattle of female patients diagnosed as having borderline personality disorders (Hawton, 2000). Some of the results showed reduction in repeating the self-harm, more time in employment activities and less time in hospital.

M.10 Empirical Research of Treatment and Intervention Efficacy of Suicidality

1. Some empirical evidence that follow-up can have preventative value over a long period of time. (Motto, 1976 quoted in Rudd, 2000)
2. Improved access to emergency services can reduce subsequent attempts for first time attempters. (Morgan, Jones & Owen, 1993 in Rudd, 2000)
3. Home visiting can improve compliance to treatment after an attempt. (van Heeringen et al., 1995 in Rudd, 2000)
4. Intensive but time-limited treatment can reduce attempting over only brief periods. (Welu, 1977 in Rudd, 2000)

5. Behaviour therapy (time-limited) can reduce ideation and related symptoms for extended periods but is effective for only brief periods in reducing attempts. (Lieberman & Eckman, 1981 in Rudd, 2000)
6. Problem solving (brief time limited) can reduce acute suicidality and improve problem solving skills. (Patsiokas & Clum, 1985 in Rudd, 2000)
7. Cognitive-behavioural therapy can reduce suicidal ideation and other symptoms over long time periods, but attempts are reduced briefly. (Salovkiks, Atha & Storer, 1990 in Rudd, 2000)
8. Reduction in suicidal ideation, depression, hopelessness can be reduced for brief periods with brief problem-solving group therapy. (Lerner & Clum, 1990 in Rudd, 2000)
9. Intensive and brief problem-solving therapy is effective for high-risk (co morbid) suicidal patients. (Rudd et al, 1996 in Rudd, 2000)
10. Brief problem solving therapy is more effective than treatment as usual with high risk, co morbid patients. (Joiner, Rudd & Rajab, 1991 in Rudd, 2000)
11. Effective treatment can be given with long term out patient care for multiple, severe attempters as reduction is seen in suicide attempts, better treatment compliance and fewer hospitalizations. (Linehan, Armstrong, Suarez, Allmon & Heard, 1991 in Rudd, 2000)

Out of Rudd's (2000) list of empirical finds and summaries, I have listed only those showing some usefulness, to give a picture of how the empirical studies have done with finding useful methods in helping this clientele. Many more had no useful effects and there are many criticisms to be made of the studies. There are so many variables to consider and the ethics of studying this population group presents various problems as well. Robbins (1998) discusses the problems in studying treatment groups of suicidal clients. He says there are scores of studies looking at treatments for depression, as it is considered all right to use control groups of depressed people and then later treat them with what is considered useful. He remarks "But from an ethical standpoint, how can you not offer treatment to potentially suicidal people? Someone may die!" (Robbins, 1998, p. 116) He does not consider it surprising that we do not have "large-scale, convincing type of data for the effectiveness of psychotherapy in treating suicide..." (p. 116)

Heard (2000) reviews various treatment modalities (problem solving, cognitive, cognitive-behavioural, and psychotherapy) and affirms that there is little evidence of effectiveness of treatments in general, although there was some positive evidence. Heard also discusses lack of compliance and states that although blame has been placed on clients' lack of motivation, one experimental study (Torhorst et al, 1987, referred to in Heard, 2000) found use of motivational interviewing did not improve attendance (compliance). So, although there were some hopeful results here and there, there is still a great deal to be learned about helping clients in this regard. However, something more needs to be said about research in this difficult area. The field does not have strong evidence for the usefulness of suicide prevention programs or any interventions. This is partly the problem of how empirical style research can be done and partly the nature of suicide itself and the problems with predicting it. Goldney (2000) in discussing the difficulties makes several insightful comments. Goldney reflects: "When one considers the uncritical enthusiasm with which some researchers and clinicians approach suicide

prevention in areas such as individual schools or school regions, it is quite evident that there is a lack of understanding of the limitations of the low base rate of suicide and the impossibility of ever demonstrating scientifically that the intervention would be effective". (p. 589). He refers to Gunnell & Frankel, 1994 stating that their comments are not unexpected when they expressed that "No single intervention has been shown in a well-conducted randomized control trial to reduce suicide" (p. 592). Goldney (2000) counters with: "Whilst such a statement is technically correct, and whilst one must acknowledge the importance of evidence-based medicine, the question must be posed as to whether or not there could ever be a randomized control trial of sufficient magnitude to demonstrate the efficacy of any particular suicide prevention strategy" (p. 592). Another worthwhile remark by Goldney is that: "Whilst on a statistical basis, the majority of those who are treated would not have committed suicide; the dilemma is that there is no way of knowing when a suicide has actually been prevented" (p. 593). This is not to discourage either researchers or clinicians, but to make it clear that when "best practices" are implemented, none of it is carved in the proverbial stone, but yet there are positive indicators that generally, but gradually the field is finding ways to be helpful, even if this cannot be clearly proven in absolute terms. How many people have been helped sufficiently to avoid taking their lives, who would have suicided without caring assistance? This is unknown.

M.11 Reasons to Contact Significant Others

1. Can inform about information the person might hide such as mental illness, substance abuse, extenuating circumstances that may be stressing the person.
2. They may be a resource in terms of monitoring the person.
3. They may have misinformation that you can correct to help them be a better resource or they may need a referral to resources themselves for support Shea (1999).

M.12 Postvention

"I believe that the person who commits suicide puts his psychological skeleton in the survivor's emotional closet..." (Shneidman in Kamerman, 1993, p.346). When community helpers are faced with a postvention situation, if the situation becomes multiplied in complexity because of system glitches, this result in increased stress for survivors. (Hoff, 1983 in Renaud, 1995). Pre existing protocol is essential to deal with these situations smoothly and helpers need to be prepared to facilitate this smoothness in crisis intervention for the sake of survivors and the increased risk of those close to the deceased. Protocol regarding postvention should be regularly updated and improved as situations dictate.

P. Robbins (2000) paraphrased the American Suicide Foundations' advice to survivors:

1. Maintain contact with other people, particularly during the months following the suicide.

2. When you are ready, share your feelings of loss and pain with your family and friends.
3. Think of what the children may be going through. Remind them that they are still loved.
4. Anniversaries and holidays are likely to be particularly painful and need to be planned ahead of time in order to meet your emotional needs and your family's.
5. You may feel guilt for a time before you can accept the fact that you were limited in what you could do and were not to blame.
6. Avoid the temptation to focus at length on trying to understand the suicide. Don't make an obsession out of it.
7. Healing means that a person needs to get on with life, but also in time, to resume the capacity to enjoy life.
8. The survivors of suicide need support. Trusted listeners can help. A support group is an option to consider.
9. Counselling with a mental health specialist or a member of the clergy can also help you through these difficult times. (p. 134)

Cleiren & Diekstra (1995) literature review holds some important ideas for professionals in intervening with the bereaved. These ideas are:

1. Rebuilding of instrumental and adaptation skills in the bereaved may be more useful than a support group.
2. Check for vulnerability in the bereaved such as seeing suicide as a mode of death and a method of problem solving.
3. Knowing that anger or self-blame can be a sign for problematic and prolonged grieving.
4. Roles in regards to the deceased will affect how the death impacts the survivor. For example, the death of the child is most devastating for a parent. The death of a sibling with similarities in circumstances to the deceased increases the sibling's vulnerability.
5. Extent of resources, perhaps especially social resources, affects impact.
6. Attribution styles and coping skills affect impact.
7. Questions regarding who and what are responsible for the death need to be explored.
8. Survivors who discovered the body need to be considered for posttraumatic stress.

Considerable ranges of how people experience bereavement can be found. This is influenced by factors other than how the person died, such as kind of kinship lost, how old the person was when they died, gender as well as the culture of the bereaved (Cleiren, 1993; Cleiren et al, 1996, Seguin et al 1995a, 1995b found in Clark & Goldney, 2000). Note that there is empirical evidence that support groups can reduce depression and anxiety, as well as helping to resolve many other factors. (Renaud, 1995) Farberow (1996) refers to a review of survivor groups by him in 1992. One in particular stood out, which did an evaluation of survivors and found positive results from the group. This was an evaluation of the Survivors after Suicide Program offered at the Los Angeles Suicide

Prevention Center. Briefly described it had a closed-end approach, just once per week sessions with mixed kinship in the group, but especially noteworthy is that both a facilitator and a survivor-facilitator led sessions. This latter fact seemed to produce many positives from the group feedback, most finding this helpful. Clark & Goldney (2000) reviewed studies, controlled trials, and offer some points from one study:

1. In one study of a 10-week group, the participants rated the programme as beneficial, but the outcome scores on mental health and grief issues did not suggest benefits in this area (Murphy et al, 1998, in Clark & Goldney, 2000).
2. Changes in the study scores showed the most benefit to very distressed mothers; fathers appeared to be “worse off (p. 481)” along with those originally less stressed.

In a sense, sometimes helpers can help too much and make matters worse for survivors! Another treatment consideration is whether to do family therapy or not. Farberow (1996) recommends that if there are signs of “scapegoating, blaming, isolation, and disturbed behaviour, especially children (p. 343)” then family therapy together is indicated. With regards to unresolved grieving on the part of a parent of a suicided adolescent, helping professionals need to consider that the parent entering into counselling a few years later. Contrary to the professional’s expectation of an exploration of past and current concerns, regarding the deceased the parents may regress and in a sense become “an expendable child in conflict with his/her parents” (Samy, 1995, P. 40). Ambivalence towards the child may have influenced the child to feel psychologically abandoned, but the ambivalence with the death of the child remains unresolved. Samy (1995) review of literature leads to a discussion that “messages of hatred, incestuous activity or dynamics, and death fantasies toward the child are common manifestations of repressed parental ambivalence” (p. 42). Family violence is a common factor in the background of adolescent suicide in Samy’s (1995) review of the literature.

In general, bereavement from a suicide does not differ from other bereavements, but some intensity may be greater, and there are some differences noted by Farberow (1993):

1. By nature, suicide is a voluntary act. “The fact that the decedent chose to die, to leave behind all loved ones, to sever irreparably all ties with family and friends, to deliver an unanswerable message, and to deprive the survivors of any opportunity to help or to change his mind, make the fact of suicide very hard to reconcile”. (p. 338)
2. The reactions that survivors are often left with such as guilt, wondering why, stigma, now seeing suicide as an option for problem solving, difficulties in relationship trust, feeling abandoned, and repressed, unconscious or unrepressed anger (social pressure not to be angry with a dead person). Hauser (1987) in Farberow (1993) points out that unconscious anger may lead to scapegoating; blaming and distancing that can create terrible rifts in families.

Dunne (1987) discussed in Farberow (1993) indicates some symptoms; similar to Post traumatic stress in children, may be found in survivors. An abbreviation of this list of symptoms is:

1. Various cognitive-perceptual problems may occur such as perceptual difficulties about what actually took place; overgeneralizations, losses of memory details; confusion over event sequences and other distortions.
2. Children may sense they will die young or think they will not live beyond a particular period.
3. Developmental regression may take place.
4. Posttraumatic acting out of events, nightmares, dreams regarding events may occur.
5. Suicidal ideation/fantasy and possible contagion may be seen to occur. Preoccupation with death is noteworthy.
6. Flashbacks.
7. Taking on roles left by the deceased is common. (Example: a parent suicides and a child assumes parent's responsibilities. (p. 339-40)

M.13 Impact on a Helping Professional/Caregivers

In these roles, guilt and self-blame can be extra powerful issues (Tanney, 1995). After a suicide, helping professionals and caregivers may be reluctant to work with or be close to someone with suicidal ideation. A Tanney (1995) state there is an "experience of injury to both personal and professional beliefs about self" (p. 109). All the normal responses to grieving are also present. Institutions or agency reviews of the suicide are usually for that agency and not particularly helpful to the caregiver or professional helper (Tanney, 1995). When encountering other individuals at risk a therapist may be at risk of employing a number of defensive mechanisms according to Tanney (1995). Those Tanny (1995) lists are:

1. Indifference, boredom, or inattentiveness.
2. Projection.
3. Reaction formation (i.e. behaviour may be seen in such things as hasty decisions regarding hospitalization).
4. Suppression or denial by negating suicidal potential in the vulnerable person is common. (p. 116)

Caregivers may need professional help to integrate their experience, may need supervision around working with other at risk people and may be advised to limit the number of at risk people working with at one time (Tanney, 1995).

Jacobs & Klein (1993) refer to Maltzberger (1992) with regards to what has been found helpful to professionals when a patient suicides. What Maltzberger suggests is:

1. Consider the usefulness of a psychological autopsy. Psychological autopsies may be useful legally as well. Litman (1965) referred to in Jacobs & Klein (1993) found reviewing the case and presenting it to a colleague as a way for a therapist to work through the pain.
2. Support groups, professional meetings including meetings with experienced supervisors.