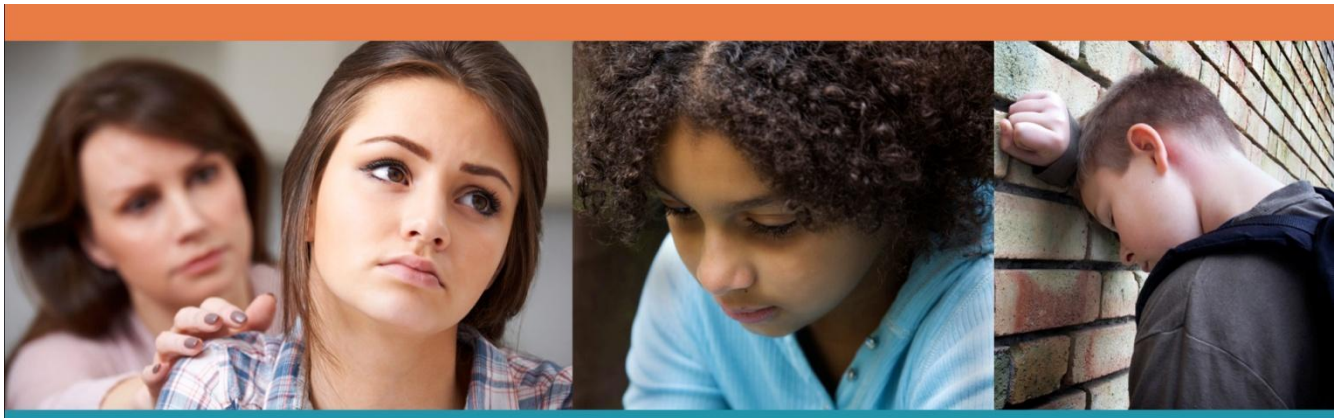

SUICIDE RISK PROTOCOL
A Coordinated Community Response for Youth at High Risk for Suicide

Developed by:

The Child, Youth and Family Services Coalition of Simcoe County

Initially Funded by:

Student Support Leadership Initiative

Supported by:

Simcoe County Child and Youth Crisis Services Steering Committee and community partners

SUICIDE RISK PROTOCOL

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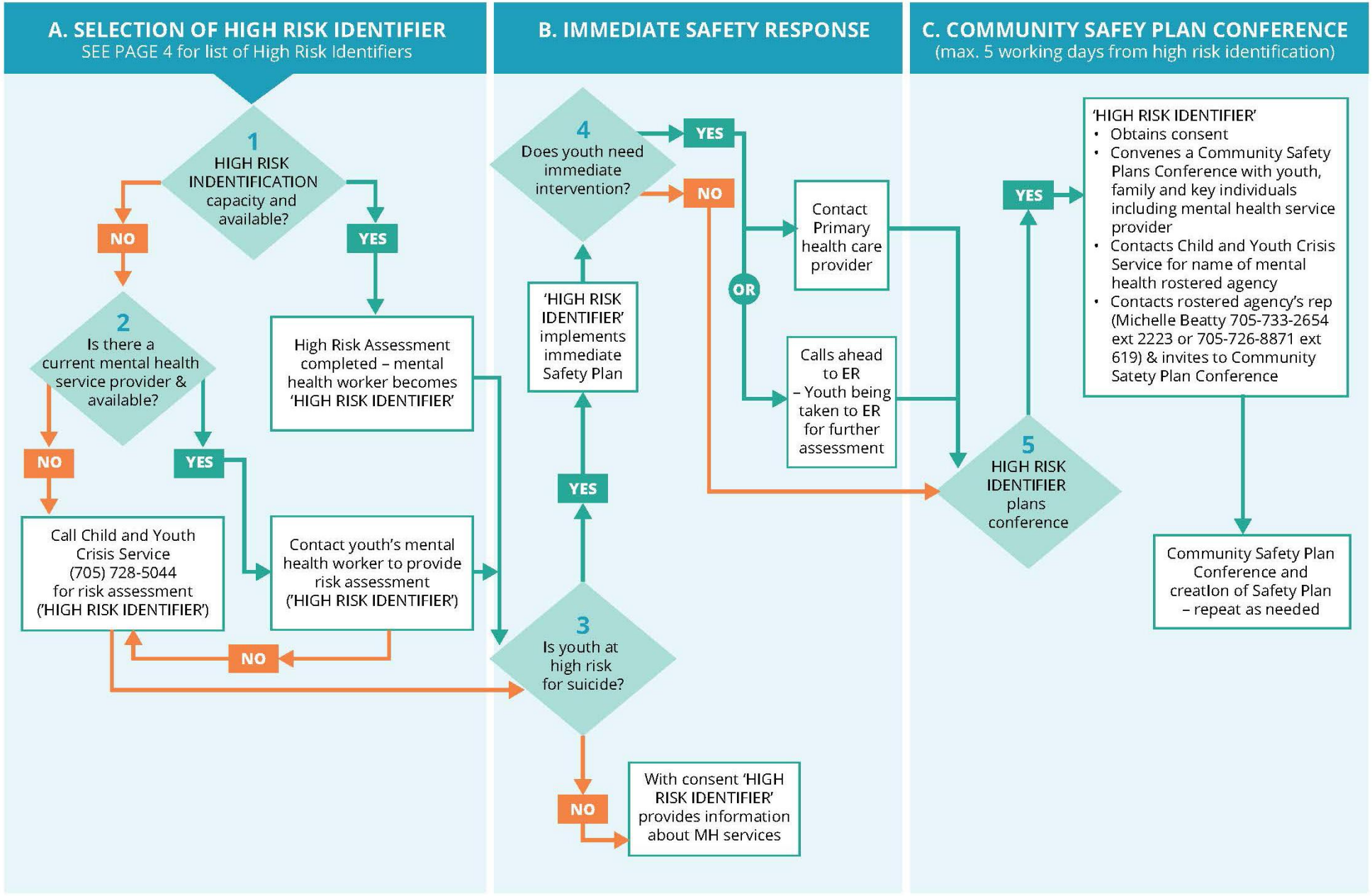
SIMCOE COUNTY SUICIDE RISK PROTOCOL



Introduction

During the past few years, service providers and a number of subcommittees of the Child Youth and Family Services Coalition of Simcoe County (The Coalition) identified the need for a more coordinated response to suicide risk recognition and prevention for children and youth in Simcoe County.

A task group of interested individuals representing educators, hospitals and community agencies was formed to review the Lambton County High Risk Suicide Youth Recognition and Prevention Protocol and to develop a local county protocol to effectively respond to the needs of children and youth who are at high risk for suicide in Simcoe County. Funding was obtained through the Student Support Leadership Initiative and a consultant was hired from Healthtech Consultants to assist in the development of the protocol.

The initial version of the protocol was pilot tested in Barrie by a small group of organizations between February and June 2010. Data was collected and recommendations regarding revisions to the protocol were made. It was suggested that the revised protocol be rolled out to one new Simcoe County community at a time using a mentorship model to facilitate consistency of implementation. The revised version of the protocol was rolled out to an expanded group of organizations in Barrie and to a new group in Orillia in April 2011 as well as to Midland in the fall of 2011. Each community struck a local Implementation Committee to guide the roll out with the chairs of each committee meeting periodically to identify issues with implementation and ensure consistency. Consultation was undertaken with the First Nations Métis and Inuit (FNMI) community and with the Francophone community to seek their input. In addition feedback from the three Implementation Committees was obtained and the Protocol underwent another revision.

The Suicide Risk Protocol: A Coordinated Community Response for Youth at High Risk for Suicide is the result of this evolutionary process**.**

Please note that the term “youth” is used throughout the protocol to refer to children and youth.

The organizational representatives during this process included individuals from across the care and service continuum including:

- Adult Mental Health
- Child Welfare
- Children’s Mental Health
- Children’s services
- Community Health
- Education
- First Nation, Métis and Inuit service providers
- Hospital based Social Workers
- Physicians
- Recreation
- Youth Justice

The Simcoe County Crisis Response Steering Committee acts as an oversight and advisory group for the implementation and continued development of the Protocol. The Steering Committee is comprised of one senior level, decision making representative from each of the crisis service system providers and representatives from affiliated mental health services, hospitals, Children’s Aid Society of Simcoe County, school boards, and police. The Steering Committee is co-chaired by two members, one of whom is a representative of Kinark Child and Family Services, as the Youth Mobile Crisis Service lead agency.

Guiding Principles

The following principles are foundational to the intent and purpose of the protocol.

1. Suicide prevention and support of the dignity of human life are everyone's responsibility.
2. Multiculturalism and diversity are respected and are accommodated whenever possible.
3. Suicidality is an interaction of multiple factors including biological, psychological, social and spiritual components.
4. Risk identification and prevention strategies must be:
   - Client focused,
   - Timely,
   - Evidence-based,
   - Focused on strengths and recovery,
   - Respectful of family, community and culture,
   - Reflective of evolving knowledge and practice, and
   - Integrated and collaborative.
5. Knowledgeable, compassionate and committed communities can play a significant role in risk identification, suicide prevention and access to treatment.
6. Ongoing evaluation will occur and inform protocol changes.

Purpose and Goals

The purpose of the Suicide Risk Protocol is to guide the process to identify children and youth who are at high risk for suicide in Simcoe County and to provide a coordinated and enhanced community service response to address their needs.

The goals of the protocol are to:

- Increase identification of children and youth under 18 years of age who are at high risk for suicide,
- Promote a common pathway to identify the most appropriate resources and short term intervention strategies for these youth
- Enhance cross sectoral inter-agency communication and collaboration through consistent and ongoing sharing of information with client consent,
- Increase community service capacity and responsiveness.

Commitment to Integrated Working and Respect for Sector Differences

It is recognized that the various service providers involved with children and youth at high risk may have different mandates, philosophies and legislative responsibilities that are integral to the ability of each sector to deliver service. It is also understood that participants will work within their scope of professional practice and the mandate of their organization. This protocol is intended to augment and enhance existing service and to provide an integrated response to a child/youth at high risk for suicide. It is NOT intended to replace any existing services.

Because these youth are at high risk, it is expected that agency participation at the Suicide Risk Protocol Community Conferences will be regarded as a high priority and that agency management will ensure and support the attendance of the appropriate personnel.

Process Steps

The process depicted in the flowchart on p. 1 is documented in detail below. The process map is divided into three key phases:

- Selection of High Risk Identifier
- Immediate Safety Response
- Community Safety Plan Conference

Please note the large numbers beside the process steps in the flow chart are cross referenced in the following process description.

For purposes of the Protocol, the professional identifying the child/youth at high risk for suicide will be referred to as the 'HIGH RISK IDENTIFIER'.

A. Selection of High Risk Identifier

NOTE: The First Responder can be any adult or youth who is suicide aware and made aware of a youth at risk of suicide. A High Risk Identifier is a trained clinician who has the skills to identify a youth at high risk of suicide.

In Simcoe County the following sectors have high risk identifiers: Child protection (Simcoe Muskoka Child and Family Services Formerly Children's Aid Society), Children's mental health (New Path Youth and Family Services and Kinark Child and Family Services), hospital ER Doctors or team lead nurses, Catholic school board social worker and psychologists, Simcoe County Child and Youth Crisis Service, Mental Health and Addictions Simcoe County-CMHA youth workers and crisis staff and CCAC Mental Health and Addictions School Nurses.

The goal of this phase in the Protocol is to ensure that each youth identified at high risk for suicide has a HIGH RISK IDENTIFIER who becomes the service navigator for the youth and their family as they proceed through the Protocol.

A Risk Identification Indicator Framework with 'red flags' for high risk is included in Appendix A. It is not intended as a checklist but rather a list of indicators to consider when using clinical judgement in evaluating level of risk.

When a youth is brought to the attention of the HIGH RISK IDENTIFIER, that person determines if the youth is at high risk for suicide, i.e. child/youth presents with active suicide planning, has strength of intent, access to lethal methods and has other high risk factors.

Each organization participating in the Protocol must:

- have an internal process for recognizing youth expressing suicidal thoughts or behaviours,
- determine if they have expertise internally to assess youth at high risk for suicide.

1) Does organization have internal HIGH RISK IDENTIFICATION capacity and availability?

IF YES, the organization determines that they have internal capacity to identify youth at high risk for suicide, that person becomes the HIGH RISK IDENTIFIER when a youth is assessed to be at high risk.

IF NO, the organization determines that they do not have internal capacity to identify youth at high risk for suicide and further assessment is required, two options are available.

2) Is youth currently involved with a mental health service provider?

IF YES, the youth is currently involved with a mental health service provider, the mental health worker is contacted. If the worker is available, they assess the youth and that person becomes the HIGH RISK IDENTIFIER.

IF NO, the youth is not currently involved with a mental health service provider or the worker is not available, the individual who has concerns about the youth's suicidal intent follows their own organization's internal process to determine who, within the organization, will contact the Youth Crisis Service. Alternatively it may be decided in discussion with the parent, that the parent will contact the Youth Crisis Service. The Youth Crisis Worker becomes the HIGH RISK IDENTIFIER.

The Youth Crisis Service can be reached at 705-728-5044. Refer to Appendix F for further information about the Youth Crisis Service.

B. Immediate Safety Response

The HIGH RISK IDENTIFIER determines if the youth is at high risk for suicide, i.e. child/youth presents with active suicide planning, has strength of intent and access to lethal methods and has other high risk factors.

3) Is youth at High Risk for Suicide?

IF YES, the HIGH RISK IDENTIFIER:

a) Implements an immediate safety plan to address the concerns presented by the youth

b) Determines if further urgent assistance is needed at that point to address the youth's safety.

IF NO, (the youth is NOT at high risk for suicide), with consent the HIGH RISK IDENTIFIER refers the youth and family to an appropriate community organization.

4) Does the HIGH RISK IDENTIFIER require further assistance to address the youth's safety?

IF YES, the HIGH RISK IDENTIFIER can contact:

- Youth Crisis Service
- Primary health care provider
- Emergency Room for assessment of hospital admission for safety

IF NO, the HIGH RISK IDENTIFIER begins the process for convening the Community Safety Plan Conference within five working days.

C. Community Safety Plan Conference

Purpose

The Community Safety Plan Conference is intended to fulfill the following purpose:

I. Review high risk indicators, supporting evidence and current status of youth.

II. Create a safety plan for the youth that includes identification of specific resources and intervention strategies to reduce the risk of suicide and outline interventions to bridge the client through the wait for ongoing service if necessary. This safety plan will build on the one that was developed by the HIGH RISK IDENTIFIER in creating an immediate safety response (if one was developed).

III. Inform the youth and family of community resources that may be of assistance to them.

The HIGH RISK IDENTIFIER determines if the youth was involved with pre-existing community mental health services at time of identification of high risk.

5) Was youth receiving mental health services prior to crisis?

IF YES, the HIGH RISK IDENTIFIER contacts that mental health service provider and invites them to attend the Community Safety Plan Conference.
IF NO, a representative of a mental health agency from the local community mental health roster will be invited to attend.

Community Mental Health Roster

To assist with planning for the youth, it is important to have a representative with knowledge and skills in the child and youth mental health field in attendance at the Community Safety Plan Conference. In instances when the youth is not already involved with the child and youth mental health services, in order to ensure appropriate representation and mental health input at the Community Safety Plan Conference, a rotating roster of child and youth mental health agencies has been developed.

The Simcoe County Child and Youth Crisis Service maintains the roster of children's mental health organizations (New Path and Kinark) who have agreed to participate in the protocol and support the community conference on those occasions when the youth is not currently involved with a community children's mental health service provider. The rostered organization will designate a single contact individual to respond to protocol requests to attend the Community Safety Plan Conference. While attendance in person is preferable, given time constraints, participation may occur by teleconference. The composition of the roster is tailored to the child and youth mental health services available in each community.

As needed the following organizations can be contacted based on the needs of the client:

1. Simcoe Community Services – Laurie Straughan 705-727-1235 ext. 236
2. Catulpa – Sheryl Eastop 705 528-6894
3. Centre for Behavioural Health Sciences – Stefanie Smith – (705) 728-9143 ext 2259
4. CMHA Youth Addictions Counsellor – 705-726-5033 ask to speak to on duty support

At the community case conference, the representative of the mental health rostered organization will:

- Contribute mental health information to the discussion
- Provide information about community resources and
- Assist with referral to selected community services if the youth and family consents**.**

Preparation for the Community Safety Plan Conference

The HIGH RISK IDENTIFIER

a) Outlines Risks and Benefits

Prior to the Community Safety Plan Conference, it is important that the HIGH RISK IDENTIFIER prepare the youth and family for the conference including discussion of the expected activities and participants. They should be made aware that they will have an opportunity to discuss social, emotional and mental health issues impacting them. The conference can include family, friends, teachers and mental health workers as part of their support team.

It is also important to discuss the overall risks and benefits to participating in the conference. The risks and benefits should be tailored for the specific youth/family. They include, but are not limited to the following:

Potential benefits of participating in the Protocol:

- A safety plan and support strategies are developed to assist until community mental health services can provide further services to the youth and family
- Youth and family feel supported.

Potential risks of participating in the Protocol:

- Being withdrawn during a class
- Feeling self-conscious about receiving service
- Experiencing emotional discomfort/embarrassment about the concerns being discussed.

Potential consequences of not participating in the Protocol:

- Distress about personal issues could interfere with the youth's life
- Relationships, including family relationships, could be negatively affected
- Not being treated for mental health problems like depression can lead to ongoing suicidal thoughts and feelings

b) Obtains Consent

Obtain informed consent from the youth and/or parent/guardian to obtain/release/share information which is necessary for inter-agency communication and collaboration. The consent will have a time frame noted and an explanation that it will remain in effect to allow sufficient time for follow up. The written consent may be obtained at the meeting but verbal consent will have been obtained prior to the meeting. The consent form is found in Appendix B.

c) Issues Invitations

The HIGH RISK IDENTIFIER invites key individuals to attend the Community Safety Plan Conference in discussion with the youth and family. These may include:

- Child/youth
- Parents/guardian
- Relevant school personnel
- Any professional currently providing service to the child/youth
- Mental health professional involved with the parent(s) if appropriate
- Support person identified by the child/youth or family if requested
- Representative of community mental health services organization (by roster if not already involved)
- Family physician/pediatrician, if available, or inclusion of recent information if appropriate
- Hospital social worker, if relevant.

If identified professionals wish to attend but are unable to do so, participation by teleconference will be made available. If they cannot participate and wish to provide input at the conference, the HIGH RISK IDENTIFIER will obtain and present information on their behalf.

d) Facilitates Conference

The following responsibilities are assumed by the HIGH RISK IDENTIFIER during the Community Safety Plan Conference:

1. Obtain signatures on consent form if not secured prior to case conference.

2. Facilitate discussion and document recommendations using the Community Safety Plan Conference template. Please see Appendix C for Safety Plan Template, Appendix D for Suggested Safety Plan Components and Appendix E for No Harm Agreement which may form part of the Safety Plan.

3. Ensure Community Conference Safety Plan is signed off by all present and copies are distributed before the meeting ends.

4. Ensure distribution to those not in attendance with the consent of the client.

5. Ensure information about making a referral to children's mental health agency for ongoing service with youth/parent consent.

6. Ensure appropriate communication linkages between the key players including family physicians, school, mental health agency and family members, to ensure subsequent collaboration.

7. Follow up if required by the High Risk Identifier.

8. Email tracking form to Gail Hamelin, Kinark gail.hamelin@kinark.on.ca) for data collection immediately following the safety planning conference.

Conflict Resolution

It is expected that the community conference participants will attempt to resolve any conflicts among themselves. However, when an amicable resolution cannot be achieved, those involved will direct the conflict to the management of their respective agencies who will attempt to reach consensus.

If the conflict involves a service systems issue, the situation may be referred to the Simcoe County Crisis Response Steering Committee.

End of Protocol

The protocol and the role of the HIGH RISK IDENTIFIER are ended when:

- Youth is on wait list of a mental health organization (service coordination is picked up by the community mental health agency), or
- Youth and family decline Community Safety Plan Conference, or
- The Community Safety Plan Conference has occurred, a safety plan is in place and there is evidence of reduced risk/increased support and further service is not necessary at this time, or
- Following the Community Safety Plan Conference, the youth and family decline referral to a mental health agency.

Protocol Appendix A: Risk Identification Indicator Framework

Indicators for Identifying Suicidality in Cases Requiring Urgent Enhanced Service

Social Support and Protective Factors

In identifying risk, it is also important to look for protective or social support factors which when activated or discussed may actually lessen action to commit suicide.

These factors are important when developing the 'Community Conference Safety Plan' and when determining whether a child/youth no longer appears to be at high risk of suicide.

Please note the factors are NOT listed in any priority.

Social Support Factors	Protective Factors
Family and/or caregiver providing support or willing to provide support	Has demonstrated skills for handling emotional crises
Close friends with positive influence	Religious, cultural or spiritual beliefs
School Staff, School Support Plan	First nations beliefs about the sacredness of life
Peers, Neighbours, Co-workers, Elders, caring community	Has history to solve problems and create solutions
External social supports: teams, clubs	Expression of concrete and detailed positive future plans
Strong sense of connection to cultural and spiritual roots	Willingness to sign a No Harm Agreement *
Mental Health and Therapeutic Support in place	Family commitments: Raising children, care of siblings
Willingness of child/youth to use supports	
Perception of social acceptance	
Participation in a religious, spiritual and/or cultural community, including language, teachings, rituals and traditions	

* Components and information about a No Harm Agreement can be found in Appendix E

The following indicators are intended to assist individuals who are serving children/youth to identify those who may be at high risk for suicide and may require an urgent, community coordinated response to reduce risk and promote effective coping and adaptation. The user is advised to consider the broad range of factors in identifying a child or youth as 'high risk'.

PLEASE NOTE: This is NOT intended as a checklist. Rather, the following is a list of indicators to consider as an information-gathering tool to evaluate level of risk. One indicator alone may be enough to identify high risk.

Red Alert Indicators

All of the factors noted in this section of the protocol may contribute to high risk for suicide. The following factors in combination should receive particular attention and be seen as 'red alert' indicators.

Detailed Plan	Degree of lethality	Strength of intent	Previous attempts and/or verbal threats
Available means (e.g. guns, medication, etc.)	Diagnosis of mood disorder or psychosis	Frequent substance abuse	Relationship Loss
Impulsiveness	Statements of hopelessness	Giving away prized possessions	Experience of discrimination and/or racism

There is no absolute test or predictive method which accurately identifies children/youth who will attempt suicide.
Rather, this behaviour is best viewed as a risk potential continuum, ranging from low through moderate to high. The indicators noted on the following table relate to those which contribute to a high risk for suicide and those protective indicators which may reduce risk.

Please note the indicators are NOT listed in any priority.

Suicidal Behaviour History	Age and Gender	Mental Health Status and History	Family and Social Factors	Impaired Coping Capacity
Detailed Plan	Male and over 16 years of age	Suffering from a Mood Disorder	Demonstrates poor communication	History of poor coping response to stress
Previous suicide attempts and/or verbal threat	Female presenting as depressed with history of suicide attempts	Psychosis	Lack of warmth in relationships	Ineffective problem solving
Strength of Intent	Male displaying conduct problems	Anxiety Disorder	High levels of conflict	Pessimistic view of life
Plan including lethal method to achieve the outcome		Conduct Disorder	Parent(s) are openly rejecting of the child/youth	History of running away
Available means (e.g., medications, gun)		ADHD	Parent(s) demonstrate mental health problems	Refusal to accept help or engage with adults
Giving away prized possessions		History of psychological trauma	Death of a parent /relative/friend	Openly hostile to offers of assistance
Statements of hopelessness		Sudden mood change (e.g., disappearance of depression, sudden resolve)	Parent(s) abuse(s) drugs or alcohol	Statements of hopelessness
Indicated a clear preference for death		History of previous mental health related hospital admission (particularly previous 3 months)	Family violence is present	Suffers from a chronic illness and/or is physically disabled

Suicidal Behaviour History	Age and Gender	Mental Health Status and History	Family and Social Factors	Impaired Coping Capacity
Change in sleep, appetite and/or energy level			Experiencing discrimination, racism	
Persistent ongoing suicidal ideation			Recent attempted or completed suicide of a friend, relative or community member	Socially isolated
Positive fantasies about death			Family economic stress, situational or chronic poverty, limited educational, social engagement and job opportunities	Anniversary of a significant loss
Engaged in self-injurious behaviour			Inter-generational family trauma due to residential schools or "Sixties Scoop"	Impaired or declining school performance or attendance
Youth Populations Experiencing Discrimination, Cultural Stress *	Loss and Rejection	Personality Characteristics	Abuse and Neglect	Substance Abuse
Gay, lesbian, bi-sexual or transgendered child/youth	Relationship Loss- Love interest, Parents Friends, Peers	Impulsiveness	History of sexual, physical, emotional abuse and/or neglect	Frequent substance abuse
First Nation, Métis and Inuit (FNMI) background	Alienated from parents and family	Aggressive and hostile / violent behaviour		Ongoing use of alcohol and/or drugs
Racial targeting of other groups	Subject of ongoing bullying	Passive		
	Having a disciplinary crisis at home, school or the courts	Overly responsible and concerned with perfection		
		Easily disposed to feelings of self-blame and guilt		

* See Appendix G, Risk Factors for FNMI Youth from *The Royal Commission on Suicide Among Aboriginal People in Canada*

Appendix B: Suicide Risk Protocol for Youth

Consent to Release and/or Obtain Information and for Participation in a Community Conference

I, _____ (Self / Parent / Legal Guardian) give permission to:

List of agencies / organizations with check boxes and space for 'consenter' to initial

	Agency / Organization Name

To RELEASE, OBTAIN and/or SHARE mental health, medical, educational and family information about

_____ (child/youth). Date of birth_____

Please note exceptions to any of the above: _____

_____

This consent is valid for the period of (time duration)_____ from the date of my signature.

The purpose of this consent is to assist in the coordination of services provided to me and/or my family.

At any time, I may withdraw this consent in writing.

_____ _____

Signature of Youth over age 12 Signature of Parent/Legal Guardian

_____

Witness ☐ copy to client

_____☐ reviewed risks and benefits relative to Community Safety Plan Conference

Date

Appendix C: Community Safety Plan Conference Template

Community Safety Plan Conference Plan for Child/Youth at High Risk for Suicide

Name of Child/Youth	
Youth Address	
Youth Phone Number	
Date of Birth	
Gender	

Parent / Guardian Name(s)	
Parent/Guardian Address(s)	
Parent/Guardian Phone Number(s)	

☐ Confirmation of High Risk for Suicide

Social Support and Protective Factors Evidence	
Risk Indicators and Supporting Evidence	

Community Safety Plan Conference Safety Plan – Strategies / Activities /Interventions

Activity/Intervention	Person Responsible	Timeframe

Other Significant Information (e.g. family, medical, social, emotional)	

High Risk Identifier	
Date of Conference and Safety Plan	
Youth Signature	
Parent(s') Signature(s)	

Key Participants in Plan (add as needed)

Signature	
Name	
Organization	
Contact Information	

Signature	
Name	
Organization	
Contact Information	

Signature	
Name	
Organization	
Contact Information	

Appendix D: Suggested Components of Safety Plan for Suicidal Youth

The following components may assist in developing a safety plan at the Community Safety Plan Conference. This is a process best accomplished with the youth, family members and other key individuals in their life. The following are examples only. It is necessary to collaboratively identify components of the plan that are relevant for that individual and concretize the plan in writing. Discuss possible barriers to the use of the plan at different stages and how to overcome those barriers, where to keep the plan and who has copies of it. Ensure that individuals who are key to the plan understand their role.

1. Identify when youth should refer to the plan. Help youth:
    a. Recognize warning signs of distress -. thoughts, images, mood, behaviour, eg. 'I'm a failure, I can't cope any longer', stomach aches, feeling stressed, feeling hopeless, making references to dying
    b. Recognize triggers that are tailored to the individual – eg. can be loss of relationship, poor mark in school, repeat experience of being bullied

2. Identify and plan implementation of coping strategies youth can use on own:
    a. Include self soothing and relaxing activities that are relevant for that individual such as exercising, going for a walk, praying, listening to uplifting music, getting involved in a hobby they've enjoyed etc.

3. Increase time spent with others:
    a. List normal social environments which can distract from suicidal thoughts without youth having to specifically discuss suicide eg. going for coffee with friends, to library, for a walk with friend etc.

4. Identify specific individuals the youth can talk with about suicidal thoughts to help resolve a crisis:
    a. Develop list of appropriate individuals with their contact information
    b. Ensure these individuals are aware of their role and how to help
    c. Include mental health professionals and their contact information – ensure that it includes after hours crisis contact information too

5. Make environment safe to increase supervision and reduce potential access to means:
    a. Include home, school and community contexts
    b. Include removing or securing items that may be used for self harm such as medications, potential weapons
    c. Schedule increased supervision by friends, family etc.

6. What to do if youth is still feeling unsafe:
    a. Make doctor's appointment, use crisis service, make counselling appointment
    b. Write down ways to get immediate help to get to the Emergency Department such as calling 911, telling parent they need a drive

Appendix E: No Harm Agreement

A No Harm Agreement is an agreement which can be discussed with the youth at high risk for suicide. If willing agreement is present, it can be viewed as a protective factor in the ongoing assessment of risk and can be incorporated into the safety plan development.

However, it is important to note that it is only a tool and is NOT predictive of any action by the child/youth.

Contracting a No Harm Agreement

A No-Harm Agreement should be written but it can be a verbal/spoken plan and agreement.

The child/youth at risk should be able to describe what they are agreeing to, in their own words. If the child/youth is unable to describe the plan in sufficient detail, further discussion with the child/youth is indicated.

Components of a No Harm Agreement

The components of the No Harm Agreement are as follows:

Keep Safe

This is critical to every contract and is a statement requiring the child/youth at risk to NOT act upon thoughts of suicide for a specific period of time. It does not require the child/youth at risk to stop thinking about suicide.

It is recommended that the child/youth be asked how long they believe that they might be able to keep the agreement

For example, contracting to do no harm may read as follows: “I agree not to harm myself until after I meet with XXX. I might think about suicide but I must not act on those thoughts.”

The specifics can be tailored to the individual and their situation.

Safety Contact(s)

Safety contacts are individuals who the child/youth should contact if they feel that they are unable to keep safe. The contact individual(s) should be someone who knows that the child/youth may contact them; they have to agree to be a safety contact and/or can be an organization which regularly deals with suicide situations, such as a crisis line. A child/youth at risk may need more than one individual to act as a safety contact.

Safe/No Use of Alcohol/Drugs

It is important to assist the child/youth to understand that alcohol and drug use can increase the risk for suicide and can endanger the success of a No Harm Agreement. Ideally, alcohol and drug use should be avoided. In some situations, agreement for abstinence may be impossible to obtain. Reaching agreement for an active reduction or minimal use may be more achievable.

The child/youth should be encouraged to continue appropriately prescribed medications under supervision.

Appendix F: Youth Crisis Service Information

Available
- Monday – Friday 9am – 7pm
- Saturday and Sunday 12pm-7pm

Call the CRISIS LINE at: 705-728-5044 or 1-888-893-8333

Who is eligible for service?
- Any child or youth under the age of 18
- Families of a child or youth experiencing a crisis

When to make the call:
- When a crisis is not imminently life threatening but requires immediate intervention
- When a child or youth appears depressed, aggressive and/or suicidal
- Family members are concerned about aggressive or out of control behavior
- When there are concerns about disturbing or unusual behaviors by a youth

Youth mobile crisis workers can help:
- Immediate telephone response within 60 minutes of initial call
- Help determine level of risk for the child and to identity the next steps where there is an evident risk
- May attend on site once immediate risk is resolved to provide further crisis management
- Work with youth and their families to develop crisis plans and safety plans
- Provide information about children's mental health services and provide referral information for community services and resources depending on needs identified
- 21 day follow up with a crisis worker when appropriate

Suggested Website Resources for Youth and Families:
- **www.teenmentalhealth.org**
- **www.mindyourmind.ca**

Appendix G: Risk Factors for FNMI Youth

Risk Factors

The following is a list of the primary and secondary risk factors that contribute to the high rates of suicide, self-injury and self destructive behaviours among First Nations, Métis and Inuit (FNMI) youth as presented by The Royal Commission Report 1995 and Suicide Among Aboriginal People in Canada: National Aboriginal Health Organization (2007 p.p. 49-51)

Primary Risk Factors

Psycho-biological	low self esteem, unresolved grief, helplessness, hopelessness, hostility, unhappiness, sexual orientation, gender (male), age (over 12), marital status, no children/siblings
Situational	stressful life events, disruptions of family life, boarding school, adoption, gambling disorder, fly-out hospitalization, drug use, alcohol use, poor school performance, solvent use, family breakdown, community breakdown, physical abuse, sexual abuse, violence disorder, family history of suicide, recent loss to suicide, parents criminal behavior, previous attempts, suicide ideation, poor care by father, parental loss (prolonged separation), involvement with prostitution, beliefs that suicide is an option
Socio-economic	high rates of poverty, low levels of education, limited employment opportunities, inadequate housing, homelessness, inadequate sanitation, inadequate water quality, no child care, low levels of social supports
Culture Stress	loss of confidence in the ways of understanding life and living loss of land, loss of control over living conditions, suppression of belief systems and spirituality, weakening of political and social institutions, racial discrimination, suppression of language, identity (disorder), weak identification with culture and community, suppression of cultural identity

Secondary Risk Factors

- FAS/FASD
- Major depression/Bipolar disorder
- Post Traumatic Stress Disorder
- Anxiety disorders
- Panic disorders
- Schizophrenia disorder
- Personality disorder
- Emotional distress
- Psychiatric disorder
- Seasonal Affective Disorder (SAD)

Protective Factors

The Royal Commission on Aboriginal People Report (RCAP) was both "criticized for promoting traditional solutions that would stall modernization in Aboriginal communities and praised for attempting to address a complex problem and to move Aboriginal communities toward health and wellness on all levels."

Nancy Miller Chenier (1995) Suicide Among Aboriginal People. Library of Parliament. (www.turtleisland.org/healing/healing-suicide1.htm) Turtle Island Native Network/Healing and Wellness, accessed on Sept 3, 2010)

Paradoxically, it is the promotion and application of traditional knowledge approaches that have been identified as a protective factor against suicide and that "cultural beliefs that engender a sense of self-worth in the face of negative social perceptions" (p.69) are required to strengthen the community.

The Framework for Action proposed by RCAP includes the following protective factors:

- ✓ Cultural and spiritual revitalization
- ✓ Strengthen family and community bonds
- ✓ Focus on children and youth
- ✓ Holism
- ✓ Whole community involvement
- ✓ Partnership
- ✓ Community control
- ✓ Cultural sense of language and traditions
- ✓ Positive cultural identity
- ✓ Traditional values
- ✓ Rituals and Healing ceremonies

In order to facilitate a holistic approach to address the issue of suicide RCAP also recommended the following supportive resources required:

1) Direct suicide crisis services
2) Resources for broad prevention through community development
3) Self determination/self-sufficiency/healing
4) Reconciliation.

Appendix H: Community Wellness Bundles

First Nation, Métis & Inuit
Community Wellness Life Bundle

Background

The FNMI Community Wellness Life Bundle outlines cultural indicators and cultural approaches that will be included as the FNMI Protocol and process as part of the "High Risk Suicide Protocol for Youth" (2010).

The following list of the identified FNMI service and program providers have been invited in an Advisory capacity:

BANAC
Enaahtig Healing Lodge and Learning Centre
Enaahtig Mental Health Program
Georgian Bay Native Friendship Centre
Barrie Native Friendship Centre
Biiminawzogin Regional Aboriginal Women's Circle
Rama First Nation
Beausoleil First Nation
Georgian Bay Native Women's Association
Orillia Native Women's Association
Métis Nation of Ontario
Simcoe County District School Board
Simcoe Muskoka Catholic District School Board
Georgian College
Catulpa Community Support Services
Simcoe CAS
Kinark Child and Family Services

Introduction to the FNMI Community Wellness Life Bundle

Using traditional (cultural) community knowledge to solve contemporary issues is essential and fundamental to the continued survival of FNIM communities. Building community wellness life bundles is one way in which individuals, families and communities are encourage to stay focused on what is needed to strengthen resiliency to premature death (suicide) taking the lives of our children/youth/future leaders.

A Statistical Profile on the Health of First Nations in Canada (2003) reflects that Aboriginal people ('protected' under the Indian Act) exist well below standard living conditions, increased rates of serious diseases and poor general health.

With respect to suicide, all First Nations age groups up to age 65 are at increased risk, compared with the Canadian population (Lemchuk-Favel 1996).

> Suicide and self-injury were the leading causes of death for Aboriginal youths. In 2000, suicide accounted for 22 percent of all deaths among Aboriginal youth (aged 10 to 19 years) and 16 percent of all deaths among Aboriginal people aged 20 to 44 years.[1]
>
> Suicide rates of Registered Indian youths (aged 15 to 24) are eight times higher than the national rate for females and five times higher than the national rate for males.[2]

[1] Health Canada (2002) A Statistical Profile on the Health of First Nations in Canada, Ottawa: Health Canada.
[2] First Nations and Inuit Health Branch, Health Canada.

In 2005, there were 24 completed suicides in Nishnawbe Aski Nation territory, one of the highest rates in Canada.[3]

Background Information

The FNMI Community Wellness Life Bundle is informed by the Peigan/Blackfoot Nations philosophy in action of sacred bundles in a contemporary context. Building on the concept of sacred or medicine bundles, the FNMI Community Wellness Life Bundle is best described as the physical and abstract components of best practices for life promotion, (suicide prevention), risk management and intervention, postvention and supportive resources, and promotion of stability.

Sacred Bundles are described as a personal or community bundle that contain physical 'sacred items' such as eagle feathers, tobacco, ceremonial pipes, and any other item of spiritual value to the bundle's keeper.

In addition to the physical components of sacred bundles, there are abstract components such as songs, prayers, teachings, dances, dreams, stories, etc. In a contemporary context the physical components may also include case management, training, documentation, and evaluation.

Many First Nations people who follow their Traditional Teachings will have sacred items to help and guide them. A sacred bundle can consist of one or many sacred items. It can be the little tobacco pouch that someone wears around their neck or it can be the items that the spirits have given to a person to carry for the people.

Personal Bundles

You may have a personal bundle that you have built with items you have gathered and that you take care of. This bundle is sacred to you. It contains items that help you in your personal development; it contains items that have given you a teaching and that you use in ceremonies. Maybe your parents or your grandparents or an Elder gave you something to help you on your path. All the contents of your bundle relate to you.

Your personal bundle may include medicines, your drum, a bowl, a rock, your colours, a feather, a staff, a rattle and our pipe. You may also carry clan marker, something that represents your clan, such as a bear claw if you are of the Bear clan. Tobacco is always first in your bundle. These items remind us of the beauty of Creation.

Bundles for the People

The bundles for the people are used for healing and ceremonies. It is said that these bundles contain things that the Nations need to survive. The Healers who carry the medicine bundles say they do not own these bundles. They say that our people's understanding is that we do not own anything, not even our physical body, which is given back to the earth when we die.

They carry these items as gifts for the people. The Healers who take care of these bundles have been chosen by the spirits to carry on the teachings, the work and the responsibilities that come with these bundles. (Anishnawbe Health Toronto, 2000)[4]

The First Bundle

The Seven Grandfathers Teaching (bundle) is a central component of the Community Wellness LIfe Bundle as it provides a clear set of values to guide the community towards the common vision of survival, while ensuring clear roles

[3] Cheechoo, Catherine, Serene Spence and members of the Nishnawbe Aski Nation Decade Youth Council, Thunder Bay. (2006). The Seventh Generation Helping to Heal: Nishnawbe Aski Youth and the Suicide Epidemic. Toronto: Voices for Children.

[4] (http://www.aht.ca/resources/traditional_teachings/sacred_items_and_bundles)

and responsibilities. The community bundle must be viewed from the context of being a foundational toolkit for building families and communities, cultural and spiritual revitalization, community stability and self-determination. This seven grandfathers' bundle is based on an Aboriginal knowledge and worldview that is not structured in a hierarchy but rather focuses on balance and respect for ALL of life (Creation).

From the traditional teachings of the Ojibway peoples, one of the first bundles to come to the people was The Seven Grandfathers (Niishwaaswe Mishomisag) Teaching.

The first interpretation of the Seven Grandfather Teachings is provided by the Ziibiwing Centre of Anishinabe Culture and Lifeways, (n.d) from the Saginaw Chippewa Indian Tribe of Mt. Pleasant, Michigan, this teaching is considered to be given from the "First Elder" to provide guidance and direction to ensure the survival of "Mother Earth and the community of life."

> The First Elder gave us the gifts of knowledge that he received from the Seven Grandfathers when he was a little boy.
>
> Each Grandfather gave him a great gift. One gave him the gift of NIBWAAKAAWIN (Wisdom), and he learned to use that wisdom for his people.
>
> Another gave the gift of ZAAGIDWIN (Love), so that he would love his brother and sister and share with them.
>
> The third Grandfather offered the gift of MANAADJITOWAAWIN (Respect), so that he would give respect to everyone, all human beings and all things created.
>
> AAKODEWIN (Bravery) was the next gift, the courage to do things even in the most difficult of times.
>
> A fifth Grandfather gave the boy GWEKOWAADIZIWIN (Honesty), so that he would be honest in every action and provide good feelings in his heart.
>
> Another Grandfather offered DIBAADENDIZOWIN (Humility), to teach the boy to know that he was equal to everyone else, no better or no less.
>
> The last gift that was given to the boy was DEBWEWIN (Truth). The Grandfather said, "Be true in everything that you do. Be true to yourself and true to your people. Always speak the truth."
>
> The Grandfathers told him, "Each of these Teachings must be used with the rest. You cannot have WISDOM without LOVE, RESPECT, BRAVERY, HONESTY, HUMILITY, and TRUTH.
>
> ...We must go back to the knowledge that the Seven Grandfathers taught the First Elder, who then passed the Teachings on to the next generation, and so on. The Seven Grandfather Teachings will remind us how to treat one another and our children. Each of us is responsible for taking care of the children and of Mother Earth. The children are the ones who must care for Mother Earth tomorrow, and for the generations to come.

In another re-telling of the story by Melvina Corbiere (2007), the seven grandfather teachings were received in the sky realm and given to "Oshkaabewis" (helper) to take back to the people. These teachings "were all in a huge bundle." (p.23)

> This bundle was heavy, so Oshkaabewis got Otter (Nigig) to help with the bundle. So they set off on the long journey back to the world. Finally they arrived at the place where the people lived. By this time, the boy had become an old man. Also, by this time, the boy's parents had become very old, but they were still alive. They just knew he was their son when they saw him, and they welcomed him back

home. The people of the village also welcomed him back. He opened the bundle he had brought and told the people about the teachings the Grandfathers (mishomisag) and began to follow the teachings. (p.23-7)

Love (Zaagidwin): To care for and help one another.
Respect (Mnaadendmowin: To take care of all things the Creator has given on Mother Earth (Kiing).
Wisdom (Nbwaakaawin): To seek and share knowledge.
Bravery (Aakdehewin): To be ready to face all the things that are hard to do
Honesty (Gwekwaadziwin): To speak right of things – not to lie, cheat or deceive
Humility (Dbaadendizwin): To know that each of us is a part of creation and that all people are equal
Truth (Debwewin): To recognize the work of the Creator in all things. (p.19)

The third re-telling of the story is from the Mishomis Book: The Voice of the Ojibway (1976) by Edward Benton-Benai:

The boy had been given a huge bundle to take to his people from the Seven Grandfathers. Ni-gig' and the boy took turns carrying the bundle. Along the way, they stopped seven times. At each stop a spirit came and told the boy the meaning of one of the seven gifts that were given to him out of the vessel of the Grandfathers.

1) To cherish knowledge is to know WISDOM.
2) To know LOVE is to know peace.
3) To honour all of the Creation is to have RESPECT.
4) BRAVERY is to face the foe with integrity.
5) HONESTY in facing a situation is to be brave.
6) HUMILITY is to know yourself as a sacred part of the Creation.
7) TRUTH is to know all of these things.

As a value, The Seven Grandfathers Teaching significantly informs and sets the individual and community vision for creating community making the Seven Grandfathers a significant abstract aspect of a Community Wellness Suicide Bundle.

Addressing the Barriers

At this point, it is important to denote how cultural attitudes about suicide limit and contribute to community-based initiatives. Rather than make generalizations about community beliefs, it is important for individual communities to define their relational understanding and response to 'suicide' from their own cultural perspective. How a community understands and responds to the word 'suicide' is significant as it will impact on the community moving forward.

For example, one widely used resource to address Aboriginal suicide prevention and intervention is SuicideTALK: An Exploration in Suicide Awareness (2002). It states that suicide is kept taboo and stigmatized in society so that people avoid talking about suicide, as it is considered "evil, sick, contagious, fearful, etc." (p. 39) It also encourages speaking about suicide so the myths and taboos are shattered.

This claim of "secrecy" about suicide is similarly noted in the report, First Nations and Inuit Suicide Interventions Training "Best Practices" (2001). This report was compiled for Nishnawbe-Aski Nation during a time "when 28 young people from Nishnawbe-Aski First Nations in Northwestern Ontario committed suicide." (p.ii) The reports states that the topic of suicide has been hidden in First Nation communities and that cultural beliefs and values have prevented openly talking about suicide.

One Ojibway belief shared with me is that when a person commits suicide their spirit is troubled and their spirit will linger before they embark on their journey to the afterlife. If a family member or friend talks about the deceased this will cause the spirit to remain in the vicinity. Elders have advised not to speak of the person that has taken their life. As well, Elders in explaining why there are so many youth

> taking their lives in the Nishnawbe-Aski communities have spoken about a suicide spirit that tells the young people to take their lives. Thus cultural beliefs and values have for a long time kept a veil of silence in First Nation and Inuit communities[2] (Devlin, p. 10-11).

However, this broad claim to secrecy about suicide as <u>being inherent to cultural beliefs and values</u> is difficult to validate without reasonable evidence. It is likely that many First Nations peoples have adopted/acculturated western ideological shame and fear around suicide. The slow erosion of First Nations identity, culture, tradition and history by government (genocide) policies has resulted in fragmented worldviews. What is evident that inter-generations of grandparents and parents who went to residential school (era 1831 – 1962) were denied and disconnected from their inherent worldview, and ultimately their inherent cultural beliefs and values.

Also, other historical factors[5] have fragmentized First Nations worldviews significantly contributing to "the marginalization, dispossession and cultural devaluation of the Native way" (Devlin, p.16). The most significant historical factor is the disconnection to identity, history, land and language, traditions and practices, the children, the community, and their sovereignty of governance.

Therefore, from an Anishinaabe perspective the suicide being "taboo" (against/opposite of life) is implicitly different from western ideology (moral sin) and should not be transposed. By measuring First Nations worldviews against western worldviews and standards, continues to validate (western) meta-narratives of degenerated cultural beliefs and behaviors of First Nations people.

The context of 'suicide' from the values of the Seven Grandfathers ultimately break down perceived community cultural barriers of talking about *suicide*, shifting the dialogue to by talking about Life Promotion, community wellness and choosing life.

In essence, the community wellness life bundle is not simply about *preventing suicide* but about *promoting life*. From this perspective communities will have a broader and more wholistic opportunity to understand the multitude of factors that contribute to community health and well-being, and create thinking inclusively that strives to ensure their community vision of the physical, mental, emotional and spiritual wellness and well-being.

<u>A Wholistic Approach to Community Wellness</u>

The FNMI Community Wellness Life Bundle takes into consideration the following wholistic components as the cultural context; 1. The physical, mental, emotional and spiritual aspects, 2. The individual, family, community and nation and 3. The Continuum of Care: Life Promotion/(suicide prevention), Risk Management and Intervention, Postvention and Supportive Resources and Action and Evaluation.

These wholistic components as the cultural context are consistent with other community-based approaches and best practices such as the Assessment and Planning Tool for Suicide Prevention in First Nations Communities (2005) which is also a framework for assessing and planning a suicide prevention plan (p.1). It states that cultural continuity is a protective factor against suicide;

> Some of the promising strategies in suicide prevention include programs that are specifically focused on supporting the development of traditional culture within the community. Research seems to show that people with strong spiritual and/or religious beliefs of different kinds are linked with resilience and positive mental health. Resilience is a protective factor in suicide prevention. Programs that include cultural and/or spiritual dimensions would seem to be important in suicide prevention (Kimayer.L. et al.

[5] Examples of these policies include; The Indian Act (1876/1951), Compulsory Enfranchisement (1920), The White Paper (1969).

in NAHO, p.9).

Using a wholistic approach establishes from the onset the cultural importance and recognition of traditional (cultural community) knowledge as the foundation of strength for designing the community life promotion initiative. Additionally, the wholistic approach includes concepts identified as 'best practices' in the Aboriginal Healing Foundation Report, Suicide Among Aboriginal People in Canada (2007). These best practices are; locally initiated, owned and accountable, the responsibility of the community (community driven), community collaborated and coordinated, child and youth focused, inclusive of family and community, wholistic, long term, includes training and education, has a central coordinating group and includes prevention, intervention, postvention and evaluation (p. 104-110).

These recommended programs identified in the Aboriginal Healing Foundation Report were chosen because they contain elements consistent with the 'best practices' identified above. They have been selected as "all reasonable places to start in developing a comprehensive prevention program" (p. 113). These programs are:

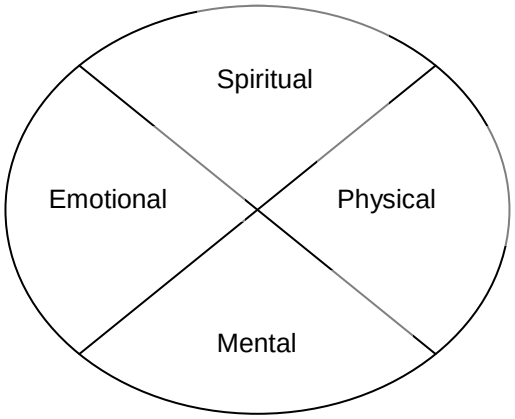
1) Applied Suicide Intervention Skills Training (ASIST) (pp.113-114)
2) 5- Day Suicide Prevention Training for Aboriginal Communities (pp.114-115)
3) White Stone: Aboriginal Youth Suicide Prevention Training for Youth Educators (pp.115-116)
4) Community-Based Suicide Prevention Program (CBSPP) (pp.116-118)
5) Zuni Life Skills Development Curriculum (ZLSD) (pp.118-119)
6) Jicarilla Suicide Prevention Program (pp. 119-120)
7) Northwest Territories Suicide Prevention Training (NTSPT) (pp. 120-121)

From the descriptions provided in the Aboriginal Healing Foundation Report (2007), it can be concluded that although these programs exceptionally meet the criteria for being community created and extensive in mobilizing a community prevention initiative, they are not definitive.

"Given the limited state of knowledge about what works in suicide prevention, research must continue to play an important role"(p. 110). Using a wholistic approach to a FNMI Community Wellness Life Bundle approach to suicide prevention is a possibility that will be a valuable contribution to what is currently available.

Cultural Concepts

I. WHOLISTIC ASPECTS



<u>Physical (body)</u>

Exercise, nutrition and proper amounts of sleep are important to maintaining physical wellness.

<u>Mental (mind)</u>

Mental stimulation is needed for the mind. Knowledge is food for the mind.

<u>Emotional</u>

Emotional well-being comes in many forms depending on the individual. Love, respect and caring are universal for emotional wellness. It is also shown that those who are joyful and enjoy laughter as a regular part of daily life live happier, healthier lives.

<u>Spiritual</u>

The true belief in a power greater than ourselves is necessary for spiritual well-being. Faith in a Creator gives hope and strength to understand that everything in life happens for a reason and that the Creator makes no mistakes. Spiritual wellness is needed to make the world a better place.

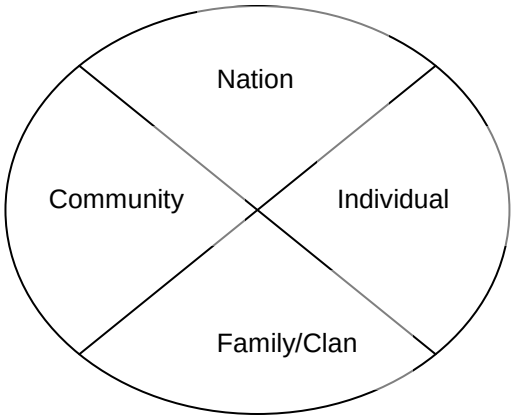
Smudging, traditional ceremonies, singing, drumming and dancing are very powerful for an Aboriginal person connected to his/her cultural identity. Attending the sweat lodge and longhouse are also very spiritual for First Nations people. Most First Nations people also have to feel a connection with Mother Earth, and respect for elders and traditions are highly regarded by most First Nations people.

(Acknowledgement to Gil Lerat,
www.healingourspirit.org/ pdfs/06living/emotionalwellness.pdf, accessed March 3, 2007)

II. KINSHIP

Individual

Individuals bring strength to their family and community; the individual skills and knowledge can be used towards building a stronger community. The individual is interconnected with family/clan and community, what affects one affects the others.



Family/Clan

Their grandparents or other family members rather than their biological parents often raised children and formal adoptions were frequent.

Such an extended family was based on cooperation to survive with clear role definitions and responsibility (Clan system of Governance) for each member.

Community

Communities are not just residents but are members who strive toward a common goal of existing together, usually families, extended families, etc. Communities have their own culture-their own beliefs, attitudes, behaviors and histories. This culture often forms a strong part of their identity- their worldview, behaviour and whom they relate to.

The individual must be free, so also his community. By having its own leaders, controlling the conduct of its own affairs, following customs of its own divisement, each community was free. No community dared presume to interfere with the affairs of another, even in war. In all matters, a community was free (Johnston, 1976, p.72).

As a community develops there is a shared understanding of the challenges it needs to overcome and will make a commitment to work together.

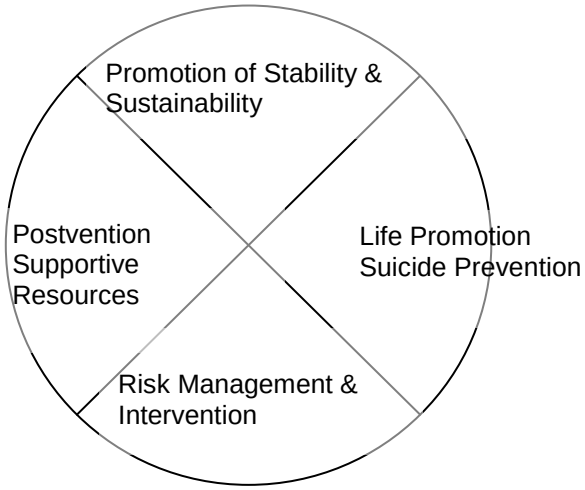
Nation

Several communities coming together would form a Nation. Similar to Peigan Tribes, communities would be scattered over their traditional lands, and meet perhaps once a year (Crowshoe, 1997,p.15).

III. CONTINUUM OF CARE

Life Promotion/Suicide Prevention

Life Promotion and Suicide Prevention is the stage of primary awareness; where community outreach, education/training, access and family (extended family) and youth involvement is mobilized. Whole community partners such as loss survivors, lived experience survivors, police services, governance and government leadership, health services, education services, child and family well-fare and Elders and spiritual leaders are essential for primary suicide and life promotion to occur. Working together, Life Promotion and Suicide Prevention awareness strategies encourage individuals and communities to make life choices that support and strengthen their well-being. It provides the whole wellness VISION of the community.



Risk Management & Intervention

Risk Management is the stage that focuses on early identification and secondary prevention, prevention/management, at-risk assessment and protective supports such as life contracts and personal assessments that build on the strengths and needs including protective factors.

Intervention includes crisis teams/centres, counselling and family programs, health advocacy, access, education and training. Intervention is the stage that requires immediate action to address a 'crisis' and cannot wait for whole community supportive resources to be developed. They must already be in place.

Postvention/Supportive Resources

The postvention stage includes referral intervention, human and financial resources identification, networking and coordination of services, policies and procedures, strategies, self-evaluation/Life Action Plan and Safety Plans. These supportive resources ensure promotion of stability through after-care supports. This stage requires 'specific' supportive resources to address the 'aftermath' of crisis or trauma for individuals, families and communities to restore health and well-being.

Supportive resources such as rehabilitative supports, resource mobilization, bereavement and grief, training and education are included in this stage.

Promotion of Stability and Sustainability

This stage promotes sustainability and stability in balance with adaptability and change. On-going evaluation and research is needed for reflective action and evaluation of practices. Training and education will build leadership and a strong community of practice. Priority funding will promote stability and protective factors and indicators will be accessible and available.

COMMUNITY PLANNING

Developing the Community Wellness Life Bundle from the cultural context of traditional knowledge supports Chandler and Lalonde's (1998) study that demonstrated a relationship between First Nations youth suicide and the community's control, which the authors term cultural continuity. The following list of cultural continuity factors are considered a 'hedge' against suicide in community planning:

- self-government
- land claims
- education
- health services
- cultural facilities
- child protection
- women in leadership
- police and fire services.

> Communities with some measure of self-government in place also had the lowest rates of youth suicide. Land claims and education followed in importance...[c]ommunities with three or more of these factors present experienced substantially fewer suicides... (http://www.hc-sc.gc.ca/fnih-spni/pubs/suicide/prev_youth-jeunes/section2_2_e.html)

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List of Community Agency participants: