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The Suicide Prevention Continuum

Dawn Caldwell

Abstract

The suicide prevention continuum illustrates a practical approach to the complex issue of suicide prevention. The continuum evolved from discussions with two Aboriginal communities in Atlantic Canada about suicide and the different types of interventions available. The continuum offers a framework and reference tool to differentiate between the different stages of suicide risk. It illustrates where the Aboriginal Community Youth Resilience Network (ACYRN) fits into suicide prevention and how it contributes to prevention knowledge, capacity building, and policy development.

Background

Suicide risk is five to seven times higher among First Nations youth than among non-Aboriginal youth of the same age. Between 1989 and 1993, the suicide rate was 126 per 100,000 among First Nations men aged 15–24 years compared with 24 per 100,000 for other Canadian men of the same age group. Young women in First Nations registered a rate of 35 per 100,000 versus only 5 per 100,000 for other Canadian women. In 1999, suicide accounted for no less than 38% of all deaths in First Nations youth aged 10–19 years (Canadian Institute of Child Health [CICH], 2003).

There is a well documented association between suicide risk and mental well being, based on standardized personality scales and inventories to measure individual proclivity to violence (Plutchik and van Praag, 1990), depression (Blatt et al., 1999; Beck et al., 1961), hopelessness (Kazden et al., 1986; Beck et al., 1974), impulsiveness (Plutchik and van Praag, 1989), substance abuse (Mayer and Filstead, 1979) and history of childhood abuse (Milton and Davis, 1993). Research has focussed on individual characteristics such as mental well being and personal coping mechanisms (Simonds et al., 2001), without a holistic approach that would take into account known

external exposures associated with suicide, such as physical violence (both as perpetrator and victim) (Evans et al., 2001), sexual violence (Davidson et al., 1996), substance abuse, and social disconnectedness. Such a holistic approach is particularly important within Aboriginal communities, many of which are small and rural, having less access to resources intended to reduce risk factors for suicide.

Suicide can adversely affect the well being of entire communities — a public health dimension probably even more important in close-knit and often isolated Aboriginal communities (Advisory Group, 2003). This requires a much stronger community — Aboriginal community — role in suicide prevention, not just as implementers of externally motivated programs, but in the conceptualization and design of prevention initiatives that build systematically on Aboriginal strengths.

Origins of ACYRN

In 2003, with technical assistance from CIET, two Aboriginal communities in Atlantic Canada explored adolescent suicide and approaches to suicide prevention that could be guided by the communities themselves. The idea was to look at suicide risk as something that might be eliminated or reduced before it ever became a threat, protecting youth from suicide before they ever reached the point of making an attempt. A first step was to document the differences between those who were resilient to suicide and those who were at risk. With this inventory of resilience characteristics, communities could begin to formulate their own interventions to strengthen these traits and conditions.

Discussions with working groups from the communities led to a questionnaire to look at youth wellness. The team reviewed research publications about youth suicide to develop a list of factors related to suicide. We then used this to guide our discussions. The working groups talked about the issues facing their youth and, based on this, developed an adolescent survey to assess factors related to suicide risk.

The youth survey would provide a snapshot of community life from the adolescents' perspective; their involvement in school and community their day to day encounters with violence and peer pressure, substance abuse, their family and peer support systems, their cultural and spiritual exposures and how this affects their self image in terms of self esteem, distress levels, and sense of control over their environment and future. Given the sensitiv-

ity surrounding suicide, we wanted to develop a nonthreatening, realistic and culturally appropriate questionnaire. We used questions from existing studies whenever these were culturally appropriate.

The development of this questionnaire, along with the protocols for community input and involvement in research, was funded by a seed grant from the Ottawa ACADRE centre. This evolved into the Aboriginal Community Youth Resilience Network (ACYRN) , a five-year project that commenced in 2005. ACYRN is a research framework for supporting Aboriginal community-led suicide prevention with academic technical resources from a variety of disciplines including epidemiology, family medicine, traditional medicine, and social sciences. This multidisciplinary approach begins in the community and accesses, as needed, the best practices of other Aboriginal communities, and the academic and medical disciplines that underlie effective interventions.

Using the youth risk questionnaire completed in 2003 as a research instrument for data collection; ACYRN analysis focuses on primary or "upstream" interventions, ways to keep resilient youth from ever reaching the point of contemplating or attempting suicide by strengthening community conditions and personal traits that are protective.

The Continuum

The Suicide Prevention Continuum developed from community discussions. The discussion groups used this tool to examine suicide as a process that might be addressed at several stages. Many individuals will never enter the continuum, and others will not progress down the path; we are really interested in knowing why. Understanding their resilience can help us to develop interventions that strengthen resilience in others. The continuum has also been useful in demonstrating ACYRN's contribution (with its focus on primary prevention) to suicide prevention overall.

In columns one to three of this prevention continuum, we classified points of prevention into primary, secondary, and tertiary interventions. Our definitions of these interventions are based on public health definitions (King, 2006) noting that several subsequent studies have redefined and/or expanded those definitions and their target audiences (Mrazek and Haggerty, 1994). Briefly, primary preventions focus on building/strengthening protective factors in youth increasing their resiliency to suicide. Secondary prevention (also called intervention) involves intervening early

when risk factors for suicide have emerged or are emerging to prevent the onset of suicide related behaviour. Tertiary preventions (also called postvention) are designed for those already displaying suicide related behaviours.

For each type of intervention, there is first a brief definition of the intervention followed (reading down the column) by examples of recognized practices for that type of intervention; who the intervention might be aimed at (target audience); potential activities for implementing that type of intervention; and finally, what the ACYRN network contributes to the knowledge about each type of intervention. The interventions listed in the continuum were based on published literature, reflecting current practices in all levels of suicide prevention. They were used to stimulate community discussion. Analyses of data from the ACYRN youth risk questionnaire will ultimately guide communities towards appropriate interventions. The process of selecting appropriate interventions will provide suitable forums for discussing ethical and safety issues around selected interventions.

To reflect ACYRN'S focus on primary interventions, the first column dealing with primary intervention is shaded. As ACYRN progresses, the continuum will eventually include those primary interventions implemented by communities, at which point the continuum becomes an evidence-based representation of community-based interventions. To reflect ACYRN's contribution to primary interventions, capacity building, and policy making, the last row of the continuum is shaded.

Primary or "upstream" interventions (column 1) prevent resilient youth from ever reaching the point of considering suicide. An example of a primary intervention would be enhancing parent-child communication through parenting programs. With improved communication, parents are more accessible to their children and better able to offer them the emotional support that protects against suicide (Flouri, 2005). Continuing with the example of parenting programs, the target population for this primary intervention would be parents and/or the educators of parents. In a community setting, this type of intervention would emerge in the forms best suited to that community (talking circles, parenting classes, parent-child involvement in recreational or cultural activities).

In the last cell of this first column, we find a brief description of the contribution ACYRN makes to the knowledge surrounding primary suicide preventions for youth. Using our youth risk questionnaire, ACYRN examines the factors that influence adolescent day to day wellness such as; their sup-

port systems of family and friends, their cultural and community ties, their self esteem, sense of control over events in their lives, and levels of distress. Knowledge of these factors and their relationship to suicide resilience will enable communities to devise new interventions or revamp existing interventions that help youth flourish.

Secondary preventions are those that recognize and assess an immediate risk of suicide (column 2). Enhancing the skills and resources of professionals and communities to better recognize and respond to those *more immediately* at risk of suicide would be such an intervention. A community might choose to train key people (teachers, health workers, police officers, Elders) to recognize individuals at risk (King and Smith, 2000) and refer them to sources offering immediate help. Another example of a secondary intervention might be a "yellow ribbon campaign" to develop a safe and unquestioning environment that encourages help-seeking by reducing the stigma associated with suicide (www.yellowribbon.org).

Tertiary interventions are also called "postventions" and refer to the care, support, and special treatment needs of those already displaying suicide-related behaviours (column 3). An example of a tertiary intervention might be the creation of new support programs for survivors where none exist or enhancing existing survivor support groups (Campbell et al. , 2004). Another example of an intervention to protect survivors might involve better coordination of existing support resources (enhancing the working relationship and referral mechanism between mental health professionals, community law enforcement, and Elders, for example, so that their efforts to protect survivors are better harmonized) (Andriessen et al., 2007).

Columns 4 (Capacity building) and Column 5 (Policy development) complete the table. While they are not in themselves interventions, capacity building goes hand in hand with developing the interventions suggested by ACYRN research; and policy development results from sound research and effective interventions. If we consider suicide as ***what*** we are researching, then capacity building is a necessary element in ***how*** we will try to change it and effective policy development to protect the vulnerable is a major result of our research (***why***).

Reading down column 4, we find first a brief definition of capacity building; then the current best practices for capacity building around all types of suicide interventions, followed by the target populations for capacity building efforts and the current activities that enable capacity build-

ing. The definition of capacity building has evolved beyond "individual" capacity building to include institutions and communities. Capacity building is now a multilayered process aimed at individuals, service delivery institutions, and community governance processes. As ACYRN communities discuss intervention options based on evidence from the youth risk survey, institutional capacity to deliver services and programs will be considered and/or improved. Improved service delivery may lead to strengthened governance and accountability but also to increased cooperation between service sectors.

Evidence-based capacity-building activities, in whatever form they take, always involve the transfer of research findings to communities and individuals. In the final cell of this column, we have a brief description of the ACYRN contribution to capacity building. In the process of interviewing youth to determine their current sense of well being, ACYRN researchers and communities will also identify the factors that contribute to that sense of well being; the idea being that if we can enhance those qualities or circumstances associated with well being; we will in effect reduce the risk of suicide among youth. In ACYRN, referring to our previous example again, we found that feeling their parents cared about them greatly enhanced adolescent well being. Once this information is transferred to communities, they might consider looking at ways to strengthen parent-child relationships through parenting programs or parent-child recreational activities.

Column 5 describes policy development. We first have a definition of policy development as it relates to suicide prevention followed by an example of current practices (making suicide risk assessment a core competency for mental health workers). The target populations in this case are those individuals or government departments responsible for mental health policy with evidence-based lobbying being the current activities used to influence policymakers. In the final cell of this column is a description of ACYRN'S contribution to policy development. By providing evidence about the factors related to resilience in an Aboriginal context, communities can more effectively facilitate and influence policy development around suicide prevention.

	Primary Prevention (column 1)	*Secondary Prevention (column 2)*	*Tertiary Prevention (column 3)*	*Capacity Building (column 4)*	*Policy Development (Column 5)*
Definition	Reduces the occurrence of factors related to suicide by promoting life enhancing conditions and reducing negative societal conditions.	Involves intervening early when risk factors for suicide have just emerged or are emerging to prevent the onset of suicide related behaviour.	Involves the care and treatment of those in whom suicide related behaviours have already occurred.	Enhances skills and abilities required by individuals and communities to recognize and address issues related to suicide; enhancing community governance and supporting cultural revitalization.	Develops formalized mental health standards identifying promotion, prevention and advocacy goals relating to mental health particularly in terms of suicide prevention
Examples of current practices	• parenting programs to enhance communication and support • reduce substance abuse • reduce exposure to violence • life skills enhancement to increase self esteem and mastery • re-establish or strengthen cultural and community ties.	• increase recognition of symptoms by self or others • timely access to broad range of crisis services by strengthening community resources • reduce stigma around suicide (increase help seeking) • appropriate media handling of suicide	assistance to return to a precrisis level of functioning by • the development of support groups • individual and family counselling • enhanced training of primary health care providers to monitor survivors • improved coordination between supports	• establishing training protocols to increase individual, organizational and community capacities to implement all levels of preventions	• Include suicide risk assessment as a core competency of mental health service staff
Who — target population	• Youth • Community gatekeepers • Teachers/health professionals/other service providers • Parents/Elders	• Adolescents identified at risk of suicide • Professionals/parents and other community members	• Survivors of suicide • Family and friends of survivors • communities	• Community members • Community organizations • Gate keepers (teachers, police, Elders) • Professional care givers • Community political leadership	• Community political leadership • Government departments (regional, provincial, federal) • Community health organizations
What activities are used to interact with the target population	• Youth groups/clubs • Parent/child classes/activities • Anti bullying campaigns • Life skills courses • Anti stigma campaigns	• Counselling (one on one, group sessions, family, and/or community sessions) • Life skills courses • Building stronger family communication and support • Yellow ribbon campaigns	• Counselling (one on one, group sessions, family sessions) • Life skills courses • Build stronger family communication and support	• Knowledge transfer how the health of the community relates to the health of the individual	• Evidence-based lobbying
ACYRN contribution	Examines factors that influence adolescent day to day well being such as • support systems (friends and family) • self esteem, sense of mastery, levels of distress • exposures to risk behaviours (drinking, drug use, violence) • cultural/community ties			Enables communities to: • identify risk factors faced by the adolescents in the community • build support systems for adolescents at risk of suicide and suicide survivors	• Provides evidence of prevalence of risk and resiliency factors in Aboriginal communities to facilitate policy development around suicide in the Aboriginal setting.

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