BC Partners for Mental Health and Addictions Information

Visions

BC's Mental Health and Addictions Journal

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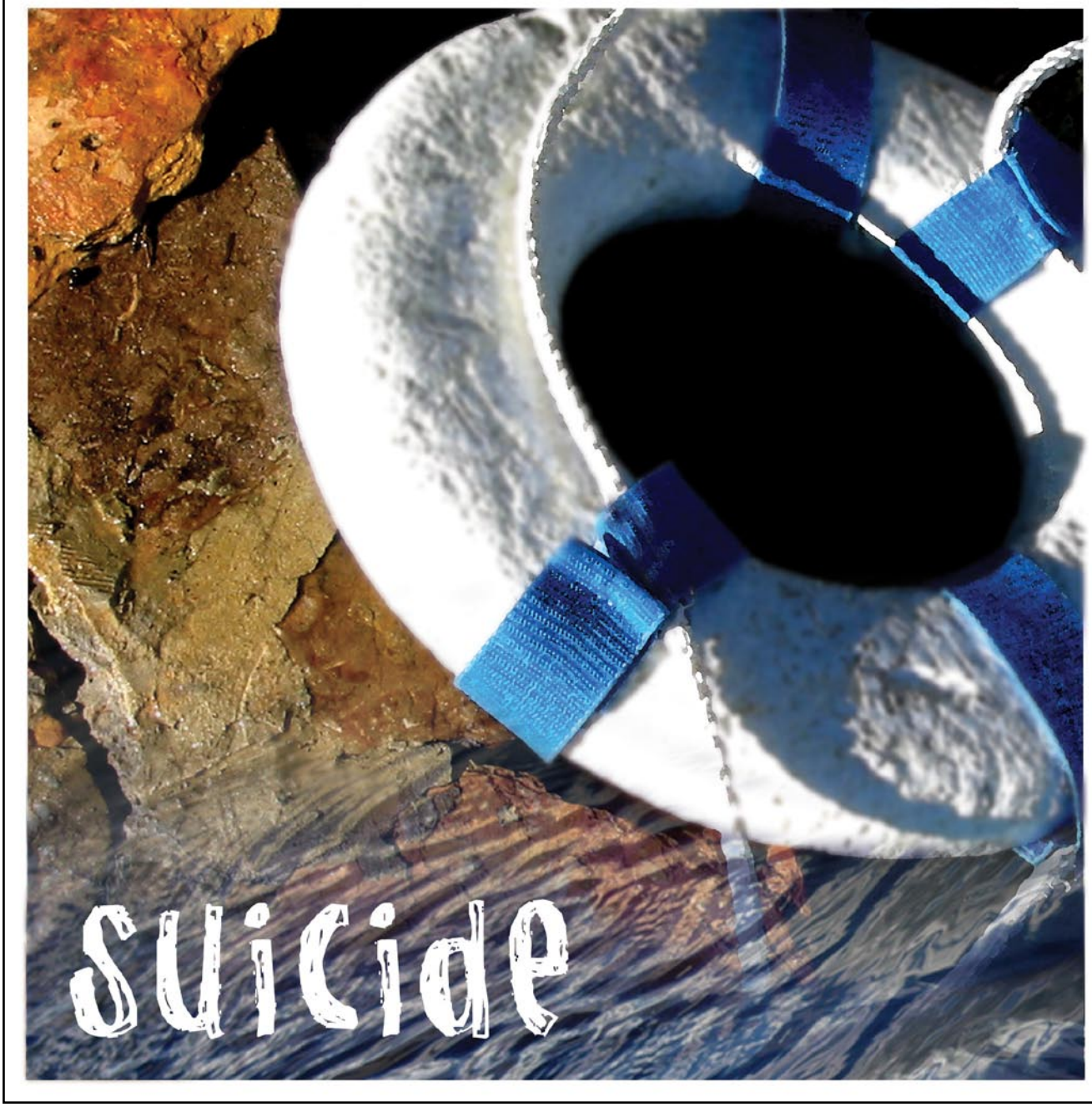

photo: Naomi Liu

background

experiences & perspectives

bc partners

Seven provincial mental health and addictions agencies are working together in a collective known as the BC Partners for Mental Health and Addictions Information. We represent the Anxiety Disorders Association of BC, Awareness and Networking around Disordered Eating, British Columbia Schizophrenia Society, Canadian Mental Health Association's BC Division, Centre for Addictions Research of BC, FORCE Society for Kids' Mental Health Care, and the Mood Disorders Association of BC. Our reason for coming together is that we recognize that a number of groups need to have access to accurate, standard and timely information on mental health, mental disorders and addictions, including information on evidence-based services, supports and self-management.

visions

Published quarterly, *Visions* is a nationally award-winning journal which provides a forum for the voices of people living with a mental disorder or substance use problem, their family and friends, and service providers in BC. *Visions* is written by and for people who have used mental health or addictions services (also known as consumers), family and friends, mental health and addictions service providers, providers from various other sectors, and leaders and decision-makers in the field. It creates a place where many perspectives on mental health and addictions issues can be heard. To that end, we invite readers' comments and concerns regarding the articles and opinions expressed in this journal.

The BC Partners are grateful to the Provincial Health Services Authority for providing financial support for the production of Visions

Like many other parts of the world, young people on the Indian subcontinent between the ages of 20 and 30 years appear to be most vulnerable group. In Sri Lanka about a quarter of suicides are by people under the age of 30 years, with similar rates in India. Studies from Pakistan show that between 50% and 82% of suicide deaths are from the under-30 age group.[1]

they revived Ranjeeth at the hospital, but he was pronounced brain-dead. Sunethra could not believe what had happened and refused to have her son taken off life support; he died after a week, while still on life support.

While she grieved for her son, Sunethra felt, at the same time, overwhelming shame that her son had taken his own life. She was reluctant to invite anyone from her cultural community to a funeral, because they might discover that Ranjeeth had died by suicide. Normally, the cultural association would be contacted and they would invite the community at large.

When it became clear that members of the extended networks were hearing the family's story through the grapevine anyway, Sunethra relented. She organized a funeral, inviting just 10 or so of the community's families to attend. Ranjeeth's close friends were also there, to join his mother in her grief. There were the expected disapproving whispers from community members: how could someone possibly do this to his parents; how selfish he was, thinking his problems were bigger than everyone else's; how he had committed a sin that God would not forgive.

When Ranjeeth was on life support, Kamala had flown out East to be with Sunethra and had brought educational materials on depression and suicide from the mental health agency in BC where she worked. Sunethra had read the materials from cover to cover. Though she still wrestled with the pervasive cultural stigma, her awareness had shifted.

In the weeks after the funeral, members of the community, who had in many cases made some of the hurtful comments about Ranjeeth killing himself, came quietly to Kamala to ask for more information, so that they too could learn more about mental illness. They wanted to ensure that their sons and daughters didn't have to deal with the pain and suffering felt by Ranjeeth.

Sunethra now understands that her son had depression, which made it easy for him to contemplate suicide. Like family members across all cultures who have lost someone to suicide and think of events in hindsight, Sunethra daily confronts the thought that her son's death could have been prevented if only she had seen the warning signs. But she didn't know what the warning signs were or what to do even if she had recognized them.

Sunethra is currently in therapy to help protect her own mental health in the face of all of her losses. And she, with her friend Kamala's support, is learning more about depression and suicide prevention in her community. Kamala told her friend that she shouldn't see the death of her son as different from the death of her husband. They were both brought about by illness; neither was due to moral failings or character flaws. In her own way, Sunethra has started to become an activist for the cause of mental illness—proving that in adversity and tragedy, there is opportunity and hope. ℹ

footnote

1. See Khan, M.M. (2002). Suicide on the Indian Subcontinent. *Crisis*, *23*(3), 104-107.

On Losing a Teenager to Suicide

Jude Platzer

Jude is Executive Director of the Josh Platzer Society for Teen Suicide Prevention and Awareness. She is a registered nurse by profession and lives with her husband and daughter in Vancouver, BC

Nell,* just 11 years old, was due home from her trip to Israel. She was returning from an international program similar to one that her older brother Josh had attended a few years earlier. Josh didn't want to come to the airport to welcome his sister, and we, the parents, did not insist. Our boy was depressed, and the professionals had told us to "back off."

Sadly, Nell did not get a chance to compare notes with Josh. He was found dead the morning after she had returned. He was only 15.

Josh was diagnosed with depression and possible bipolar disorder earlier in the year, and was in treatment at the time of his death. He had attempted suicide twice before. Antidepressants were prescribed by our GP—the same GP who chose not to impart to us his knowledge of Josh's previous suicide attempt. Instead, he had suggested Josh tell us about it himself, within a given time period.

Upon reflection, signs of suicide certainly had been present. Josh had given up the sailing that he loved; he was missing classes and often stayed home claiming to be sick. Josh died in August 1999. He hung himself in the front yard of his best friend's house.

His friends were well aware that Josh had 'emotional problems' (as Josh referred to them in an e-mail to a cousin, just before he died). Josh had discussed his imminent death and funeral with friends, had written good-bye notes and had left written instructions about where to spread his ashes. His friends never disclosed this information to us or, to our knowledge, to any other adults. All this was only discovered after the fact.

Fuelled by the grief and anger brought on by Josh's death, my husband Ben and I set up a memorial fund in Josh's name to promote suicide prevention.

Around that time, I happened to read a newspaper article about a dance drama for youth concerning teen angst. *ICE: beyond cool* was created and performed by

*pseudonym

Wonderings and Wanderings

Ongoing conversations about suicide prevention

P. Bonny Ball and Jennifer White

Bonny is a survivor[1] of her 21-year-old son's suicide. Before retiring, she was a business analyst. She is now Acting Vice-President and Chair of the Survivors Division of the Canadian Association for Suicide Prevention (CASP), and Project Manager of the Vancouver Suicide Survivors Coalition, a project of the Vancouver Community Mental Health Services' Consumer Initiative Fund

Jennifer is Assistant Professor in the School of Child and Youth Care at the University of Victoria. She worked as a clinical counsellor at Vancouver Coastal Health's SAFER Counselling Service. Prior to that she served seven years as Director of the Suicide Prevention Information and Resource Centre, Mental Health Evaluation and Community Consultation Unit, UBC Department of Psychiatry. Jennifer is a CASP award recipient and past board member

We met in 1995. With 10 years of discussions, respectful challenges and collaborative endeavours under our belts, our dialogue continues and questions still arise. This editorial highlights some of what keeps us wondering and 'wandering' across diverse intellectual, personal, political and ethical territory.

At the beginning—and beyond

Bonny: Jennifer listened. She listened through my anger and tears to the core of what I was trying to say. She understood my need to become involved and respected the skills and perspectives I had to offer. She provided "just in time" education. She introduced me to the broader suicide prevention community. She invited me to review some of her research, was willing to engage in respectful dialogue, and incorporated some of my ideas. Over the years she has continued to encourage me to learn and contribute. Our voices don't always agree, but the "edges" of our dialogue are where the learning is. We—and the projects we take on—are always enriched by working together.

Jennifer: At our first meeting, I was immediately struck by the weight of Bonny's grief. Like other parents I had met who had lost a child to suicide, Bonny's energy was taken up with trying to make sense of this life-shattering, deeply painful loss. She had many questions and her hunger for more knowledge and her clear commitment to wanting to "do something" was evident from the start. Based on my ongoing meetings with Bonny and other survivors[1] of suicide, I started wondering about how those of us who are professionally employed in the field of suicide prevention might capitalize on the special kind of knowledge that survivors of suicide possess: how can their perspectives help us to examine how we "do suicide prevention"?

With so many theories, approaches and expert, survivor and consumer knowledge to listen to, how do we ever find a way forward?

Bonny: As a business analyst, I find there is this 'mucking around' phase when tackling a new area. People untangle the 'lingo' as they try to understand the current situation. They ask questions based on their expertise and experience. They discover who the stakeholders are and what skill sets are needed. The project team (and stakeholders) go through 'forming, storming and norming' as they get to know each other, value each others' skills, trust each other and shift from their isolated views to understanding the perspectives and needs of other stakeholders. It is only through this messy-but-critical process that the group finally figures out the key issues and can begin working together toward effective solutions.

Jennifer: I agree. It is only when we are able to bring together diverse perspectives that we will be able to make a difference in reducing rates of suicide and suicidal behaviours. By relying exclusively on the interventions and judgements of "professionals and experts," or by believing that traditional scientific knowledge is the only form of knowledge that can be relied upon to solve this complex, multi-dimensional problem, we risk turning the work of suicide prevention into a specialized practice in which only a few can participate, as opposed to a collaborative community endeavour that capitalizes on the resources and knowledge of a range of community members.

What are some current sources of concern, curiosity or uncertainty with respect to contemporary efforts in suicide prevention?

Bonny: The puzzle for me is the 'disconnects.' As I learned in a project management course, problems occur when stakeholders are excluded, when no single group has responsibility and accountability, or when groups need to collaborate and don't. For example:

- Why do we just shrug our shoulders (or stay polarized) on the issue of confidentiality?
- Why don't parenting books educate families on the warning signs of mental illness?
- Why is family/gatekeeper input all too often excluded from suicide risk assessments?
- Why is so little attention given to community/school response and support after a suicide attempt?
- Why don't we have coordinated, funded federal and provincial suicide prevention strategies?

Jennifer: What I've been curious about lately is how our research traditions in the field of suicidology structure "what can be seen." For example, the finding that 80% to 90% of those who die by suicide are suffering from some form of mental disorder has been empirically validated in several international studies and systematic reviews, leading to the acceptance of this observed relationship as a "clear fact."[2]

I agree that many suicides may have been prevented if individuals had received formal mental health treatment. At the same time, I also believe that human

lives can be examined, understood and characterized through many other lenses, beyond the diagnostic filters typically used in the mental health field. While the "psychological autopsy" method has helped us to better understand some of the characteristics of those who have died by suicide, this approach to studying suicide is inevitably limited to capturing those factors that can be named, isolated and quantified. Just because we can't directly measure the effects of social and political influences (e.g., colonization, homophobia, social injustice) through our traditional research designs doesn't mean these influences are not at play.

What are some of your greatest sources of hope in the suicide prevention field?

Bonny: I am excited by the signs that indicate professionals, paraprofessionals and families are discovering the value of working in partnership:

- The CASP Blueprint for a Canadian National Suicide Prevention Strategy is a collaboration between survivors, professionals and paraprofessionals
- The Survivor Advocate Listserv is proving to be a valued informal information exchange among Canadian survivors, researchers, community/school suicide prevention teams and mental health practitioners. See groups.yahoo.com/group/SurvivorAdvocates.
- Increasingly survivors are invited to sit on planning and advisory committees, document review teams, and to become active partners on research teams.

Jennifer: Hope, for me, exists in the quality and openness of the dialogues we are having about suicide prevention. It's about who is included in the discussion and who has yet to be invited to the table. It's in recognizing the legitimacy of multiple forms of knowledge and in creating spaces and processes for grappling with the complexity and pain surrounding the issue of suicide. It's in the 'messiness' of it all that I think we have the best opportunity for living up to the ideal espoused in the message, "suicide prevention is a community responsibility."

Our invitation to you

Suicide is an 'outcome,' which emerges from multiple, unpredictable, complex and interweaving pathways. It is our belief that suicide prevention must include a wide array of personal, professional, clinical, social, cultural, spiritual, ethical and political practices. In the articles that follow, a range of personal and professional perspectives on suicide is presented, which collectively captures the rich and complex character of suicide prevention work. We invite you to join our conversation. **i**

footnotes

1. In the suicide prevention field, *survivor* is a word used to describe someone who has lost someone significant to suicide. It does not refer to those who have made a suicide attempt and "survived."

2. Cavanagh, J., Carson, A., Sharpe, M. et al. (2003). Psychological autopsy studies of suicide: A systematic review. *Psychological Medicine*, 33, 395-405.

letters

I just read the Stigma issue cover to cover. It was wonderful. Excellent quality. Please keep up the good work. *—John Harris, Delta, BC*

I would like to commend you for the *Visions* issue on Stigma. I felt that the articles were exceptional. I saw my own experience reflected in the experiences of other consumers, regardless of diagnosis. I especially want to say thank you for including an article on borderline personality disorder, and for mentioning the disorder in other articles. As a consumer who has been assigned this label, I have experienced tremendous stigma, especially from medical and mental health professionals. Many times the disorder is not even mentioned in literature about mental illness. Stigma by omission makes those of us with the diagnosis invisible. Thank you for allowing us to be visible along with those who have other diagnoses like schizophrenia, depression, etc. Excellent work. *—Lisa Marie Sterr, Vancouver, BC*

In your last issue, I appreciated the way you pointed out the responsibility for having the right attitude is on the people who are observing the mentally ill person. My son was diagnosed with schizophrenia when he was about 20. David went through about 15 years of hell, until at last the new medication, Olanzapine was given to him. That, and a home he could call his own with no landlord to threaten his security has put him on the path to a new life where he is feeling as if life is worth living.

I want to emphasize the importance of good doctors and other care workers for those with mental illness. Their expertise and compassion cannot be emphasized enough. I think only the very best people with a great desire to help should be considered for this field. David had good doctors and horrible doctors. A doctor I can only describe as an angel of mercy at Riverview Hospital helped David to see that he had recently been suffering from delusions, that he did not need to be in the locked ward, and what he needed to do to stabilize himself. Thankfully, David is now considered well adjusted and has reached the point, at 40, where he can help others like himself. I'm very proud of him and the way he manages his life.

In closing, I think a wording change away from *consumer* should be advocated. I think *participant* is a much better word and shows co-operation whereas consumer just shows using something up. *—Leone Wright, Surrey, BC*

I was very disturbed by Karen's article "Adjusting our Dreams" in the Stigma issue of *Visions*. Karen's son has a medical disorder of the brain. He needs a full medical workup to determine the cause of his psychosis, now. Even if the diagnosis is schizophrenia, it is treatable! BC's Best Practices/Early Intervention policies follow the principle, "The earlier the treatment the better the outcome." He has a right to sanity over all other rights. He needs protection from harm to himself and to others and needs to be hospitalized. This is bigger than Karen. She needs to seek help immediately even if it means changing family physicians and/or mental health service providers or using the police to help get her son to the hospital if he refuses to go. Hospitalizing him would be a profound act of love. Karen does her son and herself a disservice by adjusting their dreams to fit the psychosis. Treat the psychosis and give the son a chance to reclaim his life. There are community discharge policies which help with medication compliance. Yes, dreams may need to shift some, but maybe not. *—Eileen Callanan, family member and Family to Family Educator, BC Schizophrenia Society, Terrace, BC*

we want your feedback!

If you have a comment about something you've read in Visions *that you'd like to share, please email us at bcpartners@heretohelp.bc.ca with 'Visions Letter' in the subject line. Or fax us at 604-688-3236. Or mail your letter to the address on page 3. Letters should be no longer than 300 words and may be edited for length and/or clarity. Please include your name and city of residence. All letters are read. Your likelihood of being published will depend on the number of submissions we receive.*

The statistics of risk

Sarah Hamid-Balma

Sarah is Director of Public Education and Communications for the Canadian Mental Health Association's BC Division and Visions' Editorial Coordinator

Until I became depressed and suicidal myself in the fall of 1996, I never understood what it was like on the 'inside'—how dark and all-consuming, how someone who had everything going for them could want to go to sleep and not wake up. Waking up each morning was a daily exercise in disappointment. I'm only glad ideation (i.e., thinking about suicide) was as far as I got—glad I never actually acted on temptation to turn the wheel into oncoming traffic as I commuted home from university each day.

I also didn't realize how common suicidal thinking like mine was, particularly in almost-19-year-olds. In the most recent Statistics Canada national mental health survey, around 4%, or one in 25 Canadians, say they've had suicidal thoughts in the past year. That number nearly doubles if you just look at young women ages 15 to 24.[1]

What follows is meant to be a quick reference guide to some key statistics and trends with regard to suicide. I've adapted some materials provided by our wise guest editors and have excerpted information from the BC Partners for Mental Health and Addictions Information fact sheet on suicide. This will provide a prologue of sorts to the complex and rich points of view you'll find in the coming pages of this issue of *Visions*.

Although BC's suicide rates have remained fairly stable over time, at roughly 500 per year, suicide rates in Canada have been rising sharply for nearly five decades. Suicide deaths in Canada numbered 3,648 in 2002. By contrast, there were fewer than 500 murders and around 3,000 traffic-accident deaths.[2] A closer look at the figures reveals that suicide strikes hardest at the elderly, the young and other vulnerable members of society.

Seniors

Canadian seniors have among the highest suicide rates in the country, with men over the age of 85 having the highest rate of completed suicides of any age group.[3] In BC, in the year 2000, the suicide rate for all men averaged out to 17.5 deaths per 100,000 people; men over 85 had double that rate.[4] Major illness, the death of a spouse, a shrinking circle of friends—all contribute to stress and depression, which can lead to suicidal behaviour or suicide. One exception to this trend is the low suicide rate among Aboriginal Elders. In many cases, these Elders may be less likely to take their own lives because, traditionally, their cultures have valued and respected them for their wisdom.[5]

Youth

Canada's youth are another group at high risk for suicide. Suicide continues to be the second-leading cause of death among young people in Canada, in BC and worldwide. In the half-century between 1952 and 2002, the Canadian suicide rate for 15- to 19-year-olds rose from two deaths per 100,000 people to just over 10—a five-fold increase.[4,6,7] In 2000, 70 young people ages 15 to 24 took their own lives in BC.[4] Like the elderly, the majority of adolescents who commit suicide have related mental health issues, including depression, substance use problems and eating disorders. The increase in suicidal behaviour among Canada's youth indicates that many adolescents feel they should be able to handle their mental and emotional issues on their own. Suicidal youths may be reluctant to turn to others for help, having learned from their role models not to rely on others.[8]

Aboriginal communities

Adolescent and adult suicide rates are even higher in Aboriginal communities. Deteriorating quality of life in some Aboriginal communities may play a role, particularly among people with clinical depression, sexual abuse histories, problem alcohol and drug use and limited family

footnote

1. Statistics Canada. (2002). Suicidal thoughts, by age group and sex. *Canadian community health survey, mental health and well-being*. Retrieved August 15, 2005, from www.statcan.ca/english/freepub/82-617-XIE/htm/5110065.htm.

correction

The graph on male suicide in the Spring 2005 Men's issue of Visions Journal (p. 15) plotted the rates for both genders. While the trend line remains the same, the discrepancy between male and female rates of suicide is much greater than what the earlier graph shows. Please see the graph below for a revised and more accurate chart and data table.

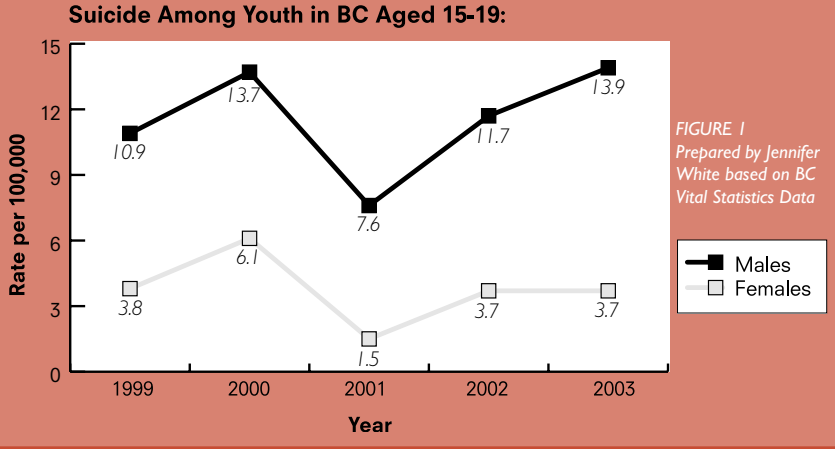

FIGURE 1
Prepared by Jennifer White based on BC Vital Statistics Data

support. The suicide rate among Aboriginal people averages triple the rate of the general Canadian population.[9]

Not all Aboriginal communities, however, are affected by suicide to the same extent. While some communities have suicide rates 800 times greater than the national average, suicide is virtually unknown in other communities. Cultural rehabilitation factors such as land claims, self government, and education services are implicated in reduced suicide rates.[10]

Immigrants and refugees

Ethnocultural communities other than Aboriginal also experience variations in suicide rates compared to the general population. On the whole, suicide rates for immigrant communities are about half those for the Canadian-born. In fact, the pattern of suicide among immigrants more closely reflects patterns in their countries of origin than that of the Canadian-born population.[11] In BC, among immigrants born outside Canada, those from India are the visible minority presenting the highest suicide rates.[12] This concern also extends to refugees from the Indian subcontinent. BC immigrant- and refugee-serving organizations indicated in a 2002 survey that 90% of their refugee clients of South Asian origin (e.g., India, Pakistan, Sri Lanka) had unmet mental health needs, more than any other cultural group. These agencies ranked depression and suicidal behaviour as the most prevalent mental health concern.[13]

Gender

Males die by suicide more than three times as often as females, a statistic that follows international trends. This may in part be due to males using, on average, more lethal methods such as hanging and firearms.[14]

Females tend to use drugs, poison, and gases more often than males in their suicide attempts, meaning there is more time to intervene and therefore a better chance to prevent death—although there is an increasing trend of females using more lethal means. Women are also more likely than males to ask for help surrounding a suicide attempt.[15]

A common thread

Mental health problems are the common thread in all groups with a high risk for suicide. Research indicates that as many as 90% of people who commit suicide are experiencing depression, an addiction or some other diagnosable disorder when they take their own lives.[16] People with major mental disorders who attempt or commit suicide do so not out of a desire to die, but out of a desperate need to put an end to their suffering. In most cases involving suicide, the act itself is not an impulsive decision. Most people who die by suicide give some indication of their intentions prior to killing themselves. In fact, most people who attempt suicide talk about it beforehand without any immediate plans to carry it out. In one study, more than 60% of participants who had made near-lethal suicide attempts had sought help for health or emotional problems from a clinician in the month before their attempt; nearly half of them had discussed suicide.[17]

Consider this...

In the year 2000, 815,000 people lost their lives to suicide worldwide—more than double the number of people who die as a direct result of armed conflict every year.[18]

Fortunately, immediate intervention and ongoing support can help a person recover from despair and reconnect with their own self-worth. If other people notice the warning signs and act on them, they may have an opportunity to save a life. For more information on how to recognize and help someone thinking about suicide, see Ian Ross' Crisis Centre prevention guidelines on page 9. i

footnotes

2. Statistics Canada. (2000). External causes of morbidity and mortality. *Causes of death*. Retrieved August 15, 2005, from CANSIM database [V01-Y89, Vital Statistics – Death Database – 3233] at www.statcan.ca/english/freepub/84-208-XIE/2000/tables.htm.

3. Centre for Suicide Prevention. (1998). *SIEC Alert #28: Suicide among the aged*. Calgary, AB: Author.

4. Suicide Prevention Initiative, Mental Health Evaluation and Community Consultation Unit (Mheccu), University of British Columbia, and BC Coroner's Office. (2001). *BC suicide deaths by age and gender – 1994-2000: Frequencies and rates per year*. Vancouver, BC: Author.

5. Kettl, P. (2002). Elder suicide in Native communities: How valuing and including our seniors can make all the difference. *Visions: BC's Mental Health Journal, 15(2)*, 9-10.

6. Health Canada. (1994). Appendix 6(2): Age-specific suicide death rates, by sex, for Canada and the provinces and territories, for the years 1950 to 1992. *Suicide in Canada: Update of the Report of the Task Force on Suicide in Canada* (pp. 161-202). Ottawa, ON: Author.

7. Statistics Canada. (2004). *Estimates of population, by age group and sex: 2002*. Retrieved August 15, 2005, from CANSIM database at cansim2.statcan.ca/cgi-win/cnsmcgi.exe?Lang=E&RootDir=CII/&ResultTemplate=CII/CII_pick&Array_Pick=1&ArrayId=510001.

8. Tousignant, M. & Hanigan, D. (1993). Suicidal behaviour and depression in young adults. In P. Cappeliez & R.J. Flynn (Eds.). *Depression and the social environment: Research and interventions with neglected populations* (pp. 93-120). Montreal, QC: McGill-Queen's University Press.

9. Centre for Suicide Prevention. (2003). *SIEC Alert #52: Suicide among Canada's Aboriginal peoples*. Calgary, AB: Author.

10. Chandler, J.J. & Lalonde, C. (1998). Cultural continuity as a hedge against suicide in Canada's First Nations. *Transcultural. Psychiatry, 35*(2), 191-219.

11. Malenfant, E.C. (2004). Suicide in Canada's immigrant population. *Health Reports, 15*(2).

12. Singh, K. (2002). Suicide among immigrants to Canada from the Indian subcontinent (letter). *Canadian Journal of Psychiatry, 47*(5), 487.

13. Refugee Mental Health Project. (2002). *Refugee mental health – moving ahead: Survey and symposium report*. Vancouver, BC: Authors.

14. Centre for Suicide Prevention. (2003). *Facing the facts: Suicide in Canada*. Calgary, AB: Author.

15. Centre for Suicide Prevention. (1998). *SIEC Alert #30: Trends in Canadian Suicide*. Calgary, AB: Author.

16. Cavanagh, J., Carson, A., Sharpe, M. et al. (2003). Psychological autopsy studies of suicide: A systematic review. *Psychological Medicine*, 33, 395-405.

17. Barnes, L.S., Ikeda, R.M. & Kresnow, M.J. (2001). Help-seeking behavior prior to nearly lethal suicide attempts. *Suicide and Life-Threatening Behavior, 32*(1 Suppl), 68-75.

18. World Health Organization. (2002). *World report on violence and health*. Geneva, Switzerland: Author.

19. White, J. & Jodoin, N. (1998). *Before the fact interventions: A manual of best practices in youth suicide prevention*. Vancouver, BC: Suicide Prevention Information and Resource Centre, Mental Health Evaluation and Community Consultation Unit, University of British Columbia.

20. Ashworth, J. (2001). *Practice principles: A guide for mental health clinicians working with suicidal children and youth*. Retrieved August 15, 2005, from www.mcf.gov.bc.ca/publications/youth/suicid_%20prev_manual.pdf

A Summary of Suicide Risk and Protective Factors

Youth and Young Adults

Jennifer White

Suicidal behaviour emerges out of a complex and dynamic interplay between individual, social and environmental risk and protective factors. In general, those at greatest risk are single, older adolescents (15–24), Caucasian and Aboriginal males, suffering from major depression and substance abuse who have a history of suicidal behaviour and have easy access to the methods for suicide. It is also true that many young people who kill themselves do not always fit this statistically generated profile. The chart below summarizes some of the most well-established risk/protective factors. Note that it is not an exhaustive list.

Key Context	Predisposing Factors	Contributing Factors	Precipitating Factors	Protective Factors
Individual	• previous suicide attempt • depression or other mental disorder (e.g., substance use disorder, schizophrenia) • hopelessness • suicidal thoughts	• rigid cognitive style • poor coping skills • gay, lesbian, bisexual or transgendered sexual orientation • impulsivity • aggression • hypersensitivity/anxiety	• personal failure • humiliation • individual trauma • health crisis	• individual coping and problem-solving skills • willingness to seek help • good physical and mental health • strong cultural identity and spiritual beliefs
Family	• family history of suicidal behaviour/suicide • family history of childhood neglect, sexual or physical abuse • family history of mental disorder • early childhood loss/ separation or deprivation	• family discord • impaired parent–child relationships	• loss of a significant family member • death of a family member, especially by suicide • recent conflict	• family cohesion and warmth • adults modelling healthy adjustment • high and realistic expectations
Peers	• social isolation and alienation	• negative youth attitudes toward seeking adult assistance • peer modelling of maladaptive behaviours	• teasing/cruelty/bullying • interpersonal loss or conflict • rejection • peer death, especially by suicide	• social competence • healthy peer modelling • acceptance and support
School	• long-standing history of negative school experience • lack of meaningful connection to school	• disruption during key transitional periods at school • reluctance/uncertainty among school staff about how to help	• failure • expulsion • disciplinary crisis	• success at school • interpersonal connectedness/ belonging
Community	• multiple suicides • community marginalization • political disenfranchisement • socioeconomic deprivation	• sensational media portrayal of suicide • access to firearms or other lethal methods • reluctance/uncertainty among key gatekeepers about how to help • inaccessible community resources	• high profile/celebrity death, especially by suicide • conflict with the law/ incarceration	• opportunities for youth participation • community self-determination • availability of resources • community control over local services

*The chart is adapted from the source in footnote 19 (see previous page). A more complete discussion can be found in the source described in footnote 20.

1-800-SUICIDE

Hope + help = just a phone call away

Ian Ross

The crisis line movement in BC began in the 1960s based on the 'Good Samaritan' principle of providing free, confidential, non-judgemental telephone support and community referrals. Today 20 crisis lines make up the BC Crisis Line Association (BCCLA).

Moving toward a national crisis line network

- In 2001, the BCCLA unanimously approved a motion to explore an easy-to-remember three-digit number between 911 (Emergency) and 211 (Information and Referral). This new number (511 or 811) would provide a direct connection to a trained volunteer, supported by a professional, who could provide emotional support and, if necessary, referral.
- In 2002, two BC crisis centres began to explore the possibility of piloting a 1-800-SUICIDE prevention number in the province, as a step toward BCCLA's dream of "three-digit access to emotional support."
- In 2003, five crisis centres, one from each of the five health regions, came together to form the Distress Line Network of British Columbia (DLNBC). Later that year, the network was successful in securing funding to pursue the dream of building an exchange routing system: i.e., callers from anywhere in BC would be directed to an open line.
- On September 10, 2004 (World Suicide Prevention Day), the DLNBC opened the 1-800-SUICIDE prevention service, and it has been operating ever since.
- In 2005, the DLNBC won the BC Association of Broadcaster's Humanity Award, which provides millions worth of TV/radio air time. Media will be broadcasting DLNBC ads: "If you need emotional support, contact your local crisis line—we want to hear it all."

Following the lead of the DLNBC initiative in BC, the Canadian Association for Suicide Prevention was successful in their grant application to the Public Health Agency of Canada. This funding is dedicated to increasing access to crisis line services by creating a Canadian Distress Line Network (CDLN) and an easy-to-remember three-digit (511 or 811 or something similar) number for accessing a distress line, building on BC's 1-800-SUICIDE project.

At the heart of the Canadian Distress Line Network (CDLN) are thousands of highly trained volunteers, supported by small teams of professionals. Our goal is to strengthen this incredible volunteer-to-staff ratio (30:1) through common best practices, ongoing evaluation, and a focus on improving outcomes for callers.

you can help prevent suicide: crisis centre guidelines

Between 6% and 10% of all crisis line calls across Canada are related to suicide.[1] Nearly 1 in 25 Canadians admit to having had suicidal thoughts in the past year.[2] It could be someone you know.

How can I recognize if someone is suicidal?

A person who is suicidal feels trapped, hopeless and alone. They feel their only choice is to die by suicide. Some possible signs are:

- *Changes in behaviour* – increased use of alcohol or other drugs; increased or decreased sleeping or eating; decreased self-care
- *Hopelessness* – a negative outlook with no positive future: "What's the point? It won't change"
- *Changes in mood* – crying easily; depressed; frequently agitated or anxious
- *Warnings* – saying "Life isn't worth it" or "Things would be better if I were gone;" jokes, poems and art about suicide
- *Preparations for death* – saying goodbye; making a will; giving away prized possessions; talking about going away
- *Impulsiveness* – actions without thought of risks or consequences; outbursts or aggressive behaviour
- *Previous Attempts* – recent intentional self-harm or suicide attempt

What can I do if someone is suicidal?

- *Talking* – It can help.
- *Reach out* and let them know you care.
- *Ask directly* – "Are you considering suicide?"
- *Be a supportive listener* – accept their feelings.
- *Offer help* – Find out who they can talk to – e.g., a counsellor, partner, teacher, relative, clergy member, doctor, nurse or crisis centre. Never promise to keep a suicide plan secret.
- *Take them to help* – If they cannot assure their own safety, take them to, e.g., a hospital, mental health clinic or suicide prevention counsellor.

What if I am thinking about suicide?

- *Seek out help* instead of keeping problems to yourself and feeling alone. Talk with someone you trust or call your local crisis centre.

Ian is Executive Director of the Crisis Intervention and Suicide Prevention Centre of BC (a.k.a. the Crisis Centre in Vancouver). He is a board member and Chair of the Crisis Intervention Committee of the Canadian Association for Suicide Prevention

did you know?

The Crisis Centre in Vancouver receives more than 24,000 calls a year on its Distress Line, operates a Web-based chat for youth, and provides over 500 interactive workshops to over 15,000 high school students each year. The Centre relies on hundreds of volunteers to deliver its services. In fact, since 1969 the Crisis Centre in Vancouver has trained over 5,000 volunteers. Learn more at www.crisiscentre.bc.ca

footnotes

1. Richard Kramer, Secretary, BC Crisis Line Association: personal communication, August 10, 2005.

2. Statistics Canada. (2002). Suicidal thoughts. *Canadian Community Health Survey: Mental Health and Well-being*. Retrieved August 9, 2005 from www.statcan.ca/english/freepub/82-617-XIE/tables.htm.

Suicide: The 'Logic' of a Human Tragedy

To breach or not to breach confidentiality...

Eike-Henner W. Kluge

Eike-Henner teaches biomedical ethics at the University of Victoria. He was the founding director of the Canadian Medical Association's department of Ethics and Legal Affairs and the first expert witness in medical ethics recognized by Canadian courts. He has published widely in biomedical ethics and was the ethics consultant in the Sue Rodriguez assisted suicide case

There are few things that strike us as more tragic than suicide. We tend to regard suicide as a failure on the part of society to help the suicidal individual. We are especially upset when we find out it was known beforehand that the person was suicidal, but next-of-kin or significant others were not informed. We also tend to view suicide as irrational—a desperate emotional reaction to what are perceived as overwhelming personal circumstances—and we believe that if someone else had known about the situation, they could have intervened and saved the person from an untimely death.

In ethics and law

Both ethics and law, however, suggest there are no simple solutions to the dilemma of breaching confidentiality.

The law against suicide was repealed in 1972. There were several reasons for this: 1) it was essentially unenforceable; and 2) in law, everyone has the right to decide what shall happen to themselves, as long as they are competent—which, minimally, means that the person understands the nature and implications of her or his actions and is not under undue pressure from others—and their actions do not interfere with the equal and competing rights of others. The law, moreover, recognizes that each person, as an autonomous decision-maker, is surrounded by a sphere of privacy that may be breached only under exceptional circumstances.

As to ethics, it has two basic principles: 1) autonomy and respect for persons, which says that everyone has the right to self-determination; and 2) equality and justice, which says that all persons are equal and their rights should be equally protected. This means that in ethics, if someone competently decides to die, then no one has the right to interfere. And, if that person decides that no one should be told about it, then this wish must be respected.

Therefore, both in ethics and law, a competent person has the right to commit suicide, and has the right to insist that their intention be kept confidential. This begs the question whether suicide is ever the result of a competent decision. Arguably, suicide does not automatically indicate incompetence. In the Sue Rodriguez case, when she was assessed for competence at the beginning of her campaign to have Section 241(b) of the *Criminal Code* (the section that criminalizes assisted suicide) repealed, the psychiatrist concluded that she was competent even though she had "suicidal ideations."[1]

On the other hand, a young man who commits suicide in a fit of clinical depression when off his medications would be considered incompetent. And an incompetent person's intention to commit suicide clearly calls for an engagement of the appropriate mental health services, and does not warrant professional confidentiality.

Never straightforward...

Suicide, however, rarely presents with clean conceptual lines of competence, rights and principles. It involves actual people who are embedded in social contexts that include family, friends and health care professionals. All these people have their own feelings and commitments, and they may be torn in opposing directions. While conceptually they may subscribe to the principles of autonomy and equality, and while intellectually they may believe in the rights to privacy and self-determination, when it comes to their own significant others, these convictions often become abstract notions. Competence and rights don't enter the picture. The desire to help a loved one predominates.

Even health care professionals do not focus simply on issues like competence and rights; they are conflicted by a variety of considerations. To begin with, it is very difficult—even as a trained professional—to suspend one's own feelings when facing a suicidal person. While professional training teaches one how to guard against being swayed by personal feeling, it does not remove the feelings themselves.

Second, there have been fundamental changes in the philosophy of health care. To be sure, medicine, as it has developed in the West since Imhotep in ancient Egypt (around 2980–2950 BC),[2] has long imposed a duty of confidentiality on its practitioners. This duty was explicitly incorporated into the Hippocratic Oath (Greece, 4th century BC) and required that confidentiality not be breached—except, it allowed confidentiality to be breached if the physician decided it was in the best interests of the patient. This best-interests-of-the-patient exception, however, was modified in the 20th century by the advent of an autonomy-centred model of the physician–patient relationship, which makes the patient and not the physician the arbiter of what is in the patient's best interests. The autonomy-centred model—which is reflected in current codes of ethics and is supported by contemporary law—requires that physicians follow the directions of their competent patients *even if that should contravene what the physician thinks is in the patient's best interests.* Not all physicians have fully accepted this autonomy-centred model—codes and laws notwithstanding.

At the same time, there is also a powerful contemporary counter-current to the autonomy-centred model of the physician–patient relationship: a current that is represented most clearly by family medicine. Here, practitioners are trained to look beyond the individual patient and to include family and significant others in the circle of considerations. It promotes, so to speak, breaches of confidentiality, because family and significant others cannot meaningfully be included in the decision-making process unless they are privy to patient information.

As if this were not enough, there is also the question of uncertainty. When people present with suicidal tendencies, the clinical picture is not always immediately clear, the complete facts are not always available then and there, and not all the players can be identified at that instant. The professional, however, has very little time to achieve clarity (and certainty) before it is too late. Should the professional wait and clarify the situation before taking any action, or should the professional breach privacy on the assumption that this is necessary to save a life?

Finally, in the back of any professional's mind is always the question of how their actions will sit with their professional peer group and the law. And there is always the nagging doubt about how other patients, or potential patients, would feel if they knew that their confidential communications might be passed on to third parties. What might the consequences be if that element of trust, which is central to the professional–patient relationship, was undermined in this way?

Always a judgement call

A professional decision about breaching confidentiality is *always* a judgement call. Such a judgement call should not be rooted in personal feelings, nor should it be based on a knee-jerk application of clinical concepts, abstract rules and legal concerns. It should be clinically competent, and it should acknowledge the regulatory context.

The judgement call should also be guided by a clear understanding of the ethics of the case. This means that, in some cases, it will be determined that privacy should be breached; and in other cases, that it should not. In some cases, where privacy is not breached because the patient has competently requested that confidentiality be maintained, suicide may occur—and that is tragic. However, as in this instance, not everything that is tragic is unethical.

Codes, principles and laws can only give general guidance. Each situation is unique and has to be evaluated on its own terms. And there are no easy answers. i

footnotes

1. *Rodriguez v. British Columbia (Attorney General,)* [1993] 3 S.C.R. 519.

2. Imhotep was the first physician of note in the history of medicine.

Suicidal Preoccupations Among Youth with Eating Disorders

D. is a 17-year-old grade 12 student who has been hospitalized for the fourth time over the past three years. She has been struggling for the past six years with anorexia nervosa. Unlike her previous admissions, her mood is **depressed** and she has shared thoughts about suicide with some staff. She has been banging her head against the wall on occasion. When I asked her about her change in mood, she said, "I'm **so scared** to put any weight on... One reason why I lose weight is, I think, because I am trying to punish myself. I have created a wall between myself and my family and I can't break it down any more. I used to be able to **escape** by not eating, but now even that does not work. Sometimes, I want to get better, get on with school and friends, but I am afraid I'll never be able to get over this. Living like this is all I know. Before, I used to pretend I could control it and I could get better any time. I have no more friends. I have hurt and let down my family so many times. **I feel so guilty**. I do not think I want to kill myself, but it would be simpler if I was gone and my family would not have to worry anymore!" [1]

One has to take these situations seriously, since suicide can account for up to 50% of the mortality encountered with patients who suffer from eating disorders (ED). Mortality rates increase with age. Sometimes patients also suffer from mood disorders, drug abuse and/or poor psychosocial functioning, which further compound the risk. Tragically, up to one-third of adults with eating disorders have experienced physical, emotional, or sexual abuse. Lastly, suicidal thoughts and attempts are quite common among adolescents in BC (up to one-third of youth have considered suicide in the past[2]). The lifetime prevalence of anorexia nervosa for women ranges from 0.5% to 3.0%, and 1.1% to 4.2% for bulimia nervosa. The male–female prevalence ratio is 1:10.[3]

During the early stages of a disordered eating condition, when denial is strong, the person often feels in control and enjoys the benefits the condition brings socially and personally. These include improved self-esteem, sense of control, and praise from peers for their appearance. However, the consequences of starvation

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Suicide in Later Life

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Suicide among older adults is more common than many people think. According to Statistics Canada, in 1997, the rate of suicide for older adults was 12.4/100,000 (23.0/100,000 for men, and 4.5/100,000 for women over the age of 65). The seniors' rate is slightly over the national average, though the rate for older males is significantly higher.[1]

A strong indicator of suicide risk among older adults is when a person simply feels that life is no longer worth living. Some of the risk factors commonly associated with suicide in later life are:[2-6]

- increasing age (more common among older seniors, i.e., people ages 80+)
- being male, and especially, Caucasian male
- being single or divorced, or living alone
- having an alcohol use problem
- poorly managed chronic pain
- social isolation or closed family systems that do not encourage discussion or help-seeking
- poor physical health or the belief that they are ill
- hopelessness and helplessness
- loss of health, status, social roles, independence, significant relationships
- depression
- fear of being forced to move to a nursing home

Ageism can play a significant role in suicide in later life. Some health care providers may erroneously assume that poor health, feelings of hopelessness, and depression are part of normal aging, or they may assume that depressed older adults cannot be helped.

In the United States the ratio of completed suicides for older adults is 1:4, compared to 1:25 in the general population. Older adults (especially those aged 85 and over) have the highest rate of completed suicides of any age group.[7] There are several reasons why older adults die in their suicide attempts. These include:

- frailty—it takes less of a prescription drug to cause death; also, injuries may cause more physical damage and there may be less ability to recuperate
- social isolation may make rescue less likely
- older people tend to use more lethal methods (prescription drugs, gun shot, falling from a high-rise) and they often have stronger suicidal intent
- causes of death may be less rigorously investigated in older persons (some 'accidental' overdoses may not be accidents).

One half of older adults do not leave a suicide note. This may reflect suicide as a sudden decision made out of desperation, protection of family or religious concern. Some may not have anyone to whom they can leave a note, while others may no longer have the ability to express themselves.[8]

Among adults at any age, the risk ratio of suicide for people with substance use problems or dependence is 5.5 times higher, compared to people without these problems.[7] The relative risk of suicide is even higher for individuals with certain dependencies:

- 10 times higher for people with opioid dependence
- 30 times higher for people with dependence/abuse of legal drugs (prescription drugs)
- 39 times higher for people using a combination of legal drugs and alcohol.[9]

Professionals, other service providers, and family members can help reduce the risk of suicide among older adults by being alert to the signs in later life and sensitively helping the older person access appropriate community resources. Help may include medication and counselling for depression, substance use counselling, grief counselling, and chronic pain management.

footnotes

1. Statistics Canada. (2005). *Suicides, and suicide rate, by sex and by age group.* Retrieved August 14, 2005, from www40.statcan.ca/l01/cst01/health01.htm.

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4. Quan, H., Arboleda-Florez, J., Fick, G.H. et al. (2002). Association between physical illness and suicide among the elderly. *Social Psychiatry and Epidemiology, 37*(4), 190-197.

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6. Waern, M., Rubenowitz, E., Runeson, B. et al. (2002). Burden of illness and suicide in elderly people: Case-control study. *British Medical Journal, 324*(7350), 1355-1358.

7. Centre for Suicide Prevention. (1998). *SIEC Alert #28: Suicide among the aged.* Retrieved August 30, 2005, at www.suicideinfo.ca/csp/assets/alert28.pdf.

8. Salib, E., Cawley, S. & Healy, R. (2002). The significance of suicide notes in the elderly. *Aging and Mental Health, 6*(2), 186-190.

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The Biological and Genetic Dimensions of Suicide Risk

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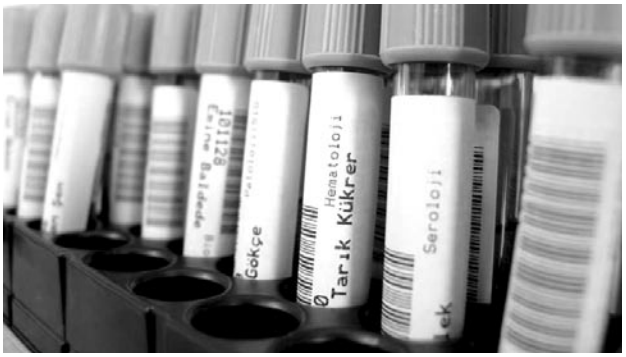

Despite the prominence of suicide as a leading cause of death throughout most of the world, the biological basis of suicide remains poorly understood and inadequately studied. While several psychosocial factors associated with suicide have been described in detail, numerous studies have also supported the role of biological factors in suicide predisposition. For example, the intergenerational transmission of suicidal behaviour is well documented and suggests that the discovery of genetic factors for suicide could, in the long run, lead to improvements in prevention.

The causes of suicidal behaviour likely overlap with causes of other psychiatric disorders, owing to the high rates of depression and other mental illnesses amongst individuals who die by suicide. However, numerous studies have indicated that an individual's likelihood to engage in suicidal behaviour is independent from the genetic factors that increase susceptibility for major psychiatric problems.[1] Other factors, like impulsive-aggressive behaviours, also play a critical role in suicide predisposition.

Perspectives on the neurobiological basis of suicide have begun to converge in recent years on several key areas. The primary biological focus of suicide studies has been oriented upon serotonin, a neurotransmitter involved in communication between neurons. Neurons are cells that are responsible for the transmission of information in our nervous systems. In the 1970s, researchers observed that those with the highest suicide risk had the lowest levels of a serotonin by-product.[2] Subsequent studies investigating serotonin receptors in the prefrontal brain cortex of suicide completers have supported the idea that suicide is associated with low serotonin levels.[3] These observations, together with a series of other findings obtained using different research methods, imply that both serotonin and the prefrontal brain region play a role in suicide.

Our brains, however, are very complex. They are composed of many brain regions, which communicate amongst themselves through multiple circuits. Moreover, neurons employ more than one neurotransmitter to transmit information. For a behaviour as complex as suicide, it would appear that multiple neurotransmitters, brain regions and circuits may be involved in individuals' increased risk for suicide.[4] Within this perspective, recent findings point to the possible implication of molecules involved in intra-neuronal communication and the way they influence how individual neurons affect the transmission of information. More specifically, findings with respect to protein kinase A and C are encouraging.[4]

Another interesting lead supported by several lines of evidence is an intriguing association between low cholesterol levels and suicidal behaviour.[5] The mechanisms explaining how serum cholesterol levels may have an effect on behaviour, however, are unclear. In any case, the investigation of lipid (i.e., fats) metabolism in the neurobiology of suicide and related behaviours has gained renewed interest in light of the growing evidence of essential roles for cholesterol in promoting brain plasticity and connectivity between cells. Evidence also suggests that the composition of brain sterol (a class of chemicals that play a role in the brain analogous to that of hormones in the rest of the body) could be involved in this association.[6]

In recent years, there has been growing interest in specific genes that may be involved in suicide predisposition. The evidence supporting the role of genes in suicide is based on the following: 1) suicide often runs in families, and 2) twin and adoption studies suggest that genes are likely to account for familial clustering of suicidal behaviour.[7]

The emphasis of the studies investigating specific genes on suicidal behaviour has been on those genes that play a role in controlling the production and activity of serotonin. Although some of the findings have been consistent—particularly those implicating a genetic variant in the regulatory region of

an individual's likelihood to engage in suicidal behaviour is independent from the genetic factors that increase susceptibility for major psychiatric problems.

footnotes

1. For more information, see Kim, C.D., Seguin, M., Therrien, N.et al. (2005). Familial aggregation of suicidal behavior: A family study of male suicide completers from the general population. *American Journal of Psychiatry, 162*(5):1017-1019.

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the gene coding for the serotonin transporter (the target molecule of most commonly used antidepressants)—the results of this type of study are preliminary at best.

One of the problems with the current findings on the role of genes is that the types of studies investigating these relationships often have key methodological shortcomings such as the infrequency of suicide completion and the degradation of genetic material over time. Another issue is that genes are just one component of suicide risk. Other biological, psychiatric and psychosocial factors are also likely to influence suicide risk, and most of the studies that examined genetic factors have focused exclusively on these. In the face of multiple factors influencing suicide risk, the power of the methods used thus far is limited.

Nevertheless, an encouraging finding recently came out using a methodology that allows testing the influence of genes, while taking into account developmental and life experience dimensions. The study indicated that individuals with a certain regulatory variant of the serotonin transporter gene are more likely to display suicidal behaviour when exposed to life stressors.[8] These promising results need to be replicated and better investigated.

Several technologies also show promise for the study of suicide. One such technology is microarray analysis of gene expression, a technique that has become increasingly used in the study of complex conditions such as suicide. This method allows for the simultaneous monitoring of tens of thousands of genes at the same time. Though the wide-scale implementation of microarray technology in studies of psychiatric conditions and behaviours has only just begun, it shows promise—particularly regarding the discovery of previously unknown aspects of suicide neurobiology. As these types of studies become more commonplace, a better picture of the genes involved in the pathophysiology of suicidal behaviours will emerge. This clearer perspective will allow researchers to then focus on particular pathways and genes.

The search for the biological basis of suicide is an enormous challenge. However, progressive research strategies are enabling us to both understand and move beyond some of the more customary domains of study. Eventually, suicide risk assessment will be less subjective, and we will be able to develop more effective treatment intervention strategies for susceptible individuals.

6. For a review, see Kaplan, J.R., Muldoon, M.F., Manuck, S.B. et al. (1997). Assessing the observed relationship between low cholesterol and violence-related mortality. Implications for suicide risk. *Annals of the New York Academy of Sciences*, 836, 57-80.

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Suicidal Preoccupations Among Youth with Eating Disorders | *continued from page 11*

and compensatory behaviour, such as binge eating and purging, eventually become a burden and create personal social loss. Over a period of time, the person becomes more isolated, helpless and hopeless as friends and family distance themselves. Performance in school and other activities, such as sport, start becoming impaired. And hospitalizations are sometimes necessary. The person becomes exhausted from battling the eating disordered thoughts and behaviours. They realize that recovery will be hard, and a lengthy process.

It is important to reach out for help in the early stages of this condition; however, for some there are barriers. The person with an eating disorder often feels they are undeserving of help or that accepting help is a weakness. They may have learned from their family and culture to value control and to avoid conflict and expression of feelings. This can be due partly to malnutrition, but also to a lack of learned ability to be assertive and to express one's voice.

There may also be ambivalence about getting better. There is a fear of losing beliefs and rituals that have helped with coping in the past. Sometimes the health care provider is not trusted, may be viewed as someone 'forcing' the client to do something he or she does not want to do.

This is a time when self-harming behaviours and suicidal ideation may become a way of coping with this turmoil—and a time when the support of friends and family is critical. Friends and family can help by providing empathetic listening and by acknowledging the ambivalence and the confusion. It is an important time to keep believing in recovery and supporting self-efficacy. However, the person always needs to be kept safe; when danger is imminent, use of professional emergency services may be needed.

A consistent, hopeful and future-oriented approach is crucial to the healing process. Open communication facilitates this, although it can be sometimes demanding for helpers. They need to recognize that they must manage their own feelings of frustration: it can be challenging to encourage someone to express their feelings and then to hear their sadness, anger and despair, while not being able to 'fix' it for them. Being honest and direct, while being compassionate, remains critical.

Help from their peers is sometimes easier for people with disordered eating to accept. In their despair, they struggle with thoughts of self-punishment and use the ED behaviours for relief from these thoughts. Feelings of shame tend to lead to further negative behaviours and further guilt. But, amidst the despair, they often also search for meaning and a better understanding of their purpose in life. Self-help groups and peer support can often help individuals manage these feelings and focus on personal values to good effect.

Ultimately, it bodes well for health care providers and significant others to help these young people "construct a sense of hopefulness that they can ultimately enjoy a life without the eating disorder."[4]

footnotes

1. Fictionalized vignette based on what patients have reported.

2. McCreary Centre Society. (2000). *Mirror images: Weight issues among BC youth, results from the Adolescent Health Survey.* Burnaby, BC: Author.

3. American Psychiatric Association. (2000). Practice guideline for the treatment of patients with eating disorders (Revision). *American Journal of Psychiatry 157*(1).

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Blueprint for a National Suicide Prevention Strategy

Adrian Hill

Adrian is an officer and director of the Canadian Association for Suicide Prevention (CASP). He practiced law for 30 years, and founded and developed national and provincial programs to help lawyers and judges with addiction and mental health problems—including the first suicide prevention program in the world for legal practitioners. Adrian was the editor and a core author of the CASP Blueprint

Many countries have developed national strategies to reduce suicide, often utilizing the expertise of Canadians. Why, then, was Canada so slow in moving forward on its own strategy regarding this most pressing of public health issues?

As a national organization, the Canadian Association for Suicide Prevention (CASP) concluded that Canadians had waited long enough. If our federal, provincial and territorial governments could not work together to create a national strategy, it was our duty, as members of our own communities, to take up the challenge. Thousands of hours of work later, the *CASP Blueprint* was released in October 2004 to all levels of government and to all Canadians. Support and gratitude has confirmed that the effort has been justified.

What is the Blueprint?

The *Blueprint* is a national suicide prevention strategy for Canada. It is also a policy agenda, a national task list, a tool for identifying best practices, and a roadmap to an integrated solution. It covers suicide prevention, research, education, treatment, crisis intervention and bereavement support. Issues, needed improvements and emerging best practices have been addressed in a practical, achievable and humane manner.

Any national strategy will require public debate and pan-Canadian input; we have put forward our *Blueprint* as a starting point for such debate and input, hoping to both challenge lawmakers and governments and to kick-start a process that is decades overdue. As members and directors of CASP, we have offered our leadership and expertise to motivate and assist our governments in fulfilling their own leadership roles.

2003: Strategy, research, planning sessions

Themes, expectations, checklists for goals and objectives, a framework for the blueprint, and a process strategy for writing, review, rewriting and correction, publication and communication were developed in 2003. This was accomplished through strategizing, planning and follow-up sessions of the CASP board members, along with a group of invited participants.

The participants comprised a talent pool of clinicians, researchers, teachers, program administrators, consumers and survivors. Everyone donated time and expertise. And each one of the participants had experienced personal loss through a suicide death—they have lost parents and children, sisters and brothers, neighbours, friends and patients. As such, we call ourselves "survivors."

2004: Writing, peer review, editing

In 2004 a writing committee, composed of a psychiatrist, a psychologist, a social worker/researcher and a lawyer/survivor, was given responsibility for writing the initial drafts and submitting them for vigorous peer review across Canada. Fourteen formally revised versions saw hundreds of changes and improvements. A project editor pulled the pieces together to create an integrated document. The decision was made to finalize the process and publish the *Blueprint,* for review by all Canadians and by members of the World Health Organization and the United Nations.

2005: implementation plan, budget, timeline

In 2005, the CASP board has made presentations to governments, associations, groups and individuals across Canada. A number of citizen presentations were made to the Kirby Commission, to the Canadian Alliance on Mental Illness and Mental Health (of which CASP is a member) and to the Canadian Mental Health Association. We believe that working in partnership with both CAMIMH and CMHA will be essential to the development of a true national suicide prevention strategy and the successful completion of an integrated solution.

The Business and Implementation Plan 2006-2008, with budget, was delivered to the federal government during CASP's annual conference in October.

guiding principles

1. Suicide prevention is everyone's responsibility
2. Canadians respect our multicultural and diverse society and accept responsibility to support the dignity of human life
3. Suicide is an interaction of biological, psychological, social and spiritual factors and can be influenced by societal attitudes and conditions
4. Strategies must be humane, kindly, effective, caring and should be:
   - **a)** evidence-based
   - b) active and informed
   - **c)** respectful of community and culture-based knowledge
   - **d)** inclusive of research, surveillance, evaluation and reporting
   - **e)** reflective of evolving knowledge and practices
5. Many suicides are preventable by knowledgeable, caring, compassionate and committed communities

Suicide and Language

Doris Sommer-Rotenberg

Mrs. Sommer-Rotenberg spearheaded the campaign to establish the Arthur Sommer Rotenberg Chair in Suicide Studies at the University of Toronto

excerpted from "Suicide and language"— CMAJ 11-Aug-98; 159(3), Page(s) 239-240 by permission of the publisher.

"Commit suicide." Two words traditionally, even facilely, used to describe the act of self-killing. They speak to the common perception of suicide which, if corrected, might help to reduce its incidence. I had never questioned the use of this phrase until my son took his life. He was an accomplished physician in his mid-30s who suffered from bipolar disorder. The hollow distance between the fullness of the years he lived and the rich potential of those that were lost was immense. To keep alive the vitality of my son's life and spirit, and to help prevent similar tragedies, I initiated a campaign to establish in his memory a research chair in suicide studies at the University of Toronto—the first of its kind in North America. This fact in itself attests to the silence that has historically surrounded the issue of suicide. As the campaign progressed I realized that raising awareness about this act of despair was as important as raising money.

The shame of those who have been bereaved by suicide is based in the fear of being associated with the forbidden act. It necessitates a repression of emotion and ends in denial—in pretending that the self-killing did not occur. The bereaved and those who merely observe collude in a silence that disallows compassion and understanding. Shame—or the presumption of shame—produces embarrassment in others. The result can be gross insensitivity. One young woman described to me how after her husband took his life her neighbours would cross to the other side of the street when she took her children for a walk, apparently to avoid having to talk to them. When a tragedy is not spoken of openly there can be no true sympathy, sharing or healing.

Silence is often an effort to avoid the "contamination" of suicide. A large corporation whose president had taken his life declined to make a donation to our ▶

Blueprint for a National Suicide Prevention Strategy | *continued from previous page*

blueprint goals

A. Awareness and Understanding
- Promote awareness in every part of Canada
- Develop broad-based support for suicide prevention and intervention
- Develop and implement a strategy to reduce stigma
- Increase media knowledge regarding suicide

B. Prevention and Intervention
- Develop, implement and sustain community-based programs that respect diversity and culture
- Reduce the availability and lethality of suicide methods
- Increase training for recognition of risk factors and warning signs and for provision of effective intervention
- Develop and promote effective clinical and professional practice
- Improve access to and integration of services
- Prioritize intervention and service delivery for high-risk groups
- Increase crisis intervention and support
- Increase services and support for those bereaved by suicide
- Increase the number of primary prevention activities

C. Knowledge Development and Transfer
- Improve and expand surveillance systems
- Promote and support the development of effective evaluation tools
- Promote and develop suicide-related research
- Increase opportunities for reporting

D. Funding and Support
- Increase funding and support for all activities connected with the *CASP Blueprint*
- Ensure access to appropriate and adequate health, wellness and recovery services for all Canadians

What next?

To quote the *Blueprint*: "The writers of this blueprint anticipate cooperation, enthusiasm and funding from all levels of government and from all segments of Canadian society. We expect our federal government to take a leading national role, to apply its own Pan-Canadian Healthy Living Strategy and to initiate the successful implementation of this *CASP Blueprint*."[1]

The *Blueprint* has been favourably received and compares well with the national strategies of England, Australia, Ireland and the US. It is the only national strategy in the world produced entirely by volunteers and without government funding, while still being comprehensive, professional and practical.

fundraising campaign for fear that such a contribution would open the door to unwanted, deprecating publicity. Such responses only serve to exacerbate the stigma of suicide, to preclude open discussion about it and to discourage research that may help to prevent it…

Words and values

We might begin by considering the words we use to describe this destructive act—particularly the phrase "commit suicide." The only acts we "commit" are heinous ones: adultery, a felony, some kind of crime. The German term *Selbstmord begehen* is similar, denoting an act of commission. By contrast the French *se suicider* and the Italian *uccidersi* are reflexive. Likewise in Hebrew: *l'hit'abbed,* "to self-destroy," is something one does to oneself, with no implication of criminality. The expression "to commit suicide" is morally imprecise. Its connotation of illegality and dishonour intensifies the stigma attached to the one who has died as well as to those who have been traumatized by this loss. It does nothing to convey the fact that suicide is the tragic outcome of severe depressive *illness* and thus, like any other affliction of the body or mind, has in itself no moral weight. As Susan Sontag describes in the case of tuberculosis, cancer and AIDS,[1] illnesses have often been regarded as if they expressed moral attributes. Tuberculosis, for example, was romanticized in the 19th century, becoming a metaphor for sensitivity and creativity. Suicide, by contrast has been demonized as a metaphor for moral weakness and failure. Many people consider any form of psychological vulnerability, including depression, as a moral lapse.

In a recent article in the *Financial Post,* suicide was described as "the ultimate act of selfishness."[2] The author can have no understanding of the pain that drives someone to make this agonizing decision and then "execute" it. Often the decision to kill oneself is taken out of a distorted consideration for those one loves; the dislocation of emotion is so immense, the feelings of unworthiness so overwhelming, that the suicidal person believes that loved ones would fare better if he or she were no longer part of the world.

The article also stated that "the God of all the major faiths rejects suicide as a fundamental sin."[2] It is true that, in the past, Jews who died by their own hand had to be buried on a remote edge of the cemetery and that Catholics could not be buried in consecrated ground. The act of self-killing was considered criminal because it was perceived as transgressing the moral authority of God and the righteous feelings of humankind. As recently as two generations ago, "it was a felony to attempt suicide in such countries as Britain, the United States and Canada. It was a reportable offense that nobody reported."[3] These attitudes of condemnation are beginning to change. As Rabbi Gunter Plant wrote with respect to the proposed chair in suicide studies, "We no longer punish, but try to understand.... Since we are dealing with the very essence of existence, this whole scientific enterprise acquires the aura of a religious undertaking."[4] Similarly, there is now greater understanding within the Catholic faith.

Toward healing

…The language we use to describe events not only reflects our own attitudes but influences those attitudes as well as the attitudes of others. A change in the words we use will not immediately dispel deep-seated prejudices, but it will inhibit their expression and, in so doing, prepare the ground for attitudinal change. When racist remarks are viewed as socially unacceptable, for example, the social environment becomes less hospitable to racism itself. The language of suicide, like the illness leading to suicide, are both mired in denial. The term "commit suicide" should be excised from the language. There are other and better alternatives: Hamlet's "self-slaughter," "death by one's own hand," "ended one's own life," "self-inflicted death," "a casualty of suicide" or the raw "killed oneself." Even the expression of a former Vietnamese prisoner of war, who described his feelings during his incarceration as a desire "to be off the planet," avoids the judgemental connotations of "commit suicide." And any of these expressions is better than the obituary euphemism, "died suddenly."

Physicians can send a powerful message to colleagues, patients and society at large by using neutral and compassionate language when they refer to suicide. By their leadership in this revision, they will be better able to help those with suicidal feelings to take a crucial step back from despair, and to help those who have been bereaved by suicide to resolve their feelings of anguish and regret. The rejection of the term "commit suicide" will help to replace silence and shame with discussion, interaction, insight and, ultimately, successful preventive research.

Editor's note: *Since this article was published, the Canadian Association for Suicide Prevention, Compassionate Friends and the major US suicide prevention organizations now all advocate for the use of the terms "died by suicide" or "suicide death," which are nonblameful, nonjudgemental and consistent with how we describe other types of death.*

"The language we use to describe events not only reflects our own attitudes but influences those attitudes as well as the attitudes of others."

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Inside my Suicidal Mind

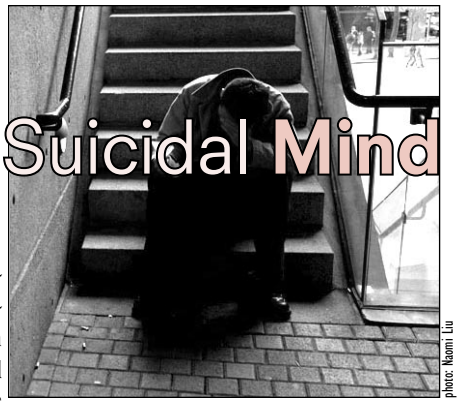
photo: Naomi Liu

Patrick Schnerch

Patrick resides in Victoria, and lives with a diagnosis of bipolar disorder

There is constant conflict between my depression and my will to live. One moment I am at high risk of falling victim to suicide, and the next moment I am rationalizing my worth as a human being. This has continued for three decades. My illness has hospitalized me on several occasions. I have survived vicious self-mutilations. Spending time in an alcohol detox centre lost me my career with the federal government.

When I'm in my depression, darkness is my life. Thoughts swirl around me, and I am engulfed by despair. My battered mind and soul are confused and weakened, unable to fight off dark thoughts. The only glimmer of hope is that death will finally bring the peace I so desperately seek. I'm supposed to be able to wipe these thoughts out of my mind just by ignoring them—but this is not as easy as it sounds, when suicide feels like the only option for relief.

Detachment from life is all I know. I have no feelings of happiness or sadness. Disconnection with reality has left me in a zombie state of mind. Life passes me by without any recollection. The only things I believe to be real are my tears. Loneliness from the outside world is my sanctuary because within my own darkness, I am safe from the outside.

I need energy to fight a battle that seems impossible to win—the battle for my life. The constant fight and resistance leaves me mortally wounded. The battles make me weary. My body can only take so much abuse. Desperately I seek other methods of relief—alcohol provides temporary respite from the misery, clouds of intoxication briefly numb the pain.

Exhaustion is overwhelming and can only be relieved by resting during the day. The mind and body feel beaten. Self-esteem is destroyed due to an inability to perform the simplest of tasks. The eating and inactivity cause weight gain. The body fat around my waist pushes me further into the abyss. Failures in life compound upon each other, paving the road toward suicide. While in a depression, nothing seems to go right; failure is the only thing I am sure of.

Other people cannot understand how some of us can even think of suicide. But to me it seems to be the most logical method of escaping a life that is not life. Minds and souls are destroyed and life is really not life without them. There seems to be no difference between life and death, since we already feel as though we are dead. This is why death is not a fearful prospect. We have been there, done that. Death is not a stranger to us; that's why it calls out for us. And we are so tired. We just want some peace. Somehow, it all has to end.

If this darkness is so devastating, then why am I still alive? There is one reason I have put up with this relentless hell: I love my wife. Suicide would be like killing two people. The stress of financial hardship and the family affairs she would have to deal with on her own would become her doom. It's my feelings for her that have stopped me from killing myself. That, and I want to feel life again...

Coda

It's difficult to write about depression when you are totally recovered. Your thoughts and feelings about life are not the same as they were when you were ill. Your thought process is totally different. I have been sober for four months now and my mental health is stabilized. I have walked through the threshold to a whole new world. For the first time in 30 years, I've started to discover things that have been buried inside me. I now have goals and dreams to conquer, but most of all, I have hope. I feel my life is important enough to fight for. My fight for survival has been a very long one, and I am willing to continue the fight. i

My First Suicide Attempt

Faith*

**pseudonym*

My 'demons'

I knew my illness was developing. I worked in the health system, so knew that isolating myself, having thoughts of despair, frequently complaining of physical symptoms—and hearing voices—were signs of something brewing. But I was ashamed to acknowledge that I might have a mental illness. I lived in a small town in northern BC, where eve-

ryone knew everyone else. The stigma surrounding mental illness kept me from seeing doctors until it was almost too late.

My doctor knew something was wrong, even though all the tests for somatic illnesses came back negative. When she asked me what was going on in my head, I asked her if she believed in good and evil—then I told her I was demon possessed. She admitted me to the local hospital.

In the hospital, I saw my GP every day for individual therapy—I didn't want to see a psychiatrist; the priest at the local church I attended had told me the voices I heard were demons, and I believed the priest. After seeing my doctor I would I try to understand the words *mental illness*. The doctor said I had a mental illness and the priest said I was demon possessed. I was so confused and didn't know who to believe. Everything got muddled in my head and a dark despair overtook my thoughts.

I had flashbacks of demonic removal rituals that had been performed on me by the priest. For about three years I had been hearing voices, and these frightening rituals were done to me in the church, three or four times a month. The so-called Christian counsellor and the priest blamed me for anything bad that happened in the town, and I came to believe that I was a bride of Satan.

It's no wonder my thoughts told me I was no good and that nobody, especially the priest, cared for me anymore. When neighbours, friends, peers and co-workers came to visit me in the hospital, I couldn't face them. And I couldn't tell anyone except my doctor about what was going on—the nurses knew the priest and attended his church. Abandonment, loneliness, emptiness and betrayal consumed my mind. I was going down a tunnel with no light.

Agonizing thoughts ruminated in my mind over and over again. Where, I wondered, had that perfect Christian girl gone who once did everything for God? I cried to God: "Why do I have this confusion? Where are you in my time of need? Do you hate me as I hate myself?" On my knees I cried out: "Why, oh why, have you forsaken me?"

I was caught in between 'good' and 'evil.' Voices were telling me to kill myself. And I had an opportunity, about a month and a half after being admitted to hospital: I went home on a day pass. I swallowed a couple of bottles of Tylenol and whatever else I could find in the house and chased it down with alcohol. Fortunately for me—though I didn't consider it fortunate back then—a friend came by unexpectedly, and rushed me to the hospital.

After I tried to kill myself, my doctor was upset with me. She ordered me sent to a larger community that had a psychiatric ward in its hospital. Two ambulance drivers accompanied me. I couldn't comprehend what was going on, and I felt like I was being 'thrown out' of the local hospital; I felt abandoned.

On the way we stopped at a rest area so I could go to the bathroom. When I looked in the rest stop bathroom mirror I could see black charcoal around my mouth and my teeth were black from the stuff the hospital gave me to neutralize the pills I had taken. I felt so humiliated when I came out of the bathroom into public view: I was still in hospital clothes; my dignity was gone. I thought this was an ongoing nightmare, and cried to myself, "Wake up, wake up, you are dreaming!" But I wasn't dreaming. My nightmare continued.

When I arrived at the hospital, I was put in a room where the bed was a cement slab with an orange comforter. A TV monitor hung in the corner of the ceiling, and the door to the room was locked. A nurse told me to wave at the TV monitor if I had to go to the washroom or needed help. I cried myself to sleep. I couldn't believe what was happening to me.

Now there's a light in the tunnel

That was my first suicide attempt, and it wasn't my last.

At the beginning of my sickness, I was very manipulative, self-harmed and had a lot of anger. I kept the door revolving at the Vancouver General Hospital psychiatric assessment unit, and professionals didn't know what to do with me. Finally, one of the psychiatrists referred me to a mental health team.

I praise the psychiatrist and the mental health team I now have. I'm being better educated about my mental illness and I can educate them about me. I'm finding that this process of rehab and recovery is no longer about *us* and *them* (i.e., mental health consumer vs. service provider), but it is getting to be more like *we!*

It has taken eight years, with many trials and tribulations, to get the medications right. With these meds and after extensive psychotherapy, I am now a person who doesn't manipulate and I have a lot less anger. I am taking the SAFE (Self Abuse Finally Ends) course, which teaches me coping skills to stop myself from self-harming. And I've now found a church that is warm, welcoming and compassionate. I'm very much at peace with God, who I know is big enough to take my confusion, anger and fears and loves me for who I am and where I'm at.

Through extensive group work in the Integrated Personality Program at Vancouver General Hospital psychiatric outpatient department over the last six years, my feelings of abandonment, loneliness, emptiness and despair are diminishing. Today, I feel that I am a capable person. I am active as a mental health consumer, advocating for other consumers, either at my mental health team or at work.

Suicide attempts are getting farther and farther apart, and I now know where to reach out to for help. I still struggle, but I'm getting better each day. And there is a light at the end of the tunnel. i

Faith has been a consumer of the mental health system, with a diagnosis of borderline personality disorder, for the past eight years. She attends a mental health team in the Lower Mainland

Through courage, and encouragement from the Vancouver Suicide Survivors Coalition, Faith has been inspired to write about what it is like to attempt suicide—and to survive. She has come to a place in her recovery process with borderline personality disorder where she can talk about her process, which began more than eight years ago

A Lesson for Me, Dear Sister

Peyton Brooks*

*pseudonym

I've always had a bit of a fascination with suicide—though not in a dangerously morbid sense. My codependent 'fix it' nature lent itself to relationships with people experiencing varying levels of suicidal ideation. From a best friend in high school who lost the promise of a stellar hockey career and a parent to divorce and alcohol, to a husband haunted by demons that he lulled with heroin and who twice nearly took his life years before he would know recovery—my fascination has been like a dance with the devil.

I remember being profoundly impacted by a suicide awareness workshop in school, noting the checklist of warning signs: giving away prized possessions, no longer finding enjoyment in activities once found enjoyable, withdrawing from friends and family... I stored this information away like Jeopardy® trivia.

The hanging death of a schoolmate, from his childhood swing set two weeks prior to graduation, left its mark—to this day I have the small yellow ribbon we wore pinned to our graduation gowns in his memory.

Praised for my compassion, strength and knowledge by those who relied on it, I was the voice of reassurance and the shoulder for many to cry on. But tragedy doesn't play by lightning's rules, striking only once in the same place: suicide would be a recurring theme in some of my most significant relationships—and I arrogantly believed I would recognize the precursors.

Then came a night I'll never forget. When I walked up the stairs of my parents' house that night and saw my sister and her friend playing some kind of game in the living room, I wondered if I should bother to acknowledge her. For some reason that seems inconsequential now, it felt like a standoff: who would acknowledge whom first!

My sister and I had grown up sharing toys and clothes, but later barely even shared words. I could list my share of excuses: chiefly, I was struggling to keep my own head above water as the reality of my husband's addiction grew clearer. But that great stress hadn't left me mute; I was still capable of uttering the word "hi," and if responded to, may have even mustered a "how are you." But, I didn't, and I'm ashamed of that.

It was hours later when my mom screamed for my husband and father to help her. She was dragging my sister's drugged body from her downstairs bedroom (a friend sworn to secrecy later told us my sister had ingested at least 17 pills).

And I, the Jeopardy® suicide-category hands-down winner, became the worst nightmare-in-a-crisis as I scrambled to think of something besides my own guilt. When my sister began drifting into the warmth of unconsciousness, instead of shaking her gently or calling her name, I slapped her hard across the face. As I drove, shoeless, in the direction of the hospital, my husband spoke to her soothingly—he was everything I should have been. I could only reel through, in my mind, the previous days, weeks, and months—her car accident, the painkillers, the doctor denying her prescription refill, me accusing the doctor of being insensitive, her late nights spent with new friends, more pills of the non-prescription kind, the distance between us... What more did she have to do...sign over her prize possessions? Later I realized I had even missed that warning sign: she had called me at work just days before to tell me I was the beneficiary of her RRSP should something happen. I had missed *all* the signs.

We sat in the waiting room for hours. We listened to my sister scream and curse as the medical staff stuck a tube full of charcoal up her nose. Once she had finally quieted down and the nurses had assured us she would survive—luckily her drug of choice would unlikely have resulted in a lethal overdose—my husband drove my father home. They offered to take my pathetic self with them, but I insisted on staying at the hospital.

As my sister lay with her hands strapped to the sides of a hospital gurney and streaks of grey charcoal marking her cheeks, I sobbed, "I'm so mean to her." And I promised her, silently, that I would be a better sister.

I wish I could say the change happened quickly—that upon her release from hospital I nurtured the relationship as I had assured her I would. It was better. I was softer, for the first time seeing my sister as fragile. And I resumed my protective older sister role—but instead of leaping across the abyss of distance between us, I crawled.

Now, with the pending birth of her first baby, my nephew, the gap between my sister and I has been steadily closing. My sister, who once believed her life was no longer worth living, is now giving life to another being. And I, the not-so-perfect knowledgeable and compassionate sister, was offered something that, tragically, isn't always possible when it comes to suicide—a second chance.

Life is not about knowing the right answer; it's about taking the time to ask the right question. The right question can be as simple as "how are you." I may have been slow to learn my lesson, but the day I hold my nephew for the first time, I will again remember the lesson and humbly thank the universe for teaching me to appreciate the gift of a sister—who is perfectly flawed, just like me. I love you, Sis. Thank you for loving me back, even in those darker days.

The Cost of Suicide

Cynthia Row

Cynthia is Editorial Assistant for Visions

Despite a proliferation of information and appeals for public awareness, the subject of suicide—and mental illness and addiction in general—has a way of flying just below the social radar when compared to other social and health issues. The behavioural and emotional manifestations of mental illness and addiction can exhaust and repel even the most compassionate. Mental health professionals experience 'battle fatigue' from exposure to so much heartbreak, pain and tragedy.

Stigma and incomprehensibility keeps mental illness on the edge of public awareness. When confronted with the subject of suicide, feeling the resulting emotions of pity, outrage and sorrow may be as far as people are willing to go in their involvement; by giving emotionally they feel they have given enough. And then there is a lingering prejudice of the social Darwinian variety—that the "fittest" in our society will (and should) survive—and its corollary that those who take their own lives are better off dead.

For those whose involvement in suicide prevention is affected by these dynamics, there is a powerful argument that should work where others fail. It is an economic argument. In our society money talks, and those who can make a difference should consider the economic costs of untreated mental illness and, in particular, the cost to society of suicide. The suicide death of my father provides a prime example of these costs.

Robert Row was a successful and well-respected physician and surgeon. He founded a much-needed medical clinic in our small town of New Hamburg, Ontario. The clinic served the 3,000 residents of the town and an additional rural population of 5,000 (mostly Mennonite) clients. With several doctors and staff, a pharmacy and dental clinic, the clinic now employs some 30 people. He also co-founded a sailing school, was a ski instructor, and built and raced a Formula Junior-class car on the national Grand Prix circuit.

My father also experienced severe depression and became addicted to morphine and alcohol—as many physicians do. And, as with many health professionals, his illness and addiction went untreated. He took his own life—by a deliberate morphine overdose—in the prime of his life, at 47 years of age.

The direct cost to society of my father's death is clear. With at least 20 years of high-earning professional life left, he would have generated at least $3 million of taxable income, as well as economic spin-offs from spending and investment. His entrepreneurial endeavours would have created even more employment and opportunity in the community.

But the cost of suicide can be tallied beyond the death of a parent. It compounds in future generations—as it did with me.

I was the youngest of four children, in my mid-teens, living with and dependent upon my father when he took his life. My mother was also mentally ill and unable to care for me. As a consequence of my father's illness and addiction, he had not updated his will in 15 years, had divorced in the meantime, and thus died with his financial matters in disarray—leaving no resources for my care or support. Therefore, after his death I was left at great risk—without home or support, and with no parent to protect me. I went to live with a teacher, where I was repeatedly sexually and psychologically abused.

The emotional fallout of my father's death and the subsequent sexual assault has seriously interfered with my ability to reach my own economic potential. I have experienced severe depression, addiction, poverty and homelessness. During my recovery I have had to depend on social assistance and health services. As statistics presented in this issue of *Visions* suggest, I am at increased risk for suicide.

The impact of my father's suicide on me (and the related cost to society) is complex: my own mental illness would not have been compounded by childhood sexual abuse if he had not killed himself. And my life, with mental illness or not, would definitely have been easier if he were alive today: I would likely be less reliant on social assistance, less at risk for poverty and homelessness, and would more likely be fulfilling my own economic potential.

> "But the cost of suicide can be tallied beyond the death of a parent. It compounds in future generations—as it did with me."

In addition to the measurable economic costs of my father's untreated mental illness and subsequent suicide, there are other costs, less easily measured but highly valued in our society. There is the loss of *potential*, an especially poignant consideration in the case of youth suicide. We cannot begin to measure the economic and social costs of these preventable losses, of lives that are cut so short.

The economic and social costs of untreated mental illness and addiction in our society are profound. Suicide is the most costly of all.

related resources

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Involving Families to Help Avert Tragedy

Marguerite Hardin

Marguerite is President of the BC Schizophrenic Society, North Shore Branch, and was instrumental in establishing its Family Support Centre. She also currently sits on the Family Advisory Committee for Vancouver Community Mental Health Services, which is promoting the acceptance of family involvement in care across all levels of the mental health system

For many years now, families have been making the case that they need to be involved in the care of loved ones suffering from serious mental illness. They point out that they know the real person behind the illness and so have a unique advantage in being able to distinguish behaviour generated by the illness from that of the real person: they can spot the person they care about emerging from the cumbersome mantle of psychosis, and they can pick up the subtle shifts in thought and behaviour that signal an impending relapse. If that kind of information from family members were heeded and acted upon by professionals involved in the care of their relatives, they say, much turmoil and grief, and sometimes downright tragedy, could be avoided. If suicide is seen as one of the worst possible outcomes in psychotic illness, then family involvement in care constitutes a large positive step in the direction of suicide prevention.

What we are talking about here is not whether families care about their relatives—almost all of them undoubtedly do. What families know they need, and believe their relatives could greatly benefit from, is recognition of their unique caregiving role and the contribution they can make.

Most families are eager to learn all they can, from many sources, about the illness that, in many cases, hit their family like a thunderbolt. Self-help groups, where families get together to share their experiences, their grief and joy, and to support and learn from each other, have been a boon for many. Gaining a measure of understanding and acceptance of the illness, and regaining a sense of balance for oneself, is important for any family member. In the end though, this is not enough.

Having to stay on the periphery of the treatment process—not being allowed to ask questions or even contribute observations—has been an exercise in anguish and frustration for many families, particularly when they can see that their ill family member is not doing well and they may have a very good idea of what the problem is. Worst of all, they may have to witness the decline of their loved one yet again into a state of exacerbated psychosis, sometimes with grievous incidents along the way, before they can find the help they need.

The appropriate exchange of information between caregivers is crucial to providing a high level of care when dealing with any serious medical condition.[1] Realistically, families need to be part of the mental health care team.[2,3] They need *peer status* as caregivers if their relatives are to receive maximum benefit.

The suicide last spring of Stephanie James, a young UBC student from Portland, Oregon, underscored the kind of tragedy that can happen when families are cut off. The affair caused a furor when Stephanie's mother, grieving and aggrieved, spoke to a *Vancouver Sun* reporter.[4] Her complaint? That, although the university administration knew that Stephanie had been hospitalized after attempting suicide earlier in the year, she, Stephanie's mother, had not been informed. The necessary steps to ensure that Stephanie received professional follow-up and monitoring were not put in place, but were left to her to pursue on her own. Stephanie was only 18 when she died, alone in her dorm room.

Subsequent coverage had the university protesting that they could not have told Mrs. James about the suicide attempt—that it was their legal and ethical duty to protect Stephanie's privacy. This was simply not the case, as a follow-up article in the *Sun* made clear.[5] It quoted privacy commissioner David Loukidelis firmly stating that, yes, the university could have informed the mother in this case. Mrs. James declared that she "would have been up there in a minute" if she had known about the earlier attempt, and would have seen that her daughter got adequate treatment. The headline on an article by Richard Dolman, who lost his own schizophrenic* son to suicide, had a headline that neatly summarized the majority opinion: "Stephanie's life outweighed privacy."[6]

The James case highlights two salient points that many families have noted in similar situations:

1. ***The neglect or refusal of many professionals in the mental health field to communicate with families*** about their relatives' care is not only brutal, offending some of our most basic human instincts, it is also hugely counterproductive and can lead to ultimate tragedy. Some major attitude changes are needed. Those in authority who refuse to act as families think they should often insist that what they do or fail to do is correct, and legally necessary. Yet those who are familiar with the laws referred to know that the people who claim to be bound by the law frequently do not, in fact, know what the law says.
2. ***Education is clearly needed*** here. Many psychiatrists, nurses and therapists do share pertinent information with families and do take into account family members' observations and concerns. Clinical best practices calls for such family involvement and there is a growing body of literature documenting its benefits.[2,3] Too many professionals, however, still keep families on the outside. There's a lot of work on this yet to be done. ▶

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> We all need to work together when a family member becomes ill, and we all have the right to the best love, care, compassion and support that can be provided. No one should have to walk this walk alone, the 'suiciders' or the 'survivors.' Also, when a 'consumer' is not able to make their normal judgments or decisions, no matter what age they are, a trusted family member must take their place until they are able to make healthy choices/judgments when they become well again. Confidentiality is important, but when their life is in danger, and a consumer is not in their right state of mind or has lost themselves or has impaired judgement, surely common sense alone would tell us that it is a must to have an advocate for this person.
>
> After reading the doctors' reports, I learned that my daughter actually told them she was going to hang herself! This was never told to me. We were told by the only person who got close to her (a 45-year-old male nurse) that the 'system' failed her. This isn't great consolation.
>
> No person should have to go through what she did, nor should any family have to suffer the amputative aftermath of suicide. I loved and respected my daughter and still do. I understand now that it took great courage for her to continue on when she was ill and to accomplish all that she did in her short 22 years. It is because of her tremendous courage and fight to live and overcome all obstacles in her life, that I hope to find her courage to continue to press forward to help others who suffer from brain disorders and fight so that others may receive the care and help we all deserve.
>
> —Janie Ochsendorf, Vancouver, discussing the events surrounding her suicide death of her daughter, Annemiek

resources

See the Family Involvement and Information Sharing sections under Advocacy at the BC Schizophrenia Society, North Shore Branch's website: **www.bcssnorthshore.org**

**Editor's note:* *Consistent with practices from the UN Decade of the Disabled Person (1993-2002), Visions' editorial policy is to replace labels like 'schizophrenic,' 'anorexic' etc. with "people-first language" (e.g., "person with schizophrenia") to show that illnesses or disabilities are only one part of a person's identity. In Visions, these changes are done, however, with the consent of the author. Some authors do not agree with our choice and their work remains as they wrote it.*

Ryan's Story

Kerry Jackson

Kerry is a graphic designer and the founder of 2020parenting.com,[1] a new web-based resource centre focused on providing holistic health education and resources for early prevention and early remediation. The 2020parenting.com mottoes are: Prevention Today for Success Tomorrow! and Our 20:20 Hindsight for Your 20:20 Foresight

My son Ryan came to a tragic end by suicide on January 13, 2002—just 12 days shy of his 27th birthday. He was, by that time, suffering from crystal methamphetamine addiction and drug-induced bipolar episodes.

As his mother, I was devastated—and nearly lost my own life. My physical health deteriorated so badly, in large part due to the stress of trying unsuccessfully for 10 months to find effective help for my son, that I had a few suicidal thoughts of my own. No parent should have to endure the anguish and helplessness I experienced—there was so little support provided for the family.

As a child and adolescent, Ryan had always seemed happy. He was a compassionate and gentle soul who loved babies, kids and cats, and who had many friends. His favourite pastimes included sophisticated mechanical and electronic building toys, snow skiing, skateboarding and remote-controlled toy race cars. Ryan excelled in math and science, and wanted to go into robotics and eventually become an astronaut. Mild inabilities in focusing, reading and writing, however, had always held him back in school.

In grade four Ryan was assessed as possibly having attention deficit disorder (ADD)—these were the early days of ADD recognition in the health field. I was encouraged to seek parenting skills training, since at that time poor parenting technique was exclusively considered to be the cause of ADD. In spite of my improved parenting methods, however, Ryan continued to become more difficult to handle at home and at school, where year after year he fell through the cracks as a borderline case.

I eventually came to suspect that his problems may have been due to losses and injuries he'd suffered in early childhood: the loss of his dad at two years of age, a couple of head injuries not long after, and sexual molestation by a babysitter at age four. Ryan and I did go for private counselling several times during his pre-adolescence and teens to help him with his acting-out behaviour and school performance, but he wouldn't continue when the time came for him to go alone.

In grade nine after the loss of his stepdad, Ryan began to smoke marijuana, and to drink alcohol—even bingeing on occasion. This led to skipping classes and eventually transferring to a string of alternate schools. He never finished grade 11, although he attempted his GED in his early 20s.

Ryan seemed to have trouble with organization and self-discipline, in spite of a genuine desire to

footnotes

1. **2020Parenting.com** is being created to provide quick access to comprehensive early prevention information. Ryan wanted to help others. We hope and trust that through this site we are fulfilling his wish. We are currently looking for parent volunteers, corporate seed sponsors, board members, and health article contributors. If interested, please e-mail kerry@2020parenting.com.

2. MacEwan, W. (2005, May 3). *Methamphetamine and psychosis*. Presentation at the Menace of Crystal Meth forum, Surrey, BC. Bill MacEwan, MD, FRCPC, is Director of the Schizophrenia Program in the UBC Department of Psychiatry, and Clinical Director of the South Fraser Early Psychosis Initiative.

3. From the Coroner's report on Ryan's death.

make his dreams a reality. I now understand these traits, which he'd had as far back as I can remember, as probable indicators of frontal lobe brain damage. He'd had two mild-to-moderate accidental head traumas to the centre of his forehead at two and a half. His poor executive decision-making, lack of impulse/emotional control, stubbornness and hampered follow-through capability may have originated with these early head traumas.

Ryan's recreational use of marijuana and alcohol (and possibly crystal meth) continued until, at age 22, he cleaned himself up, only to go into a suicidal spell. No suicide attempt was made: I was able to help him that time, as I had taken crisis line training and recognized his statement, "Don't blame yourself, Mom, if anything happens to me," as a warning sign. I also sponsored an excellent private counsellor for him.

The following year Ryan remained drug-free, gainfully employed and blissfully in love in his first real relationship. I had such high hopes—at last he seemed to have it all together. His girlfriend, however, left him sometime in 1999 (he was 24), and he began to self-medicate his broken heart with marijuana and, unbeknownst to me, crystal meth. I always wonder whether he would have made it through this without drugs if he had stayed with his last counsellor and learned healthy ways to cope with loss.

In the next couple of years, Ryan's work suffered as his drug use gradually impacted his performance. To meet the demands of his ongoing part-time self-employment as a security and surveillance systems installer, he needed to build a large inventory of wireless remote video cameras; no one was yet marketing this technology, and he saw a window of opportunity. Unfortunately, Ryan began using crystal meth to help him get through long hours of work. As he became more dependent on it, his judgement and productivity suffered. He got behind in his rent and was evicted from his apartment—he was a day too late with funds our family had loaned him.

On March 1, 2001, at 26, Ryan moved into a house occupied by several crystal meth addicts. I'm not sure he was aware of this initially—it was all he could find on short notice—but within a week or two he became severely addicted. He started calling me in terror and desperation. Until this point he had kept his crystal meth use a secret.

Ryan's decline was rapid: a first psychotic break on April 28, possessions stolen while in hospital, couch hopping, sexual recruitment/exploitation, sleeping under a bridge, whereabouts unknown for periods, in and out of hospital with three more psychotic episodes, one-room hotels between hospital admittances, and the final decision to end it all—all this occurred within 10 months of his first cries for help.

I tried frantically to get him help upon receiving those first terrifying phone calls, but he changed his mind so fast I couldn't catch him in time. He was convinced that a detoxification program would "reprogram his brain." And then there was the law, requiring that he first become a danger to himself or another before he could be forced into treatment. And so it was that when on two occasions he was found running in and out of heavy traffic, or when he tore up his shower stall, yelling threats and scaring his neighbours, he was finally admitted to hospital.

For Christmas 2001, prior to his final hospital discharge on New Years Day, Ryan was granted a day-and-a-half pass to come home. He certainly wasn't his usual jovial self. I have since wondered whether seeing us and how much he had lost had prompted him to make one last attempt to regain a drug-free life.

When he was discharged on New Year's Eve, Ryan didn't take his medications, and later, didn't pick them up from the pharmacy; nor did he keep his January 3 outpatient appointment. On January 10 he told two community mental health outreach workers, and me, that he had stopped his meds, was attending Narcotics Anonymous, and didn't need help. Based on the outreach workers' assessment—Ryan was pleasant, his speech was clear, and he was clean and well nourished when they visited—the community mental health agency closed his file.[3]

Three days later, having only a trace of lithium in his blood,[3] Ryan swandived off the Cambie Street bridge to the cement 30 feet below, dying instantly of a massive head trauma. The police report recorded his last words to a woman who tried to coax him down from the railing (bless her heart): "I'm breaking down at the cellular level… Is it going to hurt?"

I've since learned that when someone who is bipolar is coming out of depression, they are at the highest risk for suicide. Suddenly stopping antidepressants and/or lithium can also cause suicidality. And the horrific crystal meth withdrawal symptoms remain for a long time, even after the drug becomes undetectable in the blood and tissues.

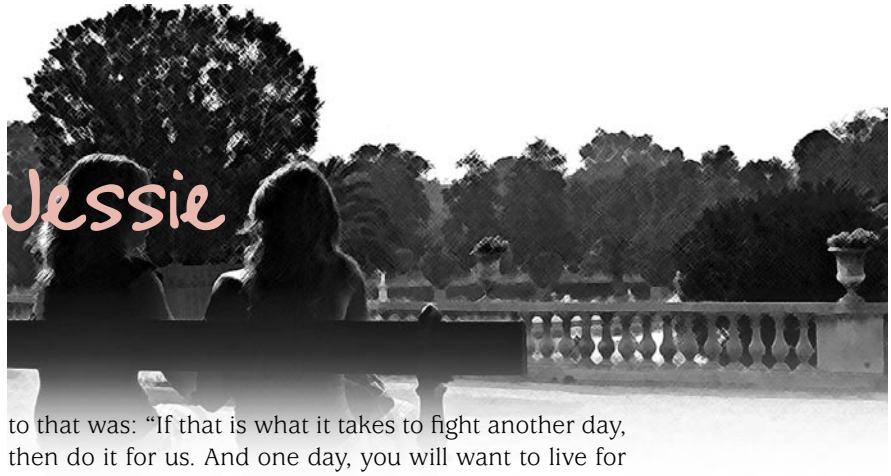
Sadly, for Ryan and for those who knew and loved him, his 'hitting bottom' was his *final* bottom.

a parent's point of view

- The law must allow involuntary admission for early crystal meth drug addiction because meth use has been shown to cause structural changes in the brain, cognitive impairment and psychosis (10–20% of users experience psychosis[2]).
- Care must be provided on demand to meet the needs of those who might only fleetingly request it (versus only providing care after several days of self-detoxification).
- Treatment needs to be secure, long-term (6 to 12 months) as well as holistic, to facilitate total rehabilitation.
- Prevention and early treatment is important for any condition that has the potential for undermining a child or youth's decision-making abilities.

—Kerry Jackson

My Best Friend, Jessie



I was introduced to the reality of suicide when I noticed the marks on my best friend's arm. I saw them even though she had tried to hide them under her sleeve. I wanted to ask her about them, but she was very secretive so I didn't want to push her. I just let her know that I had noticed, I cared and I wanted to know more. From then on, we became even closer.

Jessie let me enter her world. She struggled with eating disorders—anorexia and bulimia—as well as severe depression and self-mutilation. Later, she drank to numb her feelings. People with eating disorders are not given the compassion they need because of the simplistic assumption that their problems lie in vanity.

It is difficult to be with someone who wants to die, watching helplessly. No one can really know what it's like to be at the place where suicide becomes an option, a 'solution.' I'm sure it's different for everybody; I see it as dark, lonely and all-encompassing—a deep hole where no one hears you scream.

Jessie had numerous hospital stays. On the better stays, I'd visit her and we'd sneak out and have a laugh; other times, I couldn't see Jessie behind her glazed eyes. When she underwent more intense therapy, bits of her disappeared. I started to notice that the cards and art projects she made for me during art sessions at the hospital began to have more and more mistakes. All the thought and love were still in them, but they showed a steady decline in her ability to work. Once, when visiting her, I wore the shirt she had given me for my birthday. I told her I had received many compliments on my new shirt. She asked me where I had got it.

It was difficult to see her struggling to get out from underneath her depression. Seeing the torment in which she lived showed me the strength it took for her to live each day. I thought: *If I'm experiencing so much pain right now, trying to piece together what's going on in her world, Jessie must be experiencing 10 times the torment I feel*. I saw her beneath the masks she put on for everyone else—she knew I loved her for who she really was and that gave her strength.

Jessie had such a kind heart; it hurt her knowing she was hurting the people close to her. In one of our late night talks, she said that if she committed suicide, even though it would be hard for us at first, we would all be "better off." I tried to explain the empty hole that would be left inside us, but I couldn't convince her.

She had no regard for her own life; didn't value herself. She told me once that the only reason she lived was for her mother and brother, and me. All I could say to that was: "If that is what it takes to fight another day, then do it for us. And one day, you will want to live for yourself." That day never came.

On February 12, 2002, Jessie's rich smile, and warm laugh left this world. Jessie didn't get up that morning. She didn't brush her thick chestnut hair back; she didn't pour herself a cup of black coffee; she didn't show up at the kids' gymnastics class she worked at. There were pills and vodka at her bedside. As much as Jessie wanted to get better for the other people in her life, she couldn't bear her frail body shaking anymore.

I had seen so many reasons for her to live. I saw what a wonderful, kind, strong person she was. When I was going through her room after she died, I found a shoebox worth of letters thanking Jessie for the encouragement she had given, for the laughs, hugs and friendship she had spread to other patients during her stays in the hospital wards. These letters were so heart-felt with gratitude and love, that if any of us were to receive just one such letter, we would consider ourselves lucky. It amazes me that she was capable of so much love and encouragement toward others, and yet could not love herself.

I don't know what stopped her from loving herself. I longed to find out what was blocking her and wanted to tear it down with all my strength. But I never found it. The search to find such a thing is exhausting. One should not underestimate the strength that is needed to aid someone in this kind of search. I had to learn the distance I needed to keep so I could stay on sturdy ground while walking beside her. It didn't mean I cared any less; far from it. It was just that there was a distance she had to travel alone. She had to learn to love, or at least like, herself enough to accept that she was worthy of help.

After Jessie died, I had to find ways in which I could live my life and still be surrounded by her.

During her service, someone told a story of a little tadpole that became a dragonfly. The tadpole had to leave home, to find home. The tadpole left the depths of the water to fly high above the pond. Since then the dragonfly has been a reminder of her—a token of her left on this earth, while the rest of her is soaring somewhere high above the aches and pains of this world.

A few years after Jessie died I became a volunteer at the Crisis Centre, presenting suicide prevention workshops in high schools. I found comfort in dealing with her loss by having this active outlet for speaking

Caroline O'Brien

Caroline is studying psychology at SFU and plans to become a counsellor. She and Jessie had been best friends since elementary school and started college together

Suicide and Shame in a Southeast Asian Community

An interview with a friend

Mykle Ludvigsen

Mykle is a past communications officer at the Canadian Mental Health Association's BC Division. He's now Communications Coordinator for the BC College of Teachers

**pseudonyms*

Imagine what it would be like to lose your only child to something completely preventable. Now imagine what it would feel like if the stigma and shame surrounding the illness that caused your child's death was so strong that you couldn't have a proper funeral. For one woman in Canada, this is a true story.

Kamala* lives in BC. She immigrated to Canada 25 years ago and settled in eastern Canada, where she met Sunethra,* who was happily married with a young son. An immigrant from the same Southeast Asian community as Kamala, Sunethra was an active member of her cultural community.

In February 2003 Sunethra's husband passed away from a long-time physical illness. Their college-aged son, Ranjeeth,* witnessed the entire process and was deeply affected by the loss of his father.

Ranjeeth created a mural for his father's funeral, using cut-out faces of his father from photos and photocopies and placing them lovingly on a 10' x 10' board. It took Ranjeeth less than 24 hours to complete the tribute. It was his way of grieving.

After the funeral, both mother and son decided to see a grief counsellor, sometimes together, sometimes not. Eventually Ranjeeth started going only by himself, and even then, rarely. His mother thought this was part of the grieving and let it be.

But slowly things started to slide. Ranjeeth pulled away from the sports he loved; his relationship with his girlfriend ended; he dropped out of university in the fall; and finally, he ended up without a job. At one point he even told his then girlfriend, to get her to stay with him, that he would commit suicide if they broke up. Ranjeeth was clearly not well.

While his mother thought it was grief, it was evident to his friends that it was more than that, though nothing was said to Sunethra at the time. Kamala, who now works at a mental health agency, believes that Ranjeeth likely had a very serious case of depression, probably triggered by the death of his father. His therapist hadn't seen it; his mother hadn't seen it. Even if she had, his mother certainly wouldn't have accepted that it was a mental illness—that was what 'crazy' people got.

One day, well into winter, Ranjeeth came to his mother asking for help, asking her to take him to the doctor, to do something to ease the sadness—anything at all. Sunethra arranged to get the next day off work so she could take him for medical help.

It was too late, however; the next day Sunethra found Ranjeeth suspended from the ceiling by a belt tied around his neck. It was February, almost a year to the day he had lost his father, and she had lost her husband. Paramedics were called;▶

My Best Friend, Jessie | *continued from previous page*

about Jessie without making others around me uneasy. "The only thing not dangerous about suicide is talking about it," I tell the students. I've been trained in what to say when I'm in the classroom, but the most important part is that I'm there, talking about suicide, acknowledging it, making it not so hidden—because 'it' is an all-too-frequent reality.

I miss Jessie, and I think about how lucky I was to have her as my friend. The memories I have of her are numerous: good, bad, scary, powerful and inspiring. Jessie's life was too special to spend the rest of my life thinking about the 'what if's.' I still have questions: Why didn't she phone me like she'd done many nights before? Why didn't she say good-bye? She was supposed to speak at my wedding… But, she was here. She made her mark upon this world, and her legacy carries on—through showing the ability to be kind to others even during the height of her suffering, or through her stylish clothes that were donated to a women's shelter after she was gone. I am grateful for every memory I have of her, and that's how I live my life with her at my side.

When I was dealing with the actuality of Jessie's death, I found strength I didn't know I had. I don't even think I ever really had strength; she gave it to me. And when I 'reach the top of the pond,' I know she'll reveal the answers to my questions, if I haven't already found them. When I finish my studies as a counsellor, others may be able to benefit from my journey with Jessie. She would have wanted it that way; in fact, she'll make sure of it.

Like many other parts of the world, young people on the Indian subcontinent between the ages of 20 and 30 years appear to be most vulnerable group. In Sri Lanka about a quarter of suicides are by people under the age of 30 years, with similar rates in India. Studies from Pakistan show that between 50% and 82% of suicide deaths are from the under-30 age group.[1]

they revived Ranjeeth at the hospital, but he was pronounced brain-dead. Sunethra could not believe what had happened and refused to have her son taken off life support; he died after a week, while still on life support.

While she grieved for her son, Sunethra felt, at the same time, overwhelming shame that her son had taken his own life. She was reluctant to invite anyone from her cultural community to a funeral, because they might discover that Ranjeeth had died by suicide. Normally, the cultural association would be contacted and they would invite the community at large.

When it became clear that members of the extended networks were hearing the family's story through the grapevine anyway, Sunethra relented. She organized a funeral, inviting just 10 or so of the community's families to attend. Ranjeeth's close friends were also there, to join his mother in her grief. There were the expected disapproving whispers from community members: how could someone possibly do this to his parents; how selfish he was, thinking his problems were bigger than everyone else's; how he had committed a sin that God would not forgive.

When Ranjeeth was on life support, Kamala had flown out East to be with Sunethra and had brought educational materials on depression and suicide from the mental health agency in BC where she worked. Sunethra had read the materials from cover to cover. Though she still wrestled with the pervasive cultural stigma, her awareness had shifted.

In the weeks after the funeral, members of the community, who had in many cases made some of the hurtful comments about Ranjeeth killing himself, came quietly to Kamala to ask for more information, so that they too could learn more about mental illness. They wanted to ensure that their sons and daughters didn't have to deal with the pain and suffering felt by Ranjeeth.

Sunethra now understands that her son had depression, which made it easy for him to contemplate suicide. Like family members across all cultures who have lost someone to suicide and think of events in hindsight, Sunethra daily confronts the thought that her son's death could have been prevented if only she had seen the warning signs. But she didn't know what the warning signs were or what to do even if she had recognized them.

Sunethra is currently in therapy to help protect her own mental health in the face of all of her losses. And she, with her friend Kamala's support, is learning more about depression and suicide prevention in her community. Kamala told her friend that she shouldn't see the death of her son as different from the death of her husband. They were both brought about by illness; neither was due to moral failings or character flaws. In her own way, Sunethra has started to become an activist for the cause of mental illness—proving that in adversity and tragedy, there is opportunity and hope. ⓘ

footnote

1. See Khan, M.M. (2002). Suicide on the Indian Subcontinent. *Crisis*, *23*(3), 104-107.

On Losing a Teenager to Suicide

Jude Platzer

Jude is Executive Director of the Josh Platzer Society for Teen Suicide Prevention and Awareness. She is a registered nurse by profession and lives with her husband and daughter in Vancouver, BC

Nell,* just 11 years old, was due home from her trip to Israel. She was returning from an international program similar to one that her older brother Josh had attended a few years earlier. Josh didn't want to come to the airport to welcome his sister, and we, the parents, did not insist. Our boy was depressed, and the professionals had told us to "back off."

Sadly, Nell did not get a chance to compare notes with Josh. He was found dead the morning after she had returned. He was only 15.

Josh was diagnosed with depression and possible bipolar disorder earlier in the year, and was in treatment at the time of his death. He had attempted suicide twice before. Antidepressants were prescribed by our GP—the same GP who chose not to impart to us his knowledge of Josh's previous suicide attempt. Instead, he had suggested Josh tell us about it himself, within a given time period.

Upon reflection, signs of suicide certainly had been present. Josh had given up the sailing that he loved; he was missing classes and often stayed home claiming to be sick. Josh died in August 1999. He hung himself in the front yard of his best friend's house.

His friends were well aware that Josh had 'emotional problems' (as Josh referred to them in an e-mail to a cousin, just before he died). Josh had discussed his imminent death and funeral with friends, had written good-bye notes and had left written instructions about where to spread his ashes. His friends never disclosed this information to us or, to our knowledge, to any other adults. All this was only discovered after the fact.

Fuelled by the grief and anger brought on by Josh's death, my husband Ben and I set up a memorial fund in Josh's name to promote suicide prevention.

Around that time, I happened to read a newspaper article about a dance drama for youth concerning teen angst. *ICE: beyond cool* was created and performed by

*pseudonym

Dance Arts (now known as Judith Marcuse Projects), which is well known for its wonderful work with youth. In collaboration with Judith Marcuse and with the co-operation of Josh's school, Point Grey Secondary, a performance of *ICE* took place on what would have been Josh's 17th birthday—just 13 months after his death. Every student in the school was able to see the play.

For further information about the Josh Platzer Society, visit the website at www.teensuicideprevention.org

I believe that this dance drama has a deep effect on many students and that theatre is a powerful and effective medium for getting these messages out to youth. *ICE* is an exciting production that speaks to the many challenges the teenage years can present, including mood swings, drug use, sexual exploration, peer and parental pressure, depression and suicide.

The memorial fund is now the registered non-profit and charity, the Josh Platzer Society. The mission of the society is to educate BC youth and those around them about suicide prevention. To this end, I give presentations to parent associations in schools, and our family was featured in the WTN docu-drama series, *You, Me and the Kids*—a Canada-wide program for parents.

Working in conjunction with the Crisis Centre and the Vancouver Suicide Survivors Coalition, we are promoting World Suicide Prevention Day to encourage open dialogue about suicide and to raise awareness. The role of suicide survivors working alongside health care professionals and counsellors cannot be underestimated.

Our society is currently working on a charity bracelet campaign. The orange bracelets will have a BC crisis line phone number and the YouthInBC.com website address on them. The bracelets serve two purposes: showing support for, and interest in, this very worthy cause; but more importantly, two valuable resources are provided—literally, close at hand—should the wearer or any of their friends need them. Through education, we will remove stigma and promote dialogue, so that the signs of suicide are more readily recognized and shared. Awareness can save lives.

Sayt k'üülm goot

Of One Heart, Bringing Our Youth Together

Grand Chief Ed John and Jane Morley, QC

Grand Chief Ed John is a member of the First Nations Summit Task Group

Jane Morley is Child and Youth Officer for British Columbia

It is indescribable and unforgettable—the power, the energy and the heart of 150 youth from three First Nations in British Columbia. These youth came together to advise Elders, policy makers, leaders and service providers about how to enhance life in their communities. This gathering came to be known as *Sayt k'üülm goot*, Tsimshian for "of one heart," and was subtitled "Bringing Our Youth Together."

Aboriginal communities, being small and close-knit, are devastated by death. Even more devastating is the death of a young person by suicide. The statistics suggest suicide rates five times greater than the Canadian general population for Aboriginal males ages 15 to 24, and seven times greater for young Aboriginal females.[1]

The First Nations Summit and the Child and Youth Officer for BC agreed in 2004 to bring youth, community members and policy decision-makers together to explore ways of preventing suicide. Prince Rupert was identified as a location for the gathering. The target groups were Nisga'a, Haida and Tsimshian youth ages 15 to 27. Local community members and youth participated in planning the three-day event held May 4–6, 2005.

Prince Rupert was chosen because of the community's exemplary work in suicide crisis management following the deaths of youth from surrounding First Nations communities. Non-Aboriginal communities worked together with First Nations to prevent suicides by connecting with, and supporting, vulnerable youth. Subsequently, Prince Rupert developed a protocol for interagency response to future crises.

In preparation for the event, visits were conducted to interested First Nations communities to gather input from youth, front-line workers and concerned community members. Comments gathered through this process suggested that suicide is connected with loss or alienation from self, family, culture and community. Four barriers to healing were identified:

- inflexible government policies that interfere with leadership's capacity to meet the needs of the community
- difficulty accessing mental health services, and lack of culturally appropriate assessment and treatment
- conditioning of Canadian society to view First Nations people as inferior
- internalized colonization among Aboriginal people themselves, which fosters dependency, promoting minimal accountability to the needs of the community

A literature review of reports and research related to Aboriginal youth suicide and of jurisdictional issues was also undertaken.

On May 4, 2005, a youth pizza and dance event and an informal policy roundtable dinner were held. At the roundtable dinner, participants shared their thoughts about the community visits and literature review presentations.

On May 5, the Inter-Nations Youth Forum opened with a powerful address by a young man who had contemplated suicide twice. His story instilled hope for the future. "I'm your brother, I'm your son, I'm your uncle, I'm your father," he said simply. This was an idea that

related resource

White, J. & Jodoin, N. (2004). *Aboriginal Youth: A Manual of Promising Suicide Prevention Strategies*. Calgary, AB: Centre for Suicide Prevention.

resonated profoundly with the youth. When questioned later, the majority of the youth connected this speaker's experience with their own. The participants worked in groups, envisioning a better future. The youth then conveyed to the whole group their ideas for achieving that future:

"[The youth] invited us to become bigger. They invited us to do things differently, to truly engage and work with them to achieve community transformations…They said that the answer to these questions about suicide and community healing is WE. Using the word 'WE' has major implications, because it suggests a place that we need to arrive at together, a place where youth come to take responsibility for the changes in their communities." (from a report prepared by the facilitator)[2]

The youth challenged the adults to support them to:

1. **speak out and tell their stories (the "I" stage)** – by encouraging youth—through peer groups, mentorship, forums and other processes—to speak out about suicide; by enhancing support groups and counsellors in communities
2. **be heard (the "I-You" stage)** – by engaging with youth and listening to them about how individual or community actions impact them; by establishing and sustaining youth opportunities to speak with Elders, decision-makers and leaders; by acting on ideas from youth
3. **engage creatively (the "We" stage)** – by recognizing the valuable role youth can play in building new communities based on the traditional laws and respect; by working together with youth constructively

Recommendations included greater involvement in cultural activities; positive liaison with authorities, especially police; more recreational activities; options for volunteer work; parent involvement in youth activities; sustainable work experience programs; more community celebrations and feasts; and developing youth leadership.

On May 6, 2005, the policy roundtable met and addressed these questions: 1) How do we support the energy, the leadership and the aspirations of these young people who have invited us all to work together? and 2) What should immediate and long-term next steps be?

The roundtable participants, clearly affected by hearing the youth voice on the previous day, noted a common thread: a call for unity among nations, a return to traditional law, and the need for youth participation in programming and planning.

Some of the immediate steps suggested were a follow-up inter-Nation youth gathering; presentations to be made to First Nations organizations; quick implementation of RCMP commitments to ensure that officers train in communities and work in a positive atmosphere with youth; development of youth councils; and cross-cultural training of Ministry of Human Resources' workers.

Some longer-term recommendations were development of a comprehensive suicide prevention plan; budgets for community youth activities; a follow-up meeting to review progress; and a meeting of federal and provincial government representatives and First Nations leaders to come up with creative ways to address barriers created by inflexible funding and increase responsiveness to the needs of youth and communities.

To achieve change there needs to be respectful and inclusive commitment on the part of front-line workers, policy-makers, community leaders, Elders, police and youth themselves. Success and sustainability rest initially on the shoulders of policy-makers, but community and youth participation are vital as plans evolve. Because, in the end, there is only WE … OF ONE HEART … *Sayt k'üülm goot.*

footnotes

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2. This was a report written for policy roundtable participants; it was not published.

How to Engage Youth in Healing

Donna Murphy

Donna is a Secondary Special Education Helping Teacher for the Surrey School District. Since her son Kelly's death she has worked as a member of the FORCE Society for Kid's Mental Health to ensure that quality of care is available to all families in BC

Most youth have not had any experience with death. Some may have lost a grandparent or a beloved pet, but for the most part young people have no frame of reference for death. Adolescents are also at an age when they believe they will live forever. They have no fear and take risks that can put their lives in danger. So, when a beloved friend dies by suicide, they are faced, for the first time, with the finality of death. They find it difficult to accept that this death is real, and that their friend will not be returning from "a visit out of town."

As a mom who has experienced youth suicide, I know what has made a difference to the young people in my life. On April 3, 1997, my beloved son Kelly died by suicide at the age of 18. I thought I would never be able to be a mother again, but have remarried and am now blessed with an 18-year-old stepdaughter, Jessica. On June 16, 2004, the unthinkable happened—Jessica lost a very dear friend to suicide. This threw me back to where I had been seven years before, and made me think of all the

young people who have lost friends to suicide, and how they handle the recovery process very differently than adults do.

The best way to get young people to engage in the healing process is for professionals and other caring adults to go to the places where the young people gather. This happened in Surrey and Delta, where these two young people had lived and where their friends attended school. In both cases, critical incidence counsellors were immediately brought in to visit the schools. These counsellors reached out to the friends and were able to encourage and refer those in need to individual counselling.

This practice of going to the school and just listening and encouraging students to take care of themselves can set young people on the road to healing. Some friends will engage with a bereavement counsellor and begin to work through the stages of grieving.

Many young people came to visit me after Kelly's death. Kelly's best friends (whom I lovingly refer to as "the group") came to our door with flowers for me. They took off their hats and came into the house, letting me know of their sadness. They had come to pay their respects—and to see that I was doing okay and that I still accepted them after such a loss.

Many of Kelly's friends continue to come around or call, just to touch base and make sure I am still okay. It seems that the sound of my voice, and the knowledge that I am once again happy, has had a tremendous impact on their lives.

The funeral of a friend, with its finality, is a very sad event for young people. The ones who have fared best are those accompanied to the funeral by their parents or other trusted adults.

It is very important that young people be able to perform their own rituals and to say goodbye in their own way. Their way may be different from more traditional ways of mourning, but it is very important in the healing process for them to express their grief. At both of the funerals friends came with gifts, which were left in the coffins—gifts that didn't always meet with the approval of the adults involved. Some of the young people wrote poems, and many had a chance to speak about their friend during the funeral service. In these ways they honoured the friend they had lost.

Another thing that has made a difference to the young people I know is for them to have a place to go to remember their friend on special anniversaries or other occasions. This may be the cemetery, or it could just be a place where they used to hang out. On her friend's anniversary, Jessica told me that her friends had gone to the cemetery to visit and have a little talk. And, Kelly's friends will show up at the cemetery on his birthday, at Christmas or on other occasions, just to say "hello" and to let him know what they are doing with their lives.

It seems that, as different as youth are from the adults in their lives, they are also very much the same. For many young people, the grieving process is long. But time is the greatest healer, and youth are resilient. Those who made a prompt connection for counselling, have strong friendships and have good adult role models in their lives are able to speak of their grief and get on with their lives. They have sad moments, just like I do, when they remember what might have been if their friend had been able to make it through that time when all seemed so hopeless. They give those moments to their friend, but then come back to the present and move on. i

Self-harm and Suicide

"I cut to see the blood and then I know that I am still alive"
"If you won't listen to my pain then you're going to see it"
"I go to the emergency because I am so lonely at home alone and there they have to pay attention to me"
— SAFE BC client quotes

Mary Graham

Mary was formerly Executive Director and a co-founder of Self Abuse Finally Ends (SAFE) in Canada and a manager with Spectrum, a borderline personality disorder program in Australia. Mary has overcome her own desire to self-abuse and now shares her knowledge with professionals, consumers and family members. Mary can be reached at safebc@shaw.ca or 604-669-6552

Self-harm—what and why

Self-harm encompasses a variety of non-fatal self-injuring behaviours including cutting, burning, breaking bones and poisoning. These behaviours arise for a variety of reasons, but all of them speak of intense emotional distress in the person who deliberately hurts themselves.

The definition of self-harm is complex. It includes acts with suicidal intent and ones without suicidal intent. This distinction can be problematic for public

understanding, research and effective intervention. Some acts of self-harm are really suicide attempts; others are ways of coping with overwhelming feelings and may be more habitual. In these latter cases, sadly, death often results accidentally.[1]

Self-harm is on the increase, especially in youth; most are young women. Young males, however, are showing an alarming increase in rates of self-harm.[2] By definition, self-harm focuses on one's self, but it does affect others, especially loved ones. It is estimated that around 0.5% to 1% of the population self-injures.[3,4]

Those who self-harm do it for different reasons—to punish themselves, to stop their inner pain, to gain a sense of control, and even for revenge (my own reason, at times). Often it is said they are seeking attention. But what they're really doing is trying to tell people how bad they feel. Having being told for years not to talk about the pain they suffer, they have learned to use self-harm as a means of communication.

The suicide risk

People who have self-harmed are at greatly increased risk of suicide and should have access to assessment and support.[3] Studies have shown that around one in 100 people seen at hospitals for self-harm will die by suicide within a year of the self-harm; this suicide risk is 100 times greater than the average.[5]

The difference between self-harm and suicide, in my opinion, is often the intensity of the act. I believe that a lot of suicides are self-harming behaviours that have gone wrong. For example, someone might hurt themselves expecting that someone will come home at a certain time, but the expected person is delayed. This is often the case with overdoses.

Not all self-harming behaviour is attached to a will to die. Habitual self-harmers don't want to die; they just want their pain to go away. One distinction that might be helpful for those trying to help someone who self-harms is that a person who truly attempts suicide seeks to end all feelings, whereas a person who self-mutilates seeks to feel better.[6] Some people describe that they self-harm when they want to prove that they are alive, or they use it as a coping strategy to allow them to carry on living. In people who self-harm with suicidal intent, after the self-harming behaviour the thought of dying is often replaced with the desire to live—and this is when people will often reach out for help.

Unfortunately, it's difficult to predict the difference between the two types. One study found that the 'seriousness' of self-harm—measured by factors of the act itself, such as the method used, the extent of harm, the degree of reversibility of effects, or the type of treatment required—was *not* related to measures of suicidal intent as reported by the person. Depression and impulsivity were much more linked with the intent to die by suicide.[7] That's why it is so important to get help for someone who you know is hurting themselves, so that depression and suicide risk can be assessed.

SAFE helps stop the cycle of hurt

The act of self-harm is a behaviour. A behaviour is a choice—even when it doesn't feel like one. Therefore, when a person begins to accept that self-harm is a behaviour, they can then gain control over it.

Self-Abuse Finally Ends (SAFE) offers a 10-week program for those who use self-harming behaviour to cope with inner pain. The program manual, *Overcoming Self-abuse,*[8] specifies boundaries and guidelines for creating a group process that nurtures hope, support, companionship, empowerment and acceptance. The program helps clients understand what triggers their self-abuse—for many people, self-abuse is triggered by patterns of unhealthy thinking (called cognitive distortions). Clients develop a conceptual map that identifies the triggers that set their self-harming behaviour in motion. This helps them deliberately slow down their thinking process so they can deal with these triggers. Then, old coping strategies are countered with newer, healthier ones. SAFE also helps clients develop individual skills that help them identify and deal with their emotional reactions, formulate a variety of alternative strategies to deal with trigger events, and then choose and act on more constructive alternatives.

For someone who self-harms, turning to a support system when a trigger is on the horizon—rather that waiting for a full-blown crisis—is a very important strategy. It is most effective to have someone in the community to talk to as soon as the trigger registers. Family and friends can provide a strong system of support. Peer support developed through mental health clinical services is another source of help. Some people who self-harm may even find Internet/online support.

The process of changing the behaviour of self-harm is a long and difficult one. A person may have been self-harming for many years. As with an eating disorder or an addiction, change doesn't happen immediately. It takes new skills, practice and support. But self-harming behaviour can be changed. There is hope. i

resources

- SAFE BC at ca.geocities.com/safebc. Order *Overcoming Self-abuse* at this website
- SAFE in Canada at www.safeincanada.ca

footnotes

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ICE: beyond cool

Caitlin Pencarrick

Caitlin is with Judith Marcuse Projects, a not-for-profit arts organization using arts to make change. The organization works with youth to create performances about issues important to youth around the world. For more information, contact Caitlin at 604-606-6425 or caitlin@judithmarcuseprojects.ca

ICE: beyond cool—A history

ICE is the first production in a series of four: *ICE: beyond cool* (about teen suicide), *FIRE: where there's smoke* (about violence in youths' lives), *EARTH* (youths' concerns about environmental sustainability and social justice, to premiere in 2006) and *AIR* (thoughts on freedom of expression, issues of the spirit, not yet begun).

ICE was created after our company held three years of arts workshops with more than 250 youth. Out of these workshops came the ideas, emotions, fears and hopes of youth from across British Columbia. We put these all in a high-tech, entertaining-but-real production in 1997, which was performed for teens all across Canada and then adapted for television with CBC in 2000.

Why ICE?

More youth are committing suicide than ever before, so we decided to start with *ICE: beyond cool*. We needed to do this show because, we discovered, no one wanted to talk about teen suicide—why it was happening and, especially, why it was happening to youth. We hoped that doing a show that was entertaining but didn't skim over the topic would make it easier for youth to talk openly about why they thought about suicide, why their friends did, why their sisters and brothers did.

ICE was performed by youth in order to give the clear message that we want youth to be able to voice their thoughts, and we want to keep the shows accessible to youth. It is a high-energy performance that includes dance, theatre and music. We made sure the music would be interesting to young people; we set it up like a rock show and performed it in malls, to bring the message right to the people we needed to reach.

What is ICE all about?

ICE is about Sara, a stressed-out teen dealing with the pressures of school, her parents' divorce, friends wanting her to do drugs, and her boyfriend pressuring her to have sex. A boy Sara tutors turns up at her door when she is in the middle of a meltdown with her mom, and she yells at him to leave her alone. He does, and in the morning is found dead. Her best friend, who is battling with eating disorders, calls to tell her that she, too, is on the verge of committing suicide. Sara feels alone and ill-equipped to help her friend, but in the end manages to talk her out of killing herself.

The show covers many of the issues that can push young people to consider suicide: low self-esteem, stress from school, relationships with parents, peer pressure, poor body image—the list goes on and on.

Amelie Lefebvre and Jennifer Patterson in ICE

photo: David Cooper

Sample scene from ICE

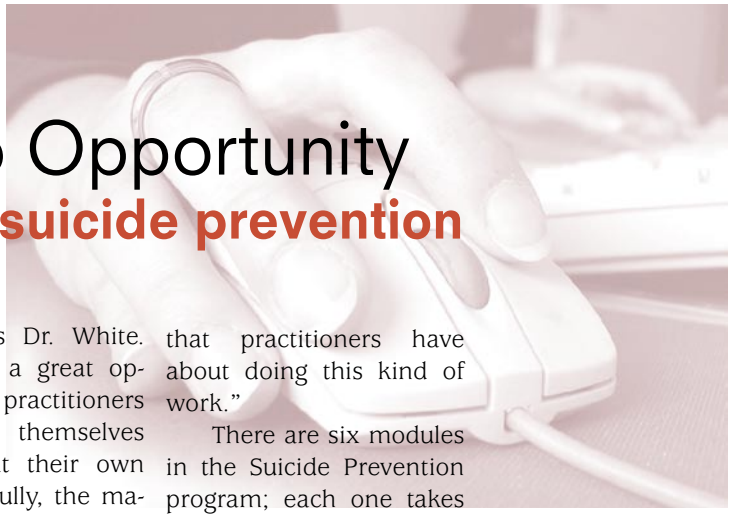
—SARA: You have to keep talking. That's the rule.
—CHRISSIE: Yeah, 'til I either feel better or decide to do it. Right?
—S: Yeah. So?
—C: So—so yeah, okay, I'm feeling a bit better. Ish.
—S: Oh, yeah? Me too.
—INNER SARA: ***(flexing).*** No kidding.
—C: So I guess it's not gonna happen.
—S: Okay. Good.
—C: At least not this time.
—S: Meaning what?
—C: What, you want me to guarantee you the rest of my life?
—S: Okay. One bit at a time, eh.
—C: Yeah. So meanwhile, hang onto these. ***(Hands over pills)***

What our audiences had to say

- "I'm not alone and I'm not crazy."
- "The original production saved three of my friends' lives."▶

key factors in suicide prevention

- *An important person in the youth's life*
  - A parent, teacher, close friend or youth worker. This presence is very important for youth with little or no family support.
- *Good coping skills*
  - This is related to a person's personality, not intelligence. Youth need support to see their ability to rise to a challenge.
- *A supportive and caring family*
  - Firm guidance, good communication, family stability and the ability to 'grow' with the young person all help to support youth.
- *Interests and activities*
  - Group activities help young people channel their energy and frustration in a socially acceptable manner. Relating with others in a semi-structured and fun-filled environment, and achieving success in activities, gives them the opportunity to raise their self-esteem.



Turning Challenges into Opportunity

E-learning training modules for suicide prevention

How would you provide training on suicide prevention to staff scattered across a large health region—geographically dispersed from Williams Lake to Fernie—when resources are limited and staff time is tight? For Interior Health Mental Health and Addictions Services, this was the challenge that led to an opportunity.

"We started to think outside the box to develop training solutions," says Dave Harrhy, leader, Mental Health and Addictions Planning and Development for the Interior Health Authority. "Distance, cost and getting the right people together were some of the issues that we were grappling with. We also wondered whether a classroom situation was really ideal for the training we wanted to do."

Working together with Dr. Jennifer White, an assistant professor at the School of Child and Youth Care at the University of Victoria, and Natalee Popadiuk, coordinator of the SAFER Counselling Service of the Vancouver Coastal Health Authority, Interior Health developed an e-learning module that offers practitioners the opportunity to access high-quality, practical, evidence-based information at their own desk.

"I liked the idea that the training was being offered to a wide variety of practitioners on a voluntary basis in a flexible delivery format," says Dr. White. "I saw it as a great opportunity for practitioners to educate themselves more fully at their own speed. Hopefully, the material they get exposed to through the modules will lead to broader discussions with their colleagues."

"We chose suicide prevention as our first e-learning course for many reasons," adds Roger Wheeler, project manager of Interior Health Performance Management. "We know that a wide range of our employees across Interior Health may come in contact with individuals at risk of suicide. This includes not only mental health and addictions staff, but also physicians working in a hospital emergency ward, public health nurses helping clients in a health unit, street nurses assisting the homeless, or home and community care nurses visiting clients in their home. So we designed the modules with the idea that a wide variety of health care professionals could use them."

And, notes Dr. White, "Suicide risk assessment is a cross-cutting issue that many health practitioners need to have basic training in. It is one of the most stressful and anxiety-provoking issues for many professionals to deal with. Offering this training may serve to alleviate some of the fears and concerns that practitioners have about doing this kind of work."

There are six modules in the Suicide Prevention program; each one takes between 15 and 30 minutes to complete. Topics include general information about suicide, how to assess risk, establishing rapport and understanding with the client, determining possible treatment methods, mobilizing other resources and choosing which treatment is best for the client. One module also deals with unique challenges clinicians face, such as practising in a rural or remote area.

The first e-learning module was launched in June and, to date, the feedback has been very positive. "At first, I was concerned about the length of time the training might take," says Ingrid Storch, a mental health clinician for Elderly Services in Cranbrook. "Once I got into it, I really enjoyed it. I appreciated that I could complete one module in about 15 minutes; so, could easily fit it into my day. Since I often work in the intake area, I feel I need to understand more about suicide. One thing I learned was that some of the people I work with, those over 85 years of age, are actually at the highest risk for suicide."

Grant Heindl, team leader for the Adult Short

Aura Rose

Aura Rose is a communications consultant working with Interior Health Mental Health and Addictions Services

ICE: beyond cool | *continued*

- "All we have to do is keep talking to break the silence."
- "At points I wanted to cry, 'cause I looked at the characters and said to myself, that was me…"

What has ICE done?

ICE has voiced the silent thoughts of many youth, not only to other youth but to the groups that support youth across Canada. *ICE* has helped these groups connect with youth they may never have reached before—youth who came forward after seeing our production. Most importantly, *ICE* has helped families talk about suicide, and about the pressures that lead to suicide. Mothers, fathers and their children have sent numerous e-mails and letters talking about how, after seeing *ICE*, they went home to share issues they never dared discuss before. This show opened the eyes of parents to the stresses their children deal with every day; stresses the parents likely didn't deal with when they were young.

For further information on Interior Health's Suicide Prevention e-learning modules, contact Roger Wheeler at 250-870-4735

Term Assessment and Treatment Team in Kelowna adds, "I've found the modules to be both relevant and informative. I wanted to try it out to see if it was a good use of time for my staff. We routinely see clients at risk of suicide. I particularly liked the self-reflective exercises and the information on transference. This type of training will certainly help Interior Health ensure that all clinicians are feeling more competent and more capable in delivering roughly the same interventions with this population."

This type of feedback is exactly what Dr. White envisioned. "In developing this course, my hope was that practitioners will become more reflective about their own practices in suicide risk assessment and increase their confidence in working with individuals who may be contemplating suicide."

If the first learning module proves successful, the plan is to develop a series of e-learning modules to support the development of core competencies for Mental Health and Addictions staff. Roger Wheeler adds, "a number of decision-makers from other portfolios within Interior Health have inquired about the development of this educational approach."

Suicide Postvention is Prevention

A Proactive Planning Workbook for Communities Affected by Youth Suicide

Brenda Dafoe, MEd, and Lynda Monk, MSW, RSW

Brenda is an Adult Education Consultant living in the Vancouver area. She has been involved in suicide prevention for over 20 years as a LivingWorks trainer, curriculum writer, workshop developer and facilitator

Lynda specializes in stress and trauma management within high-risk occupational sectors. She offers training, coaching, consulting and writing services through her business, Creative Wellness (creativewellnessworks.com), and is Executive Director of Fisher & Associates (fisherandassociates.org), located in Victoria

Postvention refers to a range of activities following a suicide. Suicide postvention is part of the overall spectrum of suicide prevention activities. Although postvention occurs *after* a death by suicide, it is preventive in that it reduces suicide risk by identifying and supporting the emotional and mental health needs of the survivors. Because youth are more susceptible to suicide contagion than older age groups, this workbook addresses the specific issue of youth suicide.

In 2003 we were asked to develop a suicide postvention plan for a northern BC community. Research and our experience with this project showed that there was little information available about the community development process specific to suicide postvention planning. Then, the BC Council for Families asked us to develop a project related to youth suicide. We realized the learning gained from our first project might serve to inform a workbook designed to help other communities both anticipate and effectively respond to the tragedy of youth suicide.

Working with a knowledgeable advisory committee, we reviewed the literature on postvention and drew from our practical experience to develop the workbook, *Suicide Postvention is Prevention: A Proactive Planning Workbook for Communities Affected by Youth Suicide*.

Hope for the future

It is our hope that the practical suggestions in this workbook, which are based on the experience of the authors, of suicide survivors and of current research, will both inspire and enable communities to develop their own suicide postvention plans. The ultimate goal is to prevent further suicides and to support these individuals and communities in their healing.

"A community commitment to immediate identification of, and intervention with, survivors can turn postvention reaction into prevention strategies."[1]

The importance of a planned postvention response following a death by suicide cannot be underestimated. No community is immune to suicide.

Did you know?

- The primary purpose of suicide postvention is to support the emotional recovery of survivors while preventing contagion or imitative suicidal behaviour
- Youth, particularly those with a history of previous suicidal behaviour or depression, may be influenced to attempt suicide in the aftermath of another's suicide
- A planned response to support friends and others can be effective in reducing psychological, physical, and social difficulties in suicide survivors

Communities that are prepared to respond can be assured that they have done everything possible to prevent further suicides. These communities ensure that at-risk and vulnerable youth receive a coordinated and timely response, including education, assessment, treatment, follow-up and caring support.

Inside the Workbook—
Building local commitment

Communities can benefit from developing a response strategy, organizing and convening a suicide postvention coordinating committee, and identifying commu-

nity resources to respond during the aftermath of a youth suicide. Community coordination is required to ensure both buy-in and the ability to actually enable the postvention plan when a crisis occurs. A workable strategy for coordination and response is outlined.

Suicide postvention tasks

When a youth dies by suicide, there is a complex set of needs that require immediate attention. This chapter identifies and discusses the crisis intervention tasks necessary for an effective community postvention response.

These tasks are based on best-practice recommendations in the field of suicide, draw upon various theoretical models, and reflect input from community consultation processes (Prince George, 2003; Sechelt, 2004). They include gathering the facts about the suicide, notifying the school and other relevant agencies, ensuring responsible media coverage, identifying and assisting youth at increased risk of suicide, initiating crisis counselling and support, debriefing and supporting professionals, communicating funeral information, considering remembrance activities, ensuring ongoing support for survivors, and facilitating a suicide postvention protocol review meeting.

Schools and postvention

School systems are an integral part of a community. As the majority of young people who die by suicide are part of a school community, the school becomes a natural place for a postvention response. Identifying youth who may be at risk for suicide, and responding to the emotional and psychological needs of all students, is crucial. Suggested postvention procedures for schools are discussed.

Cultural considerations in postvention

We must always be mindful of cultural considerations. In the aftermath of suicide, close attention should be paid to the unique cultural meaning of suicide, as well as to local healing practices for the family, community, and cultural group who have experienced the loss. Culturally respectful guidelines are outlined.

Planning for the future

This final chapter addresses suicide postvention protocol implementation, community resource allocation, follow-up of protocol effectiveness and future training needs. With proactive postvention planning your community can build overall suicide prevention capacity and create a clear sense of direction in the aftermath of a youth suicide.

Appendices

Workbook appendices expand upon important and related postvention issues, including the following:

- **Responsible media reporting** emphasizes the importance of media guidelines; research confirms there is an increase in suicides, particularly amongst youth, following a suicide story in the media
- **Death notices and the importance of language** discusses the importance of naming suicide as the cause of death and offers suggestions from survivors regarding wording in death notices
- **Psychosocial debriefing** both clarifies and cautions regarding the use of this intervention following a death by suicide
- **Grief and trauma after suicide** clarifies the difference between these two reactions through case examples
- **Supporting survivors of suicide** is informed by suicide survivors who offer insight into responding to the unique challenges of grieving the loss of a loved one by suicide
- **When a client dies** acknowledges that caregivers themselves are survivors and emphasizes the importance of personal self-care for professionals
- **Post-traumatic growth** may occur when survivors find meaning and new-found personal strength in the wake of tragedy.

Order the workbook online at www.bccf.bc.ca, or call 1-800-663-5638 in Canada or the US.

footnote

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From 'Policing' to Reconnecting

Psychiatric nursing and human-focused care

John R. Cutcliffe, RMN, RGN, BSc (Hon) Nursing, PhD, RPN

John has recently accepted a senior administration/faculty position at a major US university. He is also an educational consultant for the International School of Nursing and Health Studies, and Director of Cutcliffe Consulting

...It is well documented and accepted that registered psychiatric nurses (RPNs) often, if not inevitably, have a major role to play in caring for people who are suicidal. Despite this long-established role, it is only recently that theory is starting to be generated to guide RPNs in providing care for suicidal people.

Traditionally, 'care' of the suicidal person has focused on little more than practices attempting to keep the person physically safe: 'observations,' removing potentially dangerous objects, restricting the movement and freedom of suicidal people, and using 'seclusion rooms.' These and other 'custodial' practices have been likened to 'policing' the person and, unfortunately, do very little, if anything, to address the root of the person's suicidal ideation. Policing practices do little to help a suicidal person move from a death- to a life-oriented position and do nothing to help the person alter their constricted thinking.

In an attempt to better understand the caring processes that RPNs might use when caring for suicidal people, I, together with colleagues from the UK, undertook the largest research study of its kind. We wished to have evidence that inform RPNs about the *micro context*—what they can do to help suicidal people, day by day, hour by hour, minute by minute...

read the full article at www.heretohelp.bc.ca/articles

Kweyulus Mustimuhw
Cowichan Tribes Suicide Prevention Project
—Sharing in the Light—

Bev Williams

Bev is a Cowichan Tribes member and is Special Project Coordinator with Kweyulus Mustimuhw (People of Tomorrow), an inter-agency suicide prevention committee. She is also Site Leader for the Chronic Illness Care Project and a member of the Aboriginal Suicide Crisis Response Team

For close to three years Cowichan Tribes has been working on suicide prevention. Our theme is "sharing in the light," and we strive to create projects that work for our people.

The Kweyulus Mustimuhw (People of Tomorrow) suicide prevention inter-agency committee has a membership of 50 people, including representatives from agencies such as Canadian and Duncan Mental Health, House of Friendship (Hiiye'yu Lelum), RCMP, Cowichan Women Against Violence, Cowichan Crisis Line, Ministry for Children and Family Development, and Island Regional Coroner's Office, as well as local doctors, volunteers, Elders, and youth. As a committee we work hard to include those who want to make a difference in both big and small ways. By being part of the committee, community members have access to the entire suicide prevention project and can give and receive in ways that are healing and inspirational. This wonderfully diverse committee strives to ensure opportunities that are educational, holistic, and full of colour, creativity, care, and concern.

We implemented a suicide prevention support group as of July 2004, and offer seasonal forums/conferences, and suicide prevention training. Applied Suicide Intervention Skills Training (ASIST) is provided through the Cowichan Crisis Line. A co-ed basketball tournament and White Stone[1] youth suicide prevention training have been organized for this fall.

People are curious about why we promote playing basketball for suicide prevention. The logic behind this is "to catch youth where they are at"—we are catching our youth on *their* court, on *their* playing field. What better place to meet our youth and provide some valuable training! By agreeing to play basketball, the youth are also committing to the second day of the program, which is the suicide prevention training. Then, if they are approached by their peers or family members who may be feeling or thinking about suicide, they will have the skills to respond.

In March 2005, Cowichan Tribes had the opportunity to launch the cross-Canada Youth Suicide Prevention Walk. On March 28, nine young First Nations and Inuit walkers left the Cowichan Band gymnasium in Duncan to begin their journey to raise awareness of youth suicide on First Nations reserves and in communities. The walkers made presentations to many First Nations and community organizations, and concluded their journey in Ottawa on June 21, National Aboriginal Day. The Cowichan Sweaters walking club, as well as many community and Kweyulus Mustimuhw members, walked up to 20 kilometres to show their support.

The Kweyulus Mustimuhw committee endeavours to ensure that the Cowichan Tribes membership and community benefit from these opportunities and events regarding suicide prevention. We generally advertise in the Cowichan Tribes newsletter and local newspapers—so keep your eyes and ears peeled!

For more information feel free to e-mail or call the Ts'ewulhtun Health Centre at 250-746-6184, or e-mail Bev.Williams@cowichantribes.com.

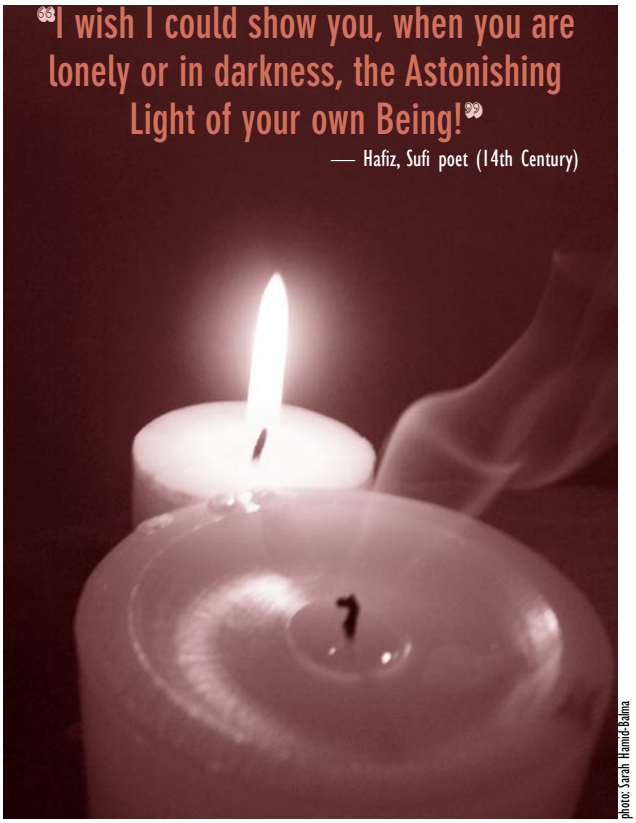

photo: Sarah Hamid-Bahma

footnotes

1. For information about White Stone, see Franssen, D. & Tayler, D. (2001, November). *A unique partnership: The RCMP and SPTP create a new national Aboriginal youth program called White Stone.* Published by Mheccu UBC; retrieved September 14, 2005, from www.suicideinfo.ca/csp/assets/sptpwhitestonearticle.pdf.

2. Also see the Centre for Suicide Prevention website at www.suicideinfo.ca/csp/go.aspx?tabid=140

Family Support
SAFER's Concerned Other Program

"After my daughter made a suicide attempt, I was so worried, because I didn't know what to do or how to best help her. After seeing a counsellor as part of SAFER's Concerned Other program, I felt more confident in my abilities to see the warning signs and take the appropriate action needed to keep her safe."—a mother in the SAFER Concerned Other Program

Natalee Popadiuk, PhD

Natalee is the Graduate Faculty Associate with the Counselling Psychology program at Simon Fraser University. Previously, she was the manager of SAFER, a suicide prevention agency within Vancouver Coastal Health, where she provided individual therapy, developed customized suicide prevention workshops, and offered consultation services to professionals in the field

Imagine that your brother, girlfriend, or best friend is suicidal. Maybe they recently made a suicide attempt, or perhaps they disclosed to you that they are thinking about suicide. What impact would this have on you? What information would you need to help and support them?

Most people feel overwhelmed and uncertain when dealing with a loved one who is suicidal. Accessing up-to-date information about suicide prevention and receiving emotional support is, therefore, crucial. In fact, if you know the signs of worsening suicidal thoughts, you could help a loved one to connect with appropriate resources and put a solid safety plan in place. You could save a life.

Families supporting a loved one who is suicidal often have many needs that can be met with counselling. There is strong evidence to indicate that providing support and counselling to families is not only beneficial to the family, but also to the person who is struggling with a mental illness, which is associated with suicide in 90% of cases. Family support leads to better client and family outcomes and coping skills, a reduction in the use of hospital services, increased awareness among family members, reduced caregiver burden, and improved ability to support the ill person.

In May 2000, SAFER (Suicide Attempt Follow-up, Education and Research) staff identified a need to formally develop the Concerned Other Program based on feedback from community workshop participants, telephone consultation with family members, other professionals in the field, and survivors who had lost a loved one to suicide. The initial goals of the program were to support the concerned individual by 1) providing information on suicidal behaviour, 2) exploring options and resources to help the suicidal individual, and 3) developing more effective coping strategies to deal with the stress of the situation.

The Concerned Other Program provides an opportunity for participants to:

- Discuss the suicidality of the loved one in safe surrounds
- Explore their emotional needs and validate their concerns
- Learn about depression, suicide prevention and safety plans
- Learn how to check for suicidal thoughts of other family members/friends
- Obtain practical coping skills and strategies

Clients in SAFER's Concerned Other Program receive validation and reassurance that what they are experiencing is normal under the circumstances. Family members often need to work through their own feelings of anger, depression, grief and loss, especially when their loved one is chronically suicidal. Others find practical counselling support, such as skills training, coping strategies and crisis management interventions, to be most helpful.

The Concerned Other Program offers up to three individual face-to-face counselling sessions at SAFER's offices to Vancouver and Burnaby residents. As an additional service to those living in other areas of BC, SAFER counsellors provide telephone consultation to people concerned about a loved one. This means that a counsellor will provide information to the caller about suicide prevention strategies and local support resources.

An important message for family members is for them to recognize the powerful and positive impact on the outcome that can occur for the suicidal individual when they are meaningfully involved in their care. When family members become aware of their role, boundaries, and needs, they are more likely to reach out for extra support and information.

There is a continued need for specialized counselling that assists family members to cope better with the stress of supporting suicidal individuals and to better help the person they love. If there are limited resources in the community, families of suicidal individuals could advocate for short-term counselling through the local hospital or mental health team. For rural and remote communities where there are only distant resources, families may use the Internet for information, accessing websites such as the Centre for Suicide Prevention or listservs. Families may also

Vancouver or Burnaby residents dealing with a loved one who is suicidal: SAFER offers up to three in-person counselling sessions at no charge. Call 604-879-9251. If you live out of the catchment area, please contact SAFER for information on suicide prevention, emotional support, and local resources

choose to organize a local support group for families dealing with a loved one who is suicidal.

It is critical for counsellors and other health care professionals who work with suicidal clients in their practice, to engage in ongoing professional development to ensure they are adequately prepared to deal with the complex issues associated with suicide prevention and family involvement. Relevant strategies for working with caregivers include recognizing the emotional impact on the family, offering short-term individual and group counselling to family members, using collaborative approaches that build on the strengths a client already has, teaching coping and skill-building interventions, encouraging regular self-care and relaxation techniques, and building support networks for caregivers. Most important is the awareness that family members are often ignored or minimally involved in the treatment planning for suicidal individuals, and this can create additional stress and unnecessary negative experiences with professionals.

Family members concerned about a loved one's suicidality are encouraged to reach out for their own counselling support. It is through helping yourself understand your role, boundaries, and emotional turmoil—plus learning more about suicide prevention strategies—that you will be in the best position to help your loved one through a suicidal crisis. i

How a Small Community Copes with Suicide

It has been said that "it take a whole community to raise a child." We have also learned that "one child can raise a whole community."

Suicide Prevention Advisory Committee, South Cariboo Region (100 Mile House, BC)

The South Cariboo Suicide Prevention Advisory Committee (SPAC) is a community-based effort comprising school counsellors, social workers with the Ministry of Children and Family Development, and representatives from the Cariboo Family Enrichment Centre and local employment programs

It was a day we would like to forget—and one that changed our community forever. As a result of a sudden tragic death in 1989, the small town of 100 Mile House was forced to open its eyes to the reality of youth suicide.

The tragic loss of one of our town's young people spurred the community to respond. Later in 1989, as suicide postvention, Mental Health Services sponsored Suicide Attempt Follow-up, Education and Resources (SAFER) community workshops. In April 1991, 100 Mile House's Suicide Prevention Task Force was formed. The task force involved a diverse group of adults, ranging from counsellors and clergy to survivors.

In 1992 and 1993 the task force sponsored additional SAFER workshops, as well as the Let's Live! program, a school-based suicide awareness and intervention program produced by the BC Council for the Family for students in grades eight to 12.

Weldwood, a local forestry employer, co-sponsored the task force for a presentation on post-traumatic stress disorder through their Employee Assistance Program.

Next, the task force, together with the Mental Health Advisory Committee and the support of the entire community, began lobbying for a crisis response worker placement in the local hospital.

Work continued, with a focus on youth prevention and education. In May of 1993, a youth survival guide was produced—in the form of a wallet card that contained a simplified response guide, as well as a list of pertinent phone numbers. This wallet card is still being produced, with minor updates, for both youth and adults. The business community of 100 Mile House has supported the task force all along by covering the printing costs.

By 1994 the first set of Community Agency Protocols for Suicide Prevention had been laboriously created and distributed.

For a time following these incentives the task force lost its impetus and struggled with its membership and funding. However, as the community would be tragically reminded by another youth suicide in 2000, the task force mandate remained an issue.

Regular meetings were reinstated, resulting in an insert in the local paper focusing on education, awareness and prevention of youth suicide; evening workshops; and fundraising for a yellow ribbon campaign.

In 2001 the local youth centre submitted a proposal to the task force to develop a guide called *Suicide Prevention—A Community Response for Youth and Families*. This project resulted in new energy—youth from the local high school were involved for a time—and a new organization name: the Suicide Prevention Advisory Committee (SPAC). SPAC continued the important work begun by the task force. A coordinator was hired to produce a new set of intervention protocols, which was released in May 2003.

SPAC continues to revise the protocol binder in an effort to meet the community's need. The committee offers educational events, provides prevention tools, and persists in keeping suicide prevention in the forefront for the people of the South Cariboo. While we hope that the reason for the committee's existence will some day disappear, until that time we will maintain the vigil. i

YouthInBC.com

Supporting suicidal and distressed youth

Julie Miller, BA, BSW, and Lindsay Killam, BA, BSW

Julie is Director of Community Education at the Crisis Intervention and Suicide Prevention Centre of BC. Her experience as a camp director for the YMCA has contributed to the development of the Crisis Centre school-based workshops and the web-based service. Julie can be reached at jmiller@crisiscentre.bc.ca

Lindsay is Youth Initiatives and Outreach Coordinator at the Crisis Intervention and Suicide Prevention Centre of BC. She has worked as an addictions counsellor and youth support worker, spending her spare time volunteering for the Distress Line. Lindsay is currently pursuing her MSW in women and addiction. She can be reached at lkillam@crisiscentre.bc.ca

For 36 years the Crisis Intervention and Suicide Prevention Centre of BC (Crisis Centre) has provided services in Vancouver, North Vancouver, Burnaby, West Vancouver, New Westminster, Sunshine Coast, Powell River, Pemberton, Whistler and Squamish. Our work in these communities has shown that the key to suicide prevention is communication. The Crisis Centre has three core programs that use communication to prevent suicides.

We are probably most well known for our 24-hour Distress Line, which allows people of all ages to call and speak to volunteers who are "Here to listen, here to help." The Distress Line provides free, confidential emotional support 24 hours a day, seven days a week, for people experiencing feelings of distress—including feelings that may lead to suicide. We receive more than 24,000 phone calls a year from women and men of all ages, all classes, minority groups and geographical areas. The goal of the 24-hour Distress Line is that no call for help shall go unanswered.

The Crisis Centre also provides free school-based workshops to youth. In the 2004-2005 school year, Crisis Centre volunteers facilitated 550 classroom workshops for more than 16,500 students. Topics covered include suicide awareness and prevention, stress management and peer helper training.

The third and newest program is YouthInBC.com. Due to an increasing demand for information and support for youth, and after observing that the number of youth reaching out through the Distress Line has decreased in the past few years, we needed a new way to provide accessible and immediate services. Partnerships with UBC, SAFER (Suicide Attempt Follow-up, Education and Research), At Large Media and representatives from the Burnaby School Board enabled us to look at alternative avenues for youth to reach out. Through youth focus groups and ongoing research and discussions we learned that many youth would prefer receiving support online rather than over the telephone.

Our goals with the site YouthInBC.com are to offer youth an alternative and relevant method of accessing emotional support and resources, to reduce the social isolation of youth and to increase the adaptive coping strategies of youth in distress.

The website includes a list of resources available in BC; information and facts about common problems that youth face; direct links to 'talk' to someone online, in real time; an e-mail address for youth to write about their problems and receive a guaranteed response within 24 to 48 hours; and the 24-hour toll-free Distress Line phone number for the Crisis Centre in Vancouver.

One of the most exciting features of the YouthInBC.com site is the one-to-one chat. Youth can select 'Wanna Talk?' and connect with a highly trained volunteer. The anonymity of online support assures confidentiality and facilitates comfortable communication between youth and volunteers. Youth express issues they are facing at school, at home and in the community—relationship problems, mental health concerns, bullying, family problems, victimization, addictions, and so on.

Statistics from the last year indicate that up to 35% of YouthInBC.com chats relate to suicide compared to 8% of Distress Line calls. Another 12% of chats involved youth disclosing a history of, or active, self-harm.

Without a doubt, this safe and confidential online tool has already become an effective and popular tool for communicating with young people in BC. Since it was launched in January 2004 the YouthInBC.com site has reached more than 8,000 individuals—youth that might otherwise not have gotten the support they needed.

We believe that online support is a crucial step in reaching youth. They are under enormous stress and face a variety of issues on a daily basis. While our 24-hour Distress Line is always available to them, it is clear that some youth prefer to use the Internet and find it more readily accessible.

excerpts from chats

"...I feel so alone and there is no one who I trust or anything...life is such a waste...everything is messed up and sometimes I'd rather die than live in this stupid place." (March 2005)

"...I was abused as a kid and that makes me not trust people...I fight with my friends all the time and my family and I are always fighting...I just can't take it anymore." (April 2005)

you can help

The ongoing success of this service requires the participation and support of communities throughout BC. If you are interested in promoting this service to youth, please contact Julie or Lindsay at 604-872-1811 for posters, stickers or info cards.

this list is not comprehensive and does not imply endorsement of resources

don't forget all the resources listed at the end of Visions articles as well

General Information

- Centre for Suicide Prevention. www.suicideinfo.ca
- Canadian Association for Suicide Prevention. www.thesupportnetwork.com/CASP/main.html. You'll find here the recent *Blueprint for a Canadian National Suicide Prevention Strategy*.
- Mental Health Evaluation and Community Consultation Unit (Mheccu), UBC. www.mheccu.ubc.ca
- American Foundation for Suicide Prevention. afsp.org
- American Association of Suicidology. suicidology.org
- Suicide Prevention Resource Center. www.sprc.org
- Health Canada. (2002). Suicide. A Report on Mental Illness in Canada. www.phac-aspc.gc.ca/publicat/miic-mmac/

Statistics

- BC Coroners Service Suicide Statistics. www.pssg.gov.bc.ca/coroners/statistics/index.htm
- BC Vital Statistics Annual Report. www.vs.gov.bc.ca/stats/annual/2003/xl/tab32.xls
- Canadian Suicide Statistics. www40.statcan.ca/l01/cst01/health01.htm
- World Health Organization Suicide Statistics. www.who.int/mental_health/prevention/suicide/suiciderates/en/

Child and Youth Suicide Prevention

- School Based Guide. theguide.fmhi.usf.edu
- Signs Of Suicide Program. www.mentalhealthscreening.org/highschool/
- SAFE Teen. www.safe-teen.com
- Mheccu. (2005). Preventing Suicide in Youth: Taking Action with Imperfect Knowledge. www.mheccu.ubc.ca/documents/publications/Mheccu_suicide_Jan05.pdf
- Youth in BC [online support]. www.youthinbc.com
- BC Ministry of Children and Families. (2001). Practice Principles: A Guide for Mental Health Clinicians Working with Suicidal Children. www.mcf.gov.bc.ca/youth/suicid_%20prev_manual.pdf

Mental Health Promotion/Resiliency for Youth

- MindMatters. cms.curriculum.edu.au/mindmatters
- Oregon Resiliency Project. orp.uoregon.edu

Gatekeeper Training in Suicide Prevention

- LivingWorks. www.livingworks.net
- QPR Institute. www.qprinstitute.com

For Survivors of Suicide (i.e., Bereaved Loved Ones)

- Survivor of Suicide support groups in Canada. www.thesupportnetwork.com/CASP/supportgroups.html
- Canadian online support group: Journey Through Suicide Grief. www.journeythroughsuicidegrief.com
- Hope and Healing: A Practical Guide for Survivors of Suicide. www.hopeandhealingguide.ca
- Supporting Children After Suicide: Information for Parents and Other Caregivers. www.nalag.org.au/pubs/Supporting_Children_After_Suicide_Booklet.pdf
- World Health Organization guidelines on setting up a survivor support group. whqlibdoc.who.int/hq/2000/WHO_MNH_MBD_00.6.pdf
- Assessing the Needs of Survivors of Suicide. www.calgaryhealthregion.ca/hecomm/mental/AssessingNeedsofSurvivorsReport.pdf
- Survivor Advocate Listserv. groups.yahoo.com/group/SurvivorAdvocates
- Wrobleski, A. (1995). Suicide, Why? 85 Questions and Answers about Suicide. www.save.org to order.
- Farr, M. (1999). After Daniel: A Suicide Survivor's Tale. Harper Flamingo.
- Gilbert, L. (2004). I Might Be Nothing. Trafford.
- Blauner, S.R. (2002). How I Stayed Alive When My Brain Was Trying to Kill Me. HarperCollins.
- (2001). Aftermath: the Legacy of Suicide [video]. 50 minutes. Order through National Film Board of Canada: www.nfb.ca or 1-800-267-7710

Media Guidelines

- Centre for Suicide Prevention. (2005). SIEC Alert #58: Media Influences on Suicide. www.suicideinfo.ca/csp/assets/alert58.pdf
- World Health Organization. (2000). Preventing Suicide: A Resource for Media Professionals. www.who.int/mental_health/media/en/426.pdf

Antidepressants & Suicidality: Recommendations

- Lam, R.W & Kennedy, S.H. (2004). Prescribing Antidepressants for Depression in 2005: Recent Concerns and Recommendations. Canadian Psychiatric Association Position Paper. www.cpa-apc.org/Publications/Position_Papers/2004-23s-en.pdf

If you are in crisis, please call 1-800-SUICIDE

BC Partners for Mental Health and Addictions Information
c/o 1200-1111 Melville St.,
Vancouver, BC Canada V6E 3V6