What we know about suicide prevention programs

Suicide Prevention programs are generally divided into three broad categories:

Primary prevention :

Primary suicide prevention aims to reduce suicide risk by improving the mental health of susceptible individuals (or populations) who have not displayed suicidal behaviour. Primary prevention strategies can be targeted at individuals or at whole communities.

- School Based programs
- Gatekeeper training
- Population and Community-Based Programs
- Family well-being based programs

Secondary prevention :

Secondary suicide prevention refers to early intervention or treatment of individuals who have displayed suicidal behaviour. This form of prevention can target people before they injure themselves (i.e. when they show signs of depression) or during a suicidal crisis.

- Screening programs
- Intervention/counseling
- Help line/crisis team/Drop-in center
- Training mental health workers

Tiertary prevention :

Tertiary suicide prevention attempts to decrease risk of further suicide attempt in persons who have already attempted suicide. This group is at high risk for a recurrence. Tertiary prevention can also be targeted at bereaved friends or family members (sometimes called 'postvention'), who may be at increased risk for mental health problems. Postvention is often accomplished through group or individual counselling and other forms of community support.

- Bereavement groups
- Psychotherapy: this may include Dialectical Behaviour Therapy (DBT) (Katz, 2004), Brief Solution Oriented Therapy and other forms of therapy
- Group or individual healing

For prevention to be efficient it should:

- Increase protective factors and decrease risk factors
- include multiple types of prevention on several levels (population, individual…)
- prevention and intervention programs and interventions should be organized around a continuum of care
- there should be clear guidelines of collaboration between various actors involved – this means clear protocols of when to refer to whom
- Include a method to identify people at risk (early risk, identifiable risk, high risk)

In Aboriginal communities suicide prevention programs and intervention should

- focus on resilience and mental, physical, spiritual and cultural wellness
- include community mobilization and capacity building – collaborative orientation
- family-oriented to ensure safe and loving home environments
- be culturally safe, sensitive and adapted
- focus on a positive personal and cultural identity, reconnecting with the land and with community, inter-generational connections
- understand the context: past trauma, healing transgenerational trauma, colonization, marginalization and globalization
- include programs to reduce socio-economic inequalities and be imbedded in a larger body of mental health programs
- Support community-driven approaches and fund locally driven decolonization efforts
- Include short-term, intermediate and long-term actions
- Based on cultural and traditional knowledge, beliefs, and practices of the community (ex: the role of elders and spiritual leaders)
- Support self-governance and empowerment
- Encourage the active participation of young people
- Integrate effective and holistic health care services at national, regional and local levels
- Be evaluated
- Include a reconceptualization of suicide and suicide prevention from the community's point of view
- Build bridges within communities - youth and old, locals and those there for shorter time, white and Inuit
- Teach to families how to deal with suicide, how to talk about it
- Make current knowledge understandable

The key components of successful programs in Aboriginal communities seem to be that they are community-based and involve active partnerships across sectors. These partnerships coordinate activities, have a well-worked out protocol to address the issues at hand, and can respond quickly to crises.

Centrality of **Belonging/Connectedness**
Feeling a sense of autonomy
Sense of competency
Both as an individual and as part of a collective group

Important barriers to suicide prevention in northern communities include

- lack of resources (community and institutional) to screen and intervene with confidence
- difficulty with coordinating service and ensuring follow-ups because of turnover of staff, third line care being out of town or coming only infrequently to town, lack of personnel to ensure follow-up, lack of trust and confidence in the system of care, patients not following up with care
- high levels of community grieving due to multiple historical and contemporary losses
- heavy community dynamics due to the fact that often small communities