Scan of Crisis Services for Children & Youth in York Region

Scan of Suicide Prevention Services for Children & Youth in York Region

Literature Review

Themes for Consideration

June 2015

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Executive Summary:

This project was jointly sponsored by a partnership between the York Region Mental Health Collaborative (MHC) and the York Region Autism Spectrum Disorder Partnership. (ASD)

The mandate of the project was to undertake a scan of crisis management services for children and youth in York Region including the perspectives of users, service providers and other players alike. In accordance with this line of inquiry, the work was also intended to comment on the level of suicide prevention strategies presently in place for children and youth across the Region.

The intention in both themes was to analyze relevant trends based on the scan and recommend potential strategies or recommendations for follow-up. The project was also directly linked to a Literature Review exercise conducted at York University on the topic of best practices within high risk groups in terms of suicide prevention. The detailed results of the Literature Review are included in the report.

Part One: Background:

The report begins by describing the Terms of Reference for the project. It then describes briefly the current policy context from the Government of Ontario in terms of crisis management and suicide prevention within communities.

References are made to the Moving on Mental Health initiative by the Ministry of Children and Youth Services as well as the broader based Open Minds Healthy Minds initiative, which was intended to bring various sectors together in a common approach to achieving healthy communities. The latter approach began in 2011-12 with a three year initial plan focusing on children and youth mental health.

This section of the report also describes the work that has been done in the areas of both crisis management and suicide prevention within York Region over the past 5-7 years.

Part Two: Scan of Crisis Management Response Services:

This section of the document describes a number of identified crisis management services in York Region for children and youth. This includes 310-COPE, Emergency Department (ER) & Community Clinics at the three regional hospitals, School Board programs related to Threat Assessment services, a crisis management program operated at Blue Hills Child and Family Centre the work of York Region Police in this area and the specialized in-patient program at Southlake Regional Health Centre.

Perceived strengths and limitations are offered based on interviews with staff, perspective from users and as a result of visits to many of the programs. Key findings include high expectations of performance in the service community relative to the capacity and mandate of the 310-COPE program. Improved awareness of the limited mandate and focus of the program (as it applies to children and youth only) as well as enhancements in its level of technology are recommended.

In a separate area, the lack of defined and consistent processes between Emergency Departments of hospitals and community mental health agencies are highlighted. Areas for suggested enhancement relate to consistency of follow-up, information sharing and referral management.

The report also notes that members of the autism and LGBT communities feel that crisis response/management involving children and youth within their communities has been marked by misunderstanding, lack of engagement and bias about where responsibility for meeting the needs of these individuals should be placed.

The report also includes the perspective of families who have immigrated to York Region from South Asian communities in terms of the challenges that they face in accessing various services in a culturally and linguistically sensitive manner including child and youth supports.

In a broader context, the report notes the lack of a true first responder level crisis management mechanism for children and youth other than police, hospitals and other traditional 911 responses. Nor will there likely be funding in the future to create this level of support. As a result of this perception, the report recommends a much stronger effort take place in terms of defined collaboration between all service providers in the area of crisis response. A leadership body is recommended to be put in place to spearhead this effort.

Part Three: Suicide Prevention Strategies:

All four Boards of Education in York Region are actively involved in a range of suicide prevention activities. Better known due to the size and scope of their mandate and reach across the community are the York Region District School Board and the York Catholic District School Boards initiatives. These include leadership in sponsoring greater use of the Applied Suicide Intervention Skills Training (ASIST) suicide prevention training program across the community as a whole.

The level of community engagement from the two francophone Boards who have a presence in the Region is not as significant as yet; however, both are anxious and willing to become fuller players in the community conversation regarding this important area. It is clearly also an important factor within their schools in York Region as well.

As per the Terms of Reference (TOR's) for the project, the review included examination of the Simcoe County Suicide Prevention Protocol for Children and Youth to determine areas of possible application to York Region.

The key findings are that the Simcoe protocol helps to broaden the number of "risk identifiers" substantially and provides a standard risk assessment tool for their use. This is viewed as a practice that should be emulated given consideration of the differing dynamics and demographics of York Region. In addition, the protocol requires the service community to commit to providing a direct and focused response to any high risk suicide scenarios in a timely and coordinated manner.

In a separate vein, the report notes the lack of attention regarding suicide prevention and management to children and youth with specialized areas of need. This is a concern within the autism community and others who feel that their direct access to community mental health services is marginalized. As well, there is a strong perception that the skill sets necessary to address complex mental health issues in these instances is not well developed in the generic mental health community.

The accompanying Literature Review section of the report makes specific reference to the elevated risk of suicide that has been demonstrated for some groups and individuals with complex needs.

The risk of suicide can be elevated due to factors such as social isolation, frequent bullying, and increased levels of anxiety, impulsivity and depression, all of which have been commonly reported. Access to mental health specialists is viewed as essential, regardless of other needs or challenges that these young persons may be living with.

Suicide Prevention Direction/Strategy:

As with the case of crisis intervention and response, there does not appear to be an integrated, cross-sectoral Suicide Prevention strategy for children and youth in place at this time within the Region. Participants tend to focus and respond more prominently to the policy and accountability requirements within their own sector. However, greater linkages between sectors in relation to suicide prevention approaches can clearly be made. Consistent training and the greater use of common risk assessment and other tools are seen as important areas for development and greater collaboration.

Part Four - Literature Review:

As noted above, the scan was partnered with a Literature Review project at York University related to best practices within high risk groups in terms of suicide prevention. The detailed research from this work is attached as an appendix to the main body of the report.

The evidence from the Literature Review is compelling. It indicates that the risk of youth suicide is significantly higher for a variety of specialized youth groups including those from Aboriginal/First Nations communities, the LGBT community, homeless youth, those with addictions issues and youth with autism.

In every group identified, evidence-based risk reduction and protective factors exist and are offered for consideration. Options include themes such as prevention, peer support, street level programs, risk management, access to therapies, greater involvement of the person, education and awareness, advocacy, life skills training, encouragement, networking, acceptance and empathy.

The data also indicates that in order to reach greater levels of suicide prevention, stronger follow-up by hospital Emergency Departments with community mental health providers is essential. This ties directly to the similar concern in York Region that more needs to be done in this specific area.

Other recommendations offered are the need for greater buy-in by all major players towards a common strategy with broader reach and the use of a single case management tool that can bring players together quickly using a common framework and language. Both of these themes would appear to be of relevance and value in terms of go forward planning in York Region.

Part Five - Systemic Issues:

Partnerships:

Linkages between service sectors involved with children and youth are viewed as supportive but underdeveloped, as it applies to crisis services and suicide prevention. Lack of mutual

awareness and other challenges including differential planning areas, (LHIN's vs. MCYS) separate funding sources and differing accountability arrangements contribute to the challenge.

However, there are examples where cross sectoral linkages are strong, such as with the 310 COPE/Kinark partnership and the growing commitment of various players to engage in the ASIST suicide prevention training.

Leadership:

To bring the challenge of combining approaches to crisis response and suicide prevention together, the community will need galvanized leadership as well as a sense of broad community ownership marked by multiple leadership efforts.

Protocol Agreements:

Protocol agreements were not seen by a number of participants as the primary answer to achieving a more coordinated service system. Relationships and trust development were frequently viewed as more important. Informal (vs. formal) arrangements are also viewed as an attractive option in order to avoid the limitations of more structured agreements.

Local Growth:

The continued rapid growth of York Region is viewed by families and organizations alike as a major issue. It is creating longer waiting lists, stretching agency capacity and is extremely frustrating for all parties in the absence of additional resources. The present level of funding is viewed as significantly inadequate given the continued rapid growth of the Region.

Background:

Terms of Reference:

The scan of Crisis Services & Suicide Prevention strategies for children and youth in York Region included responding to a number of themes as follows:

a) *Conduct a detailed scan of all current crisis response practices in use across York Region, specifically the following:*
   - *310 COPE*
   - *Emergency Room Crisis Services (ER)*
   - *Student Threat Assessment & Intervention Protocols*
   - *Simcoe County Suicide Prevention protocol (where it overlaps in York Region)*
   - *Police Crisis Response (911 Protocol)*

b) *Provide support to a Literature Review being conducted at York University on best practices within high risk groups in terms of suicide prevention. (this data is included in detail as an Appendix to this report)*

c) *Provide an analysis in both major areas (crisis response practices and suicide prevention) regarding potential new avenues of communication and practices between the groups.*

d) *Involve all stakeholders in contributing to the scan. Develop a number of themes for consideration.*

e) *Share findings in a facilitated discussion forum.*

f) *Review all relevant background documents.*

g) *Review protocol agreements in the area of youth crisis services, youth suicide prevention, threat assessment and intervention, 911, etc.*

h) *Review any related MOU's.*

i) *Review Best Practice documentation in conjunction with York University's Literature Review.*

j) *Determine needs that are not being met through existing arrangements.*

k) *Assess/confirm the need for the ASIST training program within the Region.*

Policy Context:

Open Minds Healthy Minds:

In 2011, the Government of Ontario established its Comprehensive Mental Health and Addictions Strategy, entitled Open Minds Healthy Minds. The approach began with a three year initial plan focusing on children and youth mental health. It focused on the benefits of improved early identification and intervention practices, which would lead to better outcomes for children and youth as well as society as a whole.

The policy promotes easier and faster access to services, the development of indicators to measure progress and outcomes and the need to close service gaps for the most vulnerable children and youth. It also emphasizes the growth and enhancement of culturally appropriate services. Equally important, the policy is dedicated to enhancing the capacity of the system to provide integrated services between health, education and community-based child and youth mental health programs.

Tools such as common assessment and service plans, local accountability agreements, etc. are intended to become more commonly adopted to better bring public resources together, so that every door will be the right door to help people receive the help that they need.

In its overarching policy framework document, A Shared Responsibility, MCYS stresses that the transformation of community mental health services for children and youth is a "shared responsibility". Partnerships across various sectors (health, education, social services) in local communities are viewed as essential.

Moving on Mental Health:

As part of the above strategy, the Ministry of Children and Youth Services also introduced a new strategy in 2012 designed to transform its existing children's mental health services. Moving on Mental Health is committed to promote the development of clearer pathways to service that will create more transparency and help youth and families alike to find what they need.

It also defines a continuum of core mental health services to be made available for children, youth and families at a community level across Ontario. The strategy is also intended to ensure that agencies promote collaboration with each other as well as maximize internal efficiencies.

The new direction also establishes the use of designated "Lead Agencies" across Ontario. These selected organizations are service providers who will be responsible for ensuring that the range of defined community "core services" are implemented in all designated service areas.

The various themes noted above were fully considered throughout the examination of crisis management and suicide prevention services in York Region.

Historical Perspective - Crisis Response Services for Children & Youth in York Region:

It is worth noting that a number of efforts have been made to standardize efforts in terms of how communities respond to crisis. As far back as May 2005, the Government of Ontario had developed a set of Crisis Response Service Standards for mental health providers.

Crisis response was viewed as a key part of the continuum of mental health supports for people with serious mental health needs. While applicable largely to the adult mental health system, there are a number of functions noted in the document that have application for children and youth mental health as well. The functions noted were:

- Assessment & Planning
- Crisis Support/Counselling
- Medical Intervention
- Environmental Interventions & Crisis Stabilization
- Follow-up and Referral
- Monitoring & Evaluation
- Information, Advocacy and Consultation

In 2009, a Crisis Response Protocols Resource Manual was developed by the Central LHIN, which includes York Region. The protocols in the manual were designed to ensure an integrated response to emergency mental health situations. The manual was also intended to serve as a reference guide to assist professionals in a number of areas where an emergency mental health situation must be addressed. They included:

- Referral, Assessment & Discharge Protocols
- Mobile Crisis Risk Screening Report template
- Crisis Triage Summary template
- Guidelines for addressing special populations including children & adolescents

The document also referenced the common use of a Mobile Crisis Risk Screening Report whenever an individual receives a face to face visit from a mobile crisis service such as 310 COPE or St. Elizabeth Health Care. (Adult service only)

Secondly, the manual referenced a common Hospital ER Discharge protocol. When individuals go to their local emergency department in a crisis, they would be seen by a triage nurse who provides an assessment of their situation using a common Triage & Acuity Score. A risk assessment is also completed by a crisis worker.

Where an admission did not occur, the expectation was that either a crisis response service would be contacted or if necessary, a referral to a community crisis bed would occur. There was also an expectation that a Crisis Prevention Plan would be developed between the mental health staff and the individual in crisis. Research suggests that the presence of such a plan resulted in people experiencing significantly less hospital admission and treatment going forward.

Children and Youth Focus:

In terms of child and youth populations specifically, the manual advocated for the use of customized Crisis Risk Screening Report, developed specifically for this group.

As a follow-up to this activity, in December 2009, an Integrated Crisis Community Forum took place in York Region. A Steering Committee, which was overseeing this event, had been developed to provide a structure for cross-sectoral collaborative planning that would lead to integrated crisis response services for all children, youth and families.

The forum sought input in terms of how the current system of crisis support at that time was perceived in responding to needs (strengths & limitations) and to identify opportunities for improvement. Suggestions were made subsequently in terms of better linkages and improved understanding between agencies, the development and use of shared tools for assessment, a review of best practices elsewhere, the updating of protocols, etc. As well, a single crisis intervention protocol was identified as desirable.

In March 2010, two planning days were held to create a comprehensive, integrated protocol for children and youth who experience a mental health crisis in York Region, whether it takes place at home, school or in the community. Much discussion occurred in terms of defining a crisis, defining the elements of a protocol, scenario planning, collaboration and what makes it work, assessment tools, etc. The planning days served to identify gaps, clarify the existing system and to have participants meet and spend time with players from other sectors.

The process also demonstrated strongly the need for a more collaborative, regional level crisis service for children and youth using evidence-based approaches, integrated training for suicide risk and better follow-up procedures.

Accomplishments of the past Several Years:

- Creation of York Region Integrated Crisis Services, which is a collaboration between YSSN-310-COPE, Kinark, Southlake and Markham Stouffville Hospital.

  This year 310-COPE added a 3rd crisis line (1 855-310-2673) which is accessible by cell phone as well as landlines. Over the past year, the program responded to 9,400 calls –1100 more than the prior year. 900 mobile visits were also completed under the shared program operated by 310 COPE and Kinark.

- The Mental Health Team – a partnership between York Region Police and 310 –COPE is up and running and is now available 10:00 AM to 10:00 PM. daily. This team typically responds to clients 16 years of age and over. A police officer and a 310-COPE Social Worker attend on site once a uniformed officer has ensured the situation is safe.

- Local School Boards have completed a significant amount of work on Threat Assessment protocols, suicide intervention ASIST training and mental health awareness, etc. They have also been very active in increasing awareness and education. (more details below)

Crisis Response Practices In Use for Children & Youth:

310 - Cope:

A well-known crisis response service for children and youth in York Region is 310 COPE. This service operates through York Support Services Network. (YSSN) The program's primary mandate and resources are dedicated to serving the needs of adults with developmental disabilities and mental health and/or addictions needs who are encountering a crisis.

The adult portion of the service (those who are 16 years of age and older) includes three 24/7 telephone crisis lines, a mobile crisis team (comprised of two mental health crisis workers), a Mental Health Support Team comprised of one mental health crisis worker and one plain-clothes York Regional Police officer and 4 crisis beds to provide short term stabilization. Staff may also advocate on clients behalf at local hospitals and work with police and Emergency Services (EMS) as needed. The portion of the service that supports children and youth under age 16 is operated in partnership with Kinark Child & Family Services. YSSN has a formal contract annually with Kinark to collaborate in the staffing of this service. This service also includes access to 310-COPE's 24 hour telephone assistance in the event of a crisis.

YSSN staff complete a risk assessment as part of the call response function. The tool used measures suicidal, homicidal or impulsive tendencies, the willingness to cooperate or collaborate in a solution and the availability of a support system. Calls are screened and discussed and if necessary a field visit (with the support of a Kinark social worker and a 310 COPE crisis worker) is offered.

Kinark has nine staff assigned to the latter service who assume the crisis response worker role on a weekly rotational basis. This is done in addition to their ongoing full time duties within Kinark. All participating Kinark staff have received the ASIST suicide prevention training and have also attended additional training sessions organized by 310-COPE.

Staff Feedback:

Staff at both Kinark and YSSN stressed during their interviews that the mobile crisis visit component of the service is not an emergency response. Typically, the time to establish face to face contact is in the range of 12-24 hours after the initial call is made. It was also pointed out that the service is intended to result in stabilization based on the development of a documented safety plan. The service is also intended to reduce pressure on other 911 emergency level services.

Crisis response workers may also make a referral to a community MH service. However, this does not guarantee access to a mental health treatment program.

Family/Community Feedback:

Several families and some agencies as well expressed a degree of frustration with the service. The concern heard most frequently was that face to face contact takes too long following the occurrence of the crisis event.

There was also a perception in some cases that the service was not fulfilling its core requirements. However, this is viewed as more of a misunderstanding of the actual mandate of the service than a reflection of its responsiveness level.

Internal vs. Community Expectations:

As noted, the limitations that 310-COPE functions within in terms of resources and mandate did not appear to be fully understood or appreciated by a number of participants. Since there is no funded emergency level crisis response service for children and youth in York Region, there appears to be some expectation that this program should be meeting this gap. Describing it as a "mobile crisis response" service may have helped to create an impression that this means an instant response to a perceived crisis situation.

Feedback from community agencies and families also indicated a strong desire for an immediate crisis response mechanism for children and youth. They would prefer a "first responder" type of service that would be partnered with police or ER services.

More immediate crisis response services for children and youth do exist in some Ontario communities. However, they typically have full time staffing capacity with a 24/7 presence and are very costly. Examples of this approach exist in both Peel and Waterloo regions. However, this is unlikely to occur in York Region at any point soon due to the significant cost requirements and limited resources available. As a result, other options need to be considered that can function within the existing range of services.

Demand:

The perceived demand for 310-COPE, as it applies to children and youth, was reported verbally during the scan as having been relatively low of late. However, data gathered and recently confirmed by 310-COPE suggests that it has remained relatively constant overall or is increasing.

The specific data regarding the utilization levels of the service amongst both children and youth (as well as adults) is as follows:

2013-14:

In the fiscal year 2013-14, 201 calls were received from either families or youth directly to the service. (We were not able to obtain data distinguishing whether the call was initiated by a youth or by a family member)

From this overall sum of calls, the partnered mobile response service between Kinark and 310-COPE (mobile crisis team) was used to respond to 18 individuals and their families during this time.

In the same year, the agency's Mental Health Support Team (serving youth aged 16 and above as well as adults) responded to a total of 399 calls. This broke down as follows:

- Adult Calls: 350

- Youth Calls: 49

2014-15:

In the current fiscal year, (9 months to Dec. 2014), 196 calls were received from either families or youth directly. If this pattern persists, they will likely receive in the area of 260 calls in total by March 31.

From this overall sum of calls, the partnered mobile response service between Kinark and 310-COPE (mobile crisis team) was used to respond to 27 individuals and their families during this time.

In this year, the Mental Health Support Team has responded to a total of 418 calls after nine months. (This exceeds the full year total of 399 in 13-14). If this pattern persists, they will likely receive in the area of 550 calls in total.

The breakdown in this latter area is as follows:

- Adult Calls: 347
- Youth Calls: 71

As can be seen, the data over the most recent two year period does not support the perception of reduced use of the service. In fact, growth in the use of the program appears to be occurring, based on the data noted.

Technology:

310-COPE was criticized at times during the scan for its perceived lower than desirable level of phone technology and capacity. In order to resolve this a third line is now in place with a new number (1855-310-COPE) that is capable of receiving calls directly from cell phones/internet (VoIP) phones

It was also suggested during the scan that youth prefer the Kids Help Phone service or other online options. This is not viewed necessarily as a bad thing however, as parents and other caregivers are often the people more likely to identify a crisis situation. Hence, their use of the 310-COPE service continues to be of value.

In terms of other factors that may affect demand, the local CCAC began to provide a nursing service in York Region schools in December 2013 with a specialization in mental health. This service is helping to identify risk factors and create linkages with hospitals and other mental health providers.

Analysis & Conclusions:

310-COPE is an example of collaboration between organizations from two sectors who are attempting to respond proactively to crises involving children and youth. It has never claimed to be an immediate response service beyond the initial telephone level response and cannot meet this demand under its present level of resources.

The program received mixed reviews from families and to some extent from agencies. As noted, there may well be expectations of responsiveness that are unrealistic. Improvements in technology may also reverse the declining level of direct youth engagement. The two agencies directly involved may also wish to consider a communication effort to help local

communities better understand the true nature of the service, as it applies to children and youth.

The creation of a true 24 hour immediate crisis response team for children and youth within York Region is unlikely and would be very costly. As such more collaboration between existing service providers is necessary. As well, training in evidence-based crisis response approaches in all agencies would help to make crisis response everyone's business vs. that of specialized programs only.

Hospital Emergency Departments – Crisis-Related Services:

Hospital Emergency Departments (ER's) have a primary mandate of medical and/or mental health stabilization. However, the public may expect that a visit to the ER department of a hospital will result in an immediate and comprehensive response to their physical or mental health crisis/need. They might also expect a hospital admission.

While these options are possible, in most cases, unless a severe mental health disorder is apparent or the risk of suicide is imminent, hospital admission or direct service from a community mental health organization are unlikely.

Only one in five ER arrivals of a youth in a perceived crisis state results in an admission, according to one local hospital. However, where risk factors for psychosis, suicide or major physical health issues are apparent, admission can and does occur.

The focus of ER Services, as with 310-COPE, is to stabilize the existing situation, ensure the safety of the person and provide a short term assessment of risk. While an admission may take place, discharge or possibly a referral to an out-patient hospital service are more likely. Nonetheless, an immediate discharge from the ER often leaves families feeling frustrated and unsupported if they perceive that a crisis situation is present in their case.

Follow-Up:

In a separate area, the scan revealed a perceived lack of follow-up between hospital ER departments and community agencies to ensure that information is shared and issues are picked up by a community-based service when necessary. Hospitals indicate that they do provide a discharge summary as a matter of policy. However, this was viewed as a "hit and miss" practice in several interviews with families and community organizations.

Greater communication and follow-up between ER departments and community MH professionals would appear to be necessary. There are protocols of this type in place in some communities, such as Peel Region, that define specifically how a youth will be transitioned from a hospital ER setting to a community crisis service or related program. This occurs irrespective of community agency waiting lists or whether or not the youth was formally admitted to the hospital.

This does occur at times in York Region, but the practice does not appear to be consistent, based on the scan information. There is however evidence of formal follow-up in a number of instances with hospital out-patient clinic services, such as exists at all three hospitals. (Mackenzie, Markham/ Stouffville and Southlake)

Related Research:

There is increasing emphasis in recent literature of the need to facilitate greater linkages between ER departments and community mental health services. (Heilbron et al. 2013). This is deemed important, as the period following ER visits has been demonstrated to be a particularly high risk period for suicide or recurrent suicidal behaviour. (Qin & Nordentoft, 2005) (See attached Literature Review for further detail)

In a related area, current research also suggests that parents or other family members need to be involved in any post-ER planning in order to recognize the seriousness of any future suicidal event, behaviour or other crisis, should this be the case. This is intended to increase the likelihood that they will understand and follow through with recommendations made, if they are offered. (Heilbron et al. 2013)

Staff Capacity & Planning:

As also noted in the Literature Review attachment later in the document, potentially suicidal youth may not always be able to express their needs and feelings during a crisis. The suggestion in the research in this area is that this factor can be ameliorated by the inclusion of social workers as part of the emergency department team.

This appears to be the practice across York Region with the inclusion of trained staff in the risk assessment process that occurs in the ER departments. (They may be Child & Youth workers as opposed to social workers in some cases)

Southlake Regional Health Centre:

The Child and Adolescent Mental Health program at Southlake offers a range of mental health services. They include:

In-Patient Unit: (7 short term beds)

This is the only in-patient program for children and youth experiencing mental health issues in York Region. The program is short term in nature and staffing includes RNs, RPNs, a social worker (SW) and a number of crisis workers (CYWs). The latter have a dual role of in-patient care as well as being on-call to the emergency department. (ER) In the latter case, their primary role is to conduct risk/crisis assessments for patients under 18 years of age, triaged with a mental health crisis.

The initial focus of the in-patient program is to reach medical stability followed by emotional stability. The average length of stay is five days. The unit is designed for stabilization purposes and not treatment. This role is often misunderstood by parents who are in a crisis situation and typically want a longer term solution, not just stabilization.

The program serves children and youth from across York Region including First Nations children and youth from Georgina Island and families from many cultures who now reside in York Region.

Outpatient Programs:

Individual needs may not be acute enough to warrant admission to the In-Patient unit. For patients assessed in the ER for a mental health crisis, those not requiring an inpatient admission may be referred to the Urgent Clinic. The intention of the Urgent Clinic is to stabilize the situation, manage the crisis, create teachable moments, deal with risk, be solution focused, etc. The overall program also connects children and youth with other sectors and services. The program offers a maximum of four Urgent Clinic appointments.

Child & Adolescent Outpatient Services also include:

a) Disruptive Behaviours Program
b) Child & Family Clinic
c) Eating Disorders Program – inpatient beds, Day Treatment Program, outpatient services.
d) Young Adult Eating Disorders Program – transitional aged youth from 18 – 25 years
e) Day Hospital Program

Similar outpatient services are also available at Mackenzie Health Care Centre in Richmond Hill and at the Markham Stouffville Hospital.

First responders such as police are reported to have a tendency at times to transport youth to Southlake from across the Region as a first resort, because it has in-patient capacity and because the ER is perceived to offer a comparatively lower wait time. This is not always necessary or the case however, given that ER and out-patient services exist in the other two regional hospitals as well.

York Region School Boards - Threat Assessment & Intervention Protocols:

All four School Boards in the Region (York Region District School Board, York Catholic District School Board, Conseil scolaire de district catholique Centre-Sud, Conseil scolaire Viamonde) have put into place a Student Threat Assessment & Intervention Protocol.

Threat Assessment is a formal education program that arose in the United States and was initially developed by Kevin Cameron, a first responder at the initially Columbine High School crisis in Colorado in 1999. As a result of this incident and others that followed, there has been a significantly increased emphasis on school security across North America.

In Ontario, this is also part of the impact of the introduction of Safe Schools legislation. It requires all school boards to take preventative measures against bullying and to deal proactively with any threats to the security of either students or staff. This legislation is part of a broader comprehensive action plan for school safety which includes:

- *The introduction of new mental health workers in schools and expanded tele-psychiatry (video counselling) services for students;*
- *Policies designed to put an end to bullying practices and the implications of them;*

At the York Region District School Board and others, the Student Threat and Assessment Protocol covers a number of areas where people may pose a threat. The protocol relates directly to responding to any perceived threatening behaviours directed towards either students or teachers.

The policy provides guidelines for schools that includes response expectations, assessment of risk, relationships with 911 responders, suicide prevention strategies and communication with the local mental health community.

Process:

If an incident occurs, a large group is assembled quickly to convene a threat assessment meeting and develop an intervention strategy. This includes police and community mental health representatives. The response strategy depends on the severity of the threat. It can be a same-day response if the threat is real and present. The protocol is viewed internally as comprehensive, clear, concise and easy to use.

All Boards have invested leadership at a Superintendent level in response to the Safe Schools legislation and related requirements.

In terms of the York Catholic District School Board, they too have a well-developed Threat Assessment and Intervention Protocol. It is intended to filter down to every teacher and support staff in every school as well as the expectation that all staff will have a basic knowledge of mental health issues and identification.

Similar protocols are also in place within the two Francophone Boards operating in York Region. (Conseil scolaire de district catholique Centre-Sud, Conseil scolaire Viamonde)

All Boards pointed out the requirement to fully take into account wide ranging cultural variations in the Region in terms of language, intention and practices. This is necessary in order to identify correctly and deal with any perceived threats. There can easily be misinterpretations by parties on either side of a conflict or issue. The Boards wants their staff to not overreact, nor underreact to these varying situations.

These mechanisms are viewed as well defined, detailed and intended to ensure a timely response to deal with perceived threats, which often may present in the form of a crisis. They are taken very seriously by staff at all levels of their organizations.

All School Boards include members of York Region police on the committees.

911 Services:

When a 911 call is received, it is screened to determine if a mental health issue or related need is apparent. If this is the case, York Region police are initially contacted by 911 as the first responder. Their initial task is to determine the safety level in the environment in which the occurrence is taking place.

If this is confirmed, as well as the apparent need for mental health services, police will then call in the Mental Health Team. (Age 16 +) This is a combined effort of 310-COPE staff and York Region Police. They will then work in partnership to diffuse the situation and address the mental health needs of the individual(s).

Should the 911 call relate to a person under 16, once a safety level has been confirmed, the partnered team of Kinark/310 COPE can then assess the situation in terms of the need for a mobile crisis response.

Police Crisis Response:

York Regional Police staff were routinely supported during the scan for their active engagement in crisis situations across a variety of sectors including hospital, education and community mental health. They are also increasingly being seen as being better educated than in the past in the area of mental health generally and as more understanding of the root causes of crisis-oriented behaviour, where mental health is also an issue.

Families separately noted that police responding to their crisis needs have adapted their response to take into account the unique needs and behaviours of the young person. They were viewed as adept in this regard in the areas of autism and other mental health areas as well.

Improved training and the presence of dedicated police staff in the mental health area (including child and youth mental health) are seen as being important factors in increasing the effectiveness of the response from this organization. Their investment in training and staffing is apparent in terms of the results being achieved.

Autism Spectrum Disorder Community:

There are many perceived barriers to improved crisis services for children and youth with autism, according to family members and agencies involved in supporting them. This included perceptions of negative attitudes by professionals at times, a perceived lack of detailed knowledge of various aspects of autism and being able to confidently address any behavioral aspects of the matter.

Parents also feel that in some cases Emergency Department staff at local hospital are not adequately trained in terms of understanding and dealing with autism.

There are also increasing levels of crossover occurring with the adult and youth justice system in terms of working with children and youth on the autism spectrum. York Region police have limited training in autism, but received supportive comments from a number of families in terms of how officers have dealt with a crisis involving a family member.

Families living with autism want a responsive crisis response capacity that includes staff well trained in this area as it relates to autism related issues. They feel that this should be present within a range of organizations across the children & youth system and not solely with organizations dedicated to the autism area alone. Many would prefer a system of crisis response where the first responder was not necessarily the police alone.

However, due to the fact that behaviours requiring a crisis response could at times involve risk and possibly be dangerous, crisis workers are understandably reluctant to engage in behaviourally charged situations until their safety has initially been assured by a first responder.

Families of children and youth with autism interviewed were generally of the view that the 310-COPE service is underdeveloped in terms of staff knowledge of autism specifically, in addition to its perceived limited capacity. They also suggested that emergency (first) responders also need assistance and training in ASD and in better understanding the requirements of individuals as well as the impact of a crisis on families.

LGBT Community:

As was the case with the autism community generally, the LGBT community wants child and youth mental health providers to serve all children and youth in crisis. The capacity to support fully the LGBT community should, in their view, be built into the generic system of support. The latter community does not feel that this is yet the case in terms of the legitimate and, at times, unique mental health needs of this group.

The LGBT community is also somewhat disappointed with the level of service and reach of 310-COPE as well as local hospitals in terms of their crisis response capacity for youth. The community is also not satisfied that MH professionals or first responders are totally comfortable in supporting the mental health needs of this group.

The group is pleased to note that the York Catholic District School Board is interested in supporting LGBT individuals. For their part, the School Board has developed a Positive Space Committee as well as an Equity and Diversity Committee to facilitate increased tolerance and understanding in this area and others.

There is a consistency of research data pointing to the elevated risk of crisis and suicidal behavior as well as a number of other mental health problems among sexual minority people. (See Literature Review section for more detail in this regard)

This data serves to further validate the concerns of this community in terms of the need to access mental health care on a continuous and community-wide basis.

Blue Hills Child & Family Centre:

Blue Hills Child & Family Services operates an Intensive Services Program that responds to perceived crises from families and agencies.

Calls are automatically connected to a worker within 48 hours of receipt and services are offered at both a pre and post crisis stage. Responses are individualized and may use a variety of therapy approaches such as DBT, CBT, etc.

This is an evidence-based approach that responds to the level of intensity required. There is also a risk assessment component built into the approach and some navigation services are offered as necessary as well. The program is limited to 3-6 months in duration, as it is intended to operate at an intensive level in order to maintain its focus.

Of note, agency-based referrals are apparently occurring less frequently at this time than in the past. The service does not appear to have a high profile at this time within the service community across York Region. Referrals tend to be primarily from families.

Blue Hills may wish to re-educate child and youth organizations regarding the role of Intensive Services as well as its continued presence. However, it appears to be operating at full capacity at this time with family based referrals alone, so the capacity to take on new referrals may, in fact, be limited.

Other Factors:

There is a formal arrangement in place within York Region to support crisis intervention for children & youth. This partnership between 310-COPE, Kinark, Southlake, Markham Stouffville Hospital and York Region Police supports much of the work that is being done by the participating agencies as described. However, the arrangement does not include all of the relevant players and cannot respond to current levels of need.

Nor does the partnership have the mandate or funding to become a fully specialized immediate crisis response mechanism.

Other good news is the fact that some level of crisis response capacity does exist within each sector and that there is growing evidence of collaboration between sectors. (schools, hospitals, mental health, police, etc.)

Analysis & Conclusions regarding Crisis Intervention Services:

Our overall view is that the paradigm of providing a specialized crisis response service for children and youth in York Region needs to be replaced. The new paradigm would stress the development and use of a shared approach that espouses that everyone involved in human services (all agencies) must share in the responsibility for dealing with crises when they occur within an integrated approach.

This implies that staff from different organizations would use the same or similar tools and have undergone the same training. This would result in the same skill sets and response mechanisms being used to the greatest extent possible in dealing with a crisis, e.g. a common risk assessment method for crisis identification.

Services would also be more strongly linked in terms of a common case management system with understood roles for players as well as a defined process for intervention and follow up.

There is also a perceived need for the community as a whole to place greater emphasis on prevention approaches designed to reduce the occurrence levels of crisis incidents including earlier identification of risk factors using a standard method of rating risk levels)

To reach the degree of community partnership required to put in place a community-wide response mechanism, the report recommends the creation of a Cross Sectoral Crisis Response Leadership Group at this time with a mandate to identify initial strategies to develop such as approach.

In closing, all agencies are encouraged to view crisis management and response as a shared responsibility and to become involved in creating the infrastructure necessary to make this come to fruition.

Potential Themes for Development/Response:

Potential Themes for Response:

1. *Increase acceptance and expectations that the responsibility for crisis management belongs to all community-based child & youth organizations within the ASD/MH Collaborative and one that can only be managed effectively in a collaborative approach.*

2. *In this light, consider the development of a cross-sectoral Crisis Response Leadership Group that would develop evidence-based tools for a common, community response to any crisis.*

3. *Select a common measurement tool for use that will identify risk levels of children and youth identified and trigger appropriate levels of response depending on the risk level determined.*

4. *Clarify as a community of providers the service expectations of 310-COPE relative to its mandate and resource capacity.*

5. *Create a firmer understanding as to the process ER departments will use in sharing information and following up with community mental health providers following presentation of at risk youth in ER departments of the three York Region hospitals.*

6. *Hospitals are encouraged to work directly with community agencies and the public in educating them as to the ER mandate of stabilization vs. treatment.*

7. *Acceptance of the crisis and related mental health needs of the specialized populations is required. Responses are also necessary in an informed and sensitive manner.*

8. *Blue Hill's Intensive Service Program needs to be better understood as a limited but effective crisis response service within the child and youth service delivery system.*

9. *310-COPE is encouraged to distinguish whether a call received is from a youth or a family member and report this data to the community on an annual or semi-annual basis.*

Part Two: Suicide Prevention Strategies for Children & Youth:

The second major theme to be addressed in the project was the area of suicide prevention. The Terms of Reference requested that the scan incorporate what was occurring in this area and what more possibly needed to be done.

It is obvious that in terms of children and youth, suicide prevention and a discussion of crisis response capacity are intrinsically related. For purposes of the scan, they were separated somewhat for purposes of clarifying what was occurring in each area.

The intention is to scan the area of suicide risk and response knowing that this is one major form of a crisis that can occur in the life of a child or adolescent.

York Region School Boards Suicide Prevention Strategies:

York Board of Education:

The York District Board of Education is actively involved in a range of suicide prevention activities and has a designated senior mental health lead manager assigned to this area. The Board has also been a strong proponent of the ASIST Suicide Training method as well as its smaller partner Safe Talk. The commitment to extensive training of their staff includes both programs with additional specialization for some members in ASIST. The intention is to have a minimum of three educators per school fully trained in the latter method.

ASIST is designed to assist caregivers in recognizing the signals of potential suicide from children and youth and in becoming ready and able to respond effectively in an intervention focus. The program also includes the requirement of a Safety Plan being put in place for any individual identified to be at risk.

Training in ASIST is a two-day program that is intensive, interactive and reality-focused. It includes topics such as caregiver attitude, the intervention needs of a child or youth at risk, the model of response and the need for community networking related to this issue.

The program is highly popular with a variety of social service organizations as well as in the education sector and is quite adaptable to a community vs. educational environment. A maximum of 28 participants attend each session with a minimum of two trainers.

To its credit, the York Region District School Board has sponsored a number of sessions for community participants. They have also dedicated up to 50% of available spaces for community participation. In total, they have trained 564 people over the past year using a train the trainer approach.

A number of community services have taken up the offer to have their staff participate in the Board-sponsored training including the Child & Adolescent program at Southlake. ASIST may also be adaptable in terms of its value in working with children and youth from the ASD community.

York Catholic District School Board:

The York Catholic District School Board is also actively involved in using the ASIST program to increase awareness levels in all of its schools. In addition, it also provides instruction in the area of "self-harm" to all of its students as part of its Grade Nine curriculum. They are also actively engaged in working with students in developing resilience and mindfulness.

Conseil Scholaire de District Catholique Centre-Sud:

This Board was one of the original pilot Board in the province in 2011-12 challenged with developing a strategy for acting on suicide prevention. As such, this area became and has remained a priority. Their initial priority was to educate and sensitize all school principals in terms of the need to address this topic seriously and to prepare their staff fully.

Staff in all secondary schools (Grades 7-12 in the francophone system) regardless of their role have been trained in Safe Talk, which allows each of them to pursue a 'courageous conversation' with any student that they suspect may be having suicide-related symptoms or behaviours. This practice will be extended to their elementary school system as well (early kindergarten to Grade 6) in 2015-16.

ASIST training has resulted in the certification of between two and six staff from each school as formal interveners with any children or youth involved in a risk of suicide. This Board now wants to turn its attention increasingly to undertake more activity directly with students as opposed to staff in terms of suicide prevention.

Conseil scolaire Viamonde :

Conseil scolaire Viamonde is the French Public Board of Education, which oversees a total of 47 francophone schools across Ontario, three of which are located in York Region. This includes two elementary and one secondary school. This Board was part of the third and final cohort of Boards of Education in the province to put in place a Threat Assessment and Suicide Prevention protocol. They are now in the process of finalizing their processes after a year of work in this regard.

As per the other Boards noted, they have devoted an extensive amount of time in training their leadership cadre of staff including 220 principals, guidance counselors, education consultants, etc. in ASIST training. All staff at each of their 47 schools have now been trained in Safe Talk.

The next steps for the Board include the raising of awareness with parents and other family members of the need for prevention and to establish a focus on wellness vs.suicide. They are also working directly with students in the areas of mindfulness and in the need to build more resilient children and youth.

Other Issues:

Boards of Education in York Region bring a wealth of information, training, experience and networking to the area of suicide prevention. They also face a variety of unique situations related to the multicultural landscape in York Region.

This includes areas such as parental expectations that vary from culture to culture as well as the high volume of international students in the Region who may be living without their families in alternative settings for long periods of time.

In addition to suicide prevention expertise, Boards are also becoming more active than in the past in terms of mental health generally. With their size, reach into the community and growing resources in the mental health field, we encourage them to reach out to other child and youth mental health organizations to share their insights and strengthen their collaboration in terms of both suicide prevention and crisis response.

Simcoe County Suicide Prevention Protocol:

The High Risk Suicide Protocol for Youth being used in Simcoe County was referenced as a source of information that may be useful to York Region in terms of its application, experience in the field or where it may actually cross over into York Region.

The structure of the protocol is comprised of a number of local Steering Committees situated across Simcoe County (Barrie, Orillia, and Collingwood) with each one using the common suicide prevention protocol and response.

The protocol outlines a series of eight steps to be taken following an initial observation of risk for suicide. The process culminates in a series of outcomes from a Community Conference including the creation of a Safety Plan and the development of strategies to manage the situation until additional services are available.

Risk identifiers initiate the protocol by contacting parents/guardians, obtaining consent for the sharing of information, determining the players to be involved, etc. A Risk Identification Indicator Framework has also been developed. It can be applied regardless of who the risk identifier is or where they are located.

If suicide planning appears to be active in terms of intent and access to lethal methods, a request can be made for a "same day" response by either an existing mental health worker, a family physician, staff at a local Emergency Department or a Youth Mobile Crisis Response Worker.

The Risk Identifier will then initiate a "Community Conference" with the person(s) providing intervention or a hospital member, if an admission has taken place. All agencies who are part of the protocol are expected to participate, develop a plan collectively and share responsibility for follow-up. Where the risk of suicide is not deemed imminent, a community conference is expected to be held within five working days.

The protocol also calls for the use of a "No Harm Agreement" with the individual to reduce the likelihood of suicidal behaviour in the period immediately following the suspicion of intent. It includes the identification of safety contacts and asks for a pledge to "keep safe" and not act upon thoughts of suicide for a specified period of time.

Even though all agencies have significant waiting lists, there is an agreement that all conference referrals with high risk indicators will receive a formal mental health session within fourteen days and be supported during the interim period on a rotational basis by the signature organizations to the protocol.

The latter are Kinark Child & Family Services, New Path Youth & Family Services, Canadian Mental Health Association and Catholic Family Services. School Boards are participants but did not formally sign off. As in York Region, they are developing their own internal protocols. Royal Victoria Hospital (RVH) is also involved, but has not signed off as well.

Areas that York Region may wish to consider for local use may be:

a) The widespread use of "risk identifiers" with common training. This strengthens the concept that everyone can be a suicide responder or intervener, not just designated experts.

b) The expectation that in every case where risk of suicide is viewed as legitimate, a defined Safety Plan is created for the individual.

c) The use of an evidence-based common tool from which to identify risk factors, risk levels and common language.

Autism & Suicide Risk/Prevention:

Many families with a child or youth who has been identified on the autism spectrum are experiencing very high levels of stress, frustration, anxiety and uncertainty. This is particularly apparent in terms of the transition to adult services, waiting lists and dealing with serious behavioural issues involving aggression.

Families also stated during the scan that they must serve at times as the "case manager" in some instances, as they deal with various sectors and organizations. (education, mental health, crisis support, police, health care, psychiatry, etc.) They bemoan the limited availability of navigation services in this regard.

On the other hand, they are extremely grateful with helpful organizations or a particular therapist. Many compliments were offered in terms of the work of York Regional Police, School Boards, various MH agencies, autism services such as Kerry's Place, individual social workers, various psychiatrists and others. Respite is also viewed as extremely valuable and necessary to the mental health of these families. They cannot cope without ongoing relief and much more is needed.

Many families also expressed the view that their family member with autism also experiences discrete mental health issues, including depression and anxiety. They view suicide as a valid risk in some cases. They repeatedly called for stronger identification of the mental health needs of their family member in this regard.

The accompanying Literature Review section of this report makes specific reference to the elevated risk of suicide that has been demonstrated for this group of individuals. Social isolation, frequent bullying, and increased incidences of anxiety, impulsivity and depression are commonly reported. *"There exists in youth with ASD a particular vulnerability to suicide due to the additional burdens of depression and/or trauma history."* (Storch et al., 2013)

(See attached Literature Review for further detail in this regard)

Of note, The York ASD Partnership, a collaborative of 20 organizations whose mandate is to improve the system of supports for people with ASD and their families in York Region, recently sponsored an ASD Certificate Training Program for Mental Health workers in York Region. The three day course, developed and delivered by ISAND clinic was made possible through a grant from Autism Speaks Canada. Families consistently see the global training of staff from all sectors in Autism Spectrum Disorder as a priority. It is also relevant in terms of suicide prevention, which has a higher than normative risk factor within this population. This training course will be available as an on-line learning course in 2016.

Merging Factors:

There are many crossover points for families dealing with autism in terms of crisis response, suicide prevention and mental health. They would like to see a global approach taken that links these issues and responses more seamlessly and consistently.

Transitional aged youth with autism present particular challenges for parents. Adult residential placements for this group of individuals are not apparent, even if funding were to be secured.

The level of support for York Regional Police engagement in the area of behavioural crises related to autism was consistently high. They were commonly described as well trained, sensitive, supportive and patient.

In conclusion, the ASD community wants to be taken seriously in the conversation about suicide risk and prevention.

Other Identified Groups:

Suicide risk is also clearly much higher for a variety of specialized groups including the LGBT community, Children and Youth of immigrant families, Aboriginal youth, Homeless youth and those impacted by alcohol and/or drug usage. This is strongly confirmed in the accompanying Literature Review.

One area however not addressed specifically in the Literature Review are the issues of crisis management and suicide prevention as they affect children and youth from families who have recently immigrated to Canada and to York Region. The Social Services Network is a non-profit charitable organization delivering culturally and linguistically appropriate programs and services to the diverse South Asian community in York Region that is made up of a number of cultures, languages and faith groups.

The agency also serves as a bridge or pathway for families to access mental health and many other public services as they are required. They serve in many ways as a navigator as opposed to a direct delivery service function. This includes work with the education sector as well as the child and youth mental health system.

The agency's Executive Director, Dr. Naila Butt indicated that York Region now has the third largest community in Ontario of people from South Asian countries who have immigrated to Canada. South Asians remained the largest visible minority group in the province in 2006 with a population of 794,170 that accounted for 28.9% of all visible minorities in the province.

Newer arrived families face a number of issues in York Region and other jurisdictions centred around obtaining access to various community services, coping in a very different physical and cultural environment, language differences and in accessing services in a culturally and linguistically sensitive manner, whether they be in the form of child and youth mental health, seniors services, physical health, autism, etc.

Immigrant communities also have many of the same needs as the broader community in terms of obtaining assistance with issues such as senior's supports, dealing with elder

abuse, Alzheimer's disease, unemployment, violence against women, the inability of families to navigate the various public service systems, etc.

The Social Services Network works directly in a wide range of community settings where these various needs and issues present themselves.

In terms of child and youth mental health specifically, challenges include intergenerational conflict, parental expectations, violence amongst youth, suicide risk, autism and a lack of understanding by helping organization at times of family dynamics and cultural needs.

They believe fundamentally that greater success in these areas will occur whenever trust and strong working relationships are built between various organizations and the immigrant community in general. For the latter, a sense of belonging and acceptance is essential. Working collaboratively will break down the barriers that prevent trust and mutual understanding from occurring.

They also feel that more must be done in terms of prevention approaches, delivered in a non-threatening manner that will mitigate the need for crisis response and intervening with suicidal behaviour.

Social Services Network and other immigrant service organizations wish to be part of the solution in terms of addressing issues related to suicide prevention and crisis management supports for children and youth in York Region.

Conclusions regarding Suicide Prevention:

Much of the work being done in the area of suicide prevention is very thorough and speaks to a high level of commitment, training and insight. School Boards in particular have been very proactive in this regard, to their credit. Other agencies are also engaged in a variety of programs designed to prevent or minimize the risk of suicide.

Training is also occurring and greater partnership potential exists in using a common prevention tool such as the ASIST program.

However, there does not appear to be an overall integrated cross-sectoral Suicide Prevention strategy for children and youth in place at this time. Players tend to respond primarily in relation to the policy drivers within their own sector. E.g. education, health care, police, mental health services. For example, hospitals indicated during the scan that they must conduct their own assessments of suicide risk as per the provisions of the Mental Health Act, regardless of other work that has been undertaken in the community.

Greater linkages and the increased use of common language and approaches in relation to suicide prevention approaches can be made. We note the work mentioned in terms of ASIST training, which has become very cross-sector oriented within the Region. A review of the Simcoe Suicide Prevention protocol may also be of some value in developing a common risk assessment tool such as their Risk Identification Indicator Framework.

As per the crisis response chapter, managing suicide risk is also viewed here as an area of shared responsibility. The contention is that all mental health workers need to be trained in the same core method in terms of suicide risk assessment and intervention, safety planning and monitoring.

There is also a need for continued increases in awareness and education on how to respond to risk/suicide.

"Youth suicide affects individuals, families, schools, teams, neighbourhoods and whole communities. It's an issue that requires collaborative efforts to create effective solutions. All community mobilization efforts to address youth suicide should include prevention, risk management and post intervention strategies." Together to Live, Ontario Centre of Excellence for Child & Youth Mental Health.

Increasing the Scope of Effort:

Some feel that the suicide prevention conversation also requires greater involvement from the non –professional group of organizations or individuals. The view in this regard is that the response taken needs to be "community owned" as much as "clinically driven". This view is also supported in the current literature on the topic, which stresses the notions of active mental health promotion, reducing levels of suicidal thought or ideation and viewing suicide as a challenge facing the full community.

Prevention can also occur by targeting children and youth who may be at higher risk than the community norm. The aim in this regard is to assist individuals before they hurt themselves or are at imminent risk level.

Potential Themes for Development/Response:

- *Designate the ASIST program as the preferred approach to addressing suicide prevention responses for children and youth services in York Region. Ensure that staff of all agencies and related services that support children and youth are trained in the approach as a shared community response to the risk of suicide.*

- *Review the Risk Identification Indicator Framework used in Simcoe County for possible application across a number of organizations and sectors in York Region. Create a greater sense of shared ownership and responsibility for preventing, identifying and responding to the risk of suicide.*

- *The community as a whole must respond to the high risk factors for suicide associated with a number of discrete communities such as LGBT and autism. Access to core mental health services for children and youth needs to reflect these risk factors.*

Part Four – Synopsis of Literature Review Observations:

From a research perspective, suicide risk is clearly higher for a variety of specialized youth groups including those in the Aboriginal/First Nations sector, the LGBT community, homeless youth, those with addictions issues and people with autism. The Literature Review which is attached to this report provides rich detail in this regard.

Some of the more compelling findings in the review, which are all based on well documented research includes the following:

- LGBT youth experience more suicidal behaviour than other youth. (1.5 to 3 times more likely to have reported suicide ideation) This is a consequence of the psychosocial stressors and disapproval associated with their gender non-conformity.

- When LGBT youth are confronted with rejection, their homelessness rates increase as does the risk for involvement with alcohol and/or drug use. Risk factors accelerate rapidly in terms of suicide when these additional factors are present.

- Homeless and runaway youth have elevated risks of suicide attempts and depression as well as more frequent mental illness problems, experiences with physical and sexual abuse, substance abuse and ill health.

- Youth suicide rates in Canada's First Nations, Inuit and Metis communities are reported to be higher than those of any culturally identifiable group in the world.

- Suicide occurs five to six times more frequently among First Nations youth than non-aboriginal youth in Canada. Young native women are eight times more likely to commit suicide than their non-aboriginal cohort.

- Drinking or acute intoxication in the case of youth may have immediate effects in terms of increased suicidal ideation or behaviours.

- There are a reported multitude of risk factors amongst youth with autism associated with suicidal ideation such as social isolation, frequent bullying, impulsivity, depression, etc.

These findings are a call to recognize and respond to the significant needs and risk factors that these identified groups are facing in our communities.

The good news in the research is that in every group identified, evidence-based risk reduction and protective factors, which have been proven to be effective, are offered for consideration. It is only the application of the correct responses that needs to occur in a thoughtful manner in order to mitigate the impact noted.

Options presented in the Literature Review include various prevention-oriented approaches, peer support, street level programs, risk management, access to a variety of therapeutic programs, direct engagement and involvement of the user, education and awareness, advocacy in a variety of areas, life skills training, encouragement, networking and connectedness, acceptance and empathy.

There is also research that directly informs other aspects identified in the scan. For example, the data indicates that follow-up from hospital Emergency Department visits, where mental health is the primary issue, is essential. This finding ties directly to the concern in York Region that more needs to be done in this area.

The strong concerns shared by families within the autism community regarding the mental health needs of their family members are also strongly supported in the literature review findings as well.

Of note, newer research indicates that addiction to social media is creating a great deal of stress, competition, lack of privacy, depression and increasing risk of suicide for youth.

Other lessons learned in terms of effective suicide prevention practices from a research point of view are the need for buy-in by all major players in recognizing and dealing with the threat. (formally or informally) In addition, having a strong case management tool for common use including a risk assessment template, a strong case conference process and the presence of a safety plan are also emphasized as imperative.

* For greater details regarding the Literature Review results, please see Appendix One – pages 36-66.

Potential Themes for Development/Response:

- *Review carefully the data presented in the Literature Review Appendix to the report. Use the evidence provided to develop a strategic region-wide response to the suicide prevention risk within the groups identified, as they apply to York Region.*

Part Five - Systemic Issues:

Partnership Activity:

A common view expressed during the scan was that across York Region, linkages between the various service sectors involved with children and youth, (police, hospitals, community mental health, education, etc.) while mutually supportive, remain informal and somewhat underdeveloped, as it applies to crisis services and suicide prevention.

The scan process suggests that there is a great deal of mutual respect and willingness to work together, particularly in a Region that is growing rapidly and is clearly under-resourced to deal with this reality.

While there appears to be a strong level of case-based collaboration, it appears to be less evident at a level of common strategy, shared tools, etc. However, the 310 COPE/ Kinark partnership and the growing commitment to work with the ASIST suicide prevention approach remain examples of where collaborative planning is occurring.

In the words of one participant in the scan, "*While there is some cross-over representation on committees such as the Threat Assessment Protocol groups, overall, it does not feel like a "village approach" to suicide prevention but rather a "silo response*."

It is important to note that staff may not always be aware of what is occurring in other sectors because of limited direct contact and working so hard within their own organization. For example, there may not be sufficient awareness of what the local CCAC or the Canadian Mental Health Association (CMHA) have to offer for children and youth in the topic areas. Yet, there are services such as Occupational Therapy, psychiatry, etc. that are available for youth from these organizations that may not be fully drawn upon.

Specific opportunities for partnerships may also exist with the CMHA in terms of a variety of youth education and hands-on services that they provide. People may not always be cognizant of the CMHA cross-over mandate with the 16-18 year old population.

For example, CMHA operates an Early Psychosis Intervention program for 14-35 year olds. Most participants are 18 plus, as per the typical onset of psychoses. They also operate an Early Intervention program for young people dealing with drug usage. They operate a Youth Wellness program that is geared to mental health education at an elementary and secondary school level. There is also 1-1 support available for identified youth.

Yet another program is "Why Try" a US based program with a mandate to build resilience in youth. Workshops are available for teachers, parents, schools. CMHA will also operate in York Region a new Mobile Youth Clinic beginning in 2015. It will go out to skate parks, youth shelters, etc. and work directly with youth. It will also provide primary health support (nursing level) in addition to MH support. The latter will be in the form of a MH worker and a peer specialist.

There are likely many more opportunities for apparent collaboration and shared resourcing than any single agency or person is aware of. As one professional indicated "*There are tons of separate activity occurring but not enough shared activity between us."*

Some of the challenges in addition to workload include differential planning areas (LHIN's vs. MCYS) core funding sources and different accountability expectations between the various systems.

Leadership:

To bring the challenge of combining strategies and approaches to crisis response and suicide prevention together, the community will need galvanized leadership. For its part, Kinark will need to play an additional new role in this regard, as it is now the designated Lead Agency in York Region for MCYS-funded child and youth mental health services.

Nonetheless, it will also be imperative to ensure that a sense of community ownership is also developed for the strategies that will need to be put in place in these areas. As such, there must be "multiple leadership" efforts occurring. The report recommends specifically the creation of a cross sectoral leadership group that would be mandated to address coordination and collaboration efforts in the areas of crisis response and suicide prevention alike.

Protocol Arrangements:

Protocol agreements are not seen as the answer by everyone; relationships and trust development were viewed as more important by a number of participants in the scan.

In these cases, the view expressed was that people and organizations sometimes feel confined by the notion of signing off on arrangements that may seem limiting or bring the potential of liability to the organization. Protocol arrangements are also often complex and require lengthy negotiations in some cases.

Hence, while they may be desirable, relationship building, awareness and education about other service systems may lead more quickly to an increase in cooperative arrangements being made across organizations and sectors.

Local Growth Factor:

As noted earlier, the continued rapid growth of York Region from a demographic point of view with many families relocating from Metro Toronto is viewed by families and organizational staff alike as anxiety provoking. It is making waiting lists for service longer, causing agencies to be ever more stretched, and increasing workloads and is extremely frustrating for all parties in the absence of additional resources.

Potential Themes for Development/Response:

- *Look for both formal and informal opportunities to create collaborative relationships in addition to the area of ASIST training. Consider an Emergency Department (ER) shared information protocol as a priority in this regard.*

- *Discuss a leadership strategy for the further evolution of crisis response and suicide prevention programs for children and youth in York Region.*

Synopsis Follow Up Session Feedback:

At a large, well-attended community session held on January 21st, 2015 in Richmond Hill, participants were presented with the major themes from the review. They were then asked to provide commentary and identify opportunities for change and greater impact in four separate themes as follows:

- *How can we effectively foster and create a culture of shared responsibility for crisis management and suicide prevention? Please be as specific as possible.*
- *Does the concept of prevention generate any ideas in terms of how to get at these issues earlier and more effectively as a community?*
- *Is there a need for greater engagement with the non-professional areas of the community in partnership or others that have not played a role?*
- *How do we build greater knowledge and support for the needs of the identified specialized populations within the report?*

Key responses in terms of each of the four themes included:

1. Shared Responsibility:

We must view crisis response and suicide prevention as a holistic, community responsibility involving all services, both professional and non-professional alike.

Neither should not be viewed as a discrete service or function for designated experts. This is no longer a valid approach to consider. Rather, we all need greater awareness of these issues and of the best response mechanisms that we can learn and use collectively and consistently. (embed these tools within all of us)

To do so, we first need to adopt a common vision of what the preferred approach (shared responsibility) means and follow this up with specific activities that will allow each of us to participate effectively within this framework.

This process must occur and be sustained from today in order to reach this outcome. Each organization present must be willing to designate a lead staff to represent their organization in undertaking the work necessary to build a collective capacity.

2. Prevention Orientation:

Prevention is a continuum which can be responded to on a broad community level (primary) as well as targeting specific individuals and groups who may be at risk (secondary) or those already impacted by a suicide attempt. (tertiary)

We want to be able to respond to a youth regardless of where they are on this continuum by using a common risk assessment tool as a community that can measure where a child or youth is at any point in time.

Low level risk will bring a differing response than higher levels of risk in a thoughtful and planned fashion.

3. Greater Engagement in the Broader Community in the Effort:

The formal system is clearly unable to deal with all aspects of suicide prevention and crisis response on its own.

We need to mobilize the full community to be developing a specific focus on education and awareness. "By the Community/For the Community"

This should include the use of social media as a vehicle for sharing resources and increasing awareness.

4. Identifying/Responding to the Needs of Specialized Populations:

There are specialized groups that were not specifically identified during the scan.

This includes children and youth of newly arrived immigrants who may face significant challenges in terms of family expectations, adjusting to differing social norms, etc.

We would recommend the use of a Risk Assessment Tool designed specifically for the specialized population with which we are focusing on at any point in time.

* For greater detail regarding the Group Responses, please see Appendix Two – pages 67-71.

Resources Identified for Consideration:

The availability of various resources in dealing with both crisis intervention and suicide prevention are growing rapidly. There are multiple online tools available that cover a wide range of topics including prevention, risk assessment, best practices, tools for consideration, community awareness, etc.

The need in York Region may be to reach consensus on which tools to apply and what specific strategies to employ. Regardless of the level of on-line resources, only the community itself can create a common roadmap and plan of action that binds players together in a functional and integrated manner. This may well be the greatest challenge of all going forward.

Nonetheless, it is comforting to note the range of experience, resource materials and best practices available for consideration. A very brief sample of the latter is noted below.

- Together to Live, A Toolkit for addressing suicide in your community; Ontario Centre of Excellence for Child & Youth Mental Health; www.togethertolive.ca.
- The Canadian Mental Health Association Mental Health Promotion Toolkit; cmha.ca.
- The Trevor Project, www.thetrevorproject.org;
- Preventing Suicide in Children and Youth, Children's Health Policy Centre, Simon Fraser University; www.childhealthpolicy.sfu.ca.
- Acting on What We Know: Preventing Youth Suicide in First Nations: Suicide Prevention Advisory Group.

- Policy and Practice Considerations: Clinical Assessment of Suicide Risk and Clinical Documentation; a guidebook for conducting risk assessments.

Report Conclusions:

The feedback from this scanning process has resulted in a greater understanding of the depth of commitment and effort that goes into the areas of crisis response and suicide prevention in York Region. There is much to feel good about and great potential exists to do much more in both major themes.

The scan suggests some level of frustration with the limited crisis response capacity for children and youth in York Region at this time. Some would like to see a full time, dedicated program. However, this is likely prohibitive in terms of cost and a new approach, based on a shared responsibility and collaboration is viewed as more realistic and achievable.

This includes improving communication such as noted in the context of ER services and community mental health programs. Education regarding the crisis response requirements of specific groups of children and youth must be better understood and responded to. There is also a need to better understand the mandate and limitations of the 310-COPE program.

In terms of suicide prevention, there has been a substantial efforts and improvements made in this area within York Region. The adoption of the ASIST training program as well as the creation of a common suicide prevention response process would enhance responsiveness further and potentially save lives. However, much more can be done in creating a community level of responsibility, putting prevention programs in place as well as designing and using common tools for risk assessment.

The attached Literature Review validates the concerns expressed by various groups in the community regarding elevated risk of crisis and suicide within their youth. There is compelling evidence in this regard in terms of the mental health needs of a variety of groups.

Lastly, the report emphasizes how important individual and collective leadership will be in bringing the community of providers and consumers of service together. The scan suggests that in its absence people will continue to work furiously within their primary domains in order to make a difference.

Viewing the challenge of crisis response and suicide prevention as a collective community mandate may be the most important strategy to address in York Region and the most necessary to undertake in a rapidly growing and under-resourced community.

Appendix One - Literature Review

LGBT Population

Risk Factors:

- There is a consistency of data pointing to the elevated risk of suicidal behavior and mental health problems among sexual minority people;

- LGBT youth as a group experience more suicidal behavior than other youth. A variety of studies indicate that LGBT youth are nearly 1.5 to 3 times more likely to have reported suicidal ideation than non-LGBT youth. LGBT youth are nearly 1.5 to 7 times more likely than non-LGBT youth to have reported attempting suicide. (Haas, A. P., et al, 2010)

- Elevated risk of suicide attempts among LGBT adolescents is a consequence of the psychosocial stressors associated with being lesbian, gay, or bisexual, including gender nonconformity, victimization, lack of support, dropping out of school, family problems, suicide attempts by acquaintances, homelessness, substance abuse, and psychiatric disorders.

-Stresses related to the awareness, discovery, and disclosure of being gay, which researchers refer to as "gay-related stress."

-Individuals that cross gender roles (often called gender nonconformity), that is, "personality traits associated with the opposite sex," account for almost all of the variation in suicidal behavior between heterosexuals and LGBT people.

-The social disapproval of gender nonconformity might result from its association (whether real or perceived) with an LGBT sexual orientation.

-While heterosexual adolescents also experience these stressors, they are more prevalent among LGBT adolescents.

-LGBT youth often lack important protective factors such as family support and safe schools, and more LGBT young people appear to experience depression and substance abuse.

- In addition, there is risk unique to LGBT youth related to the development of sexual orientation: disclosure at an early age raises risks.

-Stigma and discrimination are directly tied to risk factors for suicide; discrimination also has a strong association with overall mental illness.

- Some groups of LGBT youth are at particular risk: those who are homeless and runaways, living in foster care, and/or involved in the juvenile justice system;

-Study found that 62 percent of LGBT homeless youth reported having attempted suicide, compared to 29 percent of non-LGBT homeless youth (Van Leeuwen et al., 2006)

-Although family conflict is the primary reason that youth leave or are expelled from their homes, LGBT youth are at higher risk of being told to leave, or feeling that they need to leave their homes than young heterosexual people.

-Once out of the home, LGBT youth are more likely to end up on the streets than their heterosexual peers, often because of the hostile environments they face in foster or group homes and shelters for runaway and homeless youth. (Ray, 2006)

-Studies have found that gay and lesbian youth make up 11 to 35 percent of homeless and runaway youth. (Cochran, Stewart, Ginzler, & Cauce, 2002)

-Limited information is available on suicidal behavior among transgender youth; however it is plausible to hypothesize that transgender youth, in common with LGBT youth, have elevated risk and lower protective factors and higher rates of suicidal behaviour.

-A recent study focused on transgender youth aged 15 to 21. (Grossman and D'Augelli, 2007) Of the transgender youth participating in the study, 45 percent had thought seriously of killing themselves, and half of those said their thoughts were related to their transgender status.

-When comparing transgender youth who reported having attempted suicide with those who had not, researchers found that the youth who had attempted suicide had experienced more physical and verbal abuse from their parents.

-Risk factors associated with attempted suicide among transgender people were younger age (under 25), depression or a history of substance abuse, forced sex, and gender-based victimization and discrimination.

-Transgender youth have also reported parental rejection to be a particular stressor. (Grossman & D'Augelli, 2008)

- As many as one in five transgender people need or are at risk of needing homeless assistance. Yet, transgender youth face many difficulties; in most shelters, youth are housed by birth sex rather than by gender identity (Ray, 2006)

Protective Factors/Best Practices:

-Careful evaluations need to be conducted to identify sexual orientations as well as different gender identities, behaviors and expressions amongst transgender population.

-Research based on focus groups of transgender people indicates that some felt they were treated poorly by psychotherapists and attributed this poor treatment to the provider's lack of experience with transgender people or the provider's belief that transgenderism is an illness.

-Members of the focus groups reported that participating in peer support groups was helpful (Xavier & Bradford, 2005)

-Closely monitoring the safety of the youth is important, as sexual violence toward transgender youth is prevalent.

- Given the high rates of substance use disorders among LGBT men and women, which in the general population increases risk for suicidal behavior, access to culturally competent drug and alcohol treatment is critical.

- Ensure the involvement of LGBT people of all ages, racial, ethnic, and gender identity constituencies in the planning, design, development and implementation of all new mental health interventions and programs for substance abuse treatment.

-Increasing access to and participation in culturally competent drug and alcohol treatment is especially critical.

-De-stigmatize mental health disorders, particularly mood and anxiety disorders, amongst LGBT people.

-Educate LGBT people about the relationship of mood, anxiety, and substance use disorders to suicide.

-Encourage help-seeking among LGBT people who are suffering from mental health issues or suicidal thoughts.

- Implement awareness campaigns and educational programs for the general public, primary care physicians, and community and organizational gatekeepers.

- implement screening programs, hotlines and other activities that identify at-risk individuals and direct them to treatment.

- Advocate for public policies to reduce LGBT stigma.

- Advocate for anti-bullying and safe schools legislation and for the specific inclusion of sexual orientation and gender identity in protective legislation related to school safety.

- Connect youth with supportive adults.

- Promote organizations that support LGBT youth, such as Gay-Straight Alliances and Parents, Families, and Friends of Lesbians & Gays (PFLAG)

-Include the topics of coping with stress and discrimination and integrate specific activities for LGBT youth in life skills training and programs in order to prevent risk-oriented behaviors.

- Improve the ability of parents and other influential adults to connect with and support adolescents grappling with issues of sexual identity and sexual questioning.

Attachment-Based Family Therapy:

- Attachment theory serves as the main theoretical framework to guide the process of repairing relational ruptures and rebuilding trustworthy relationships. (Diamond, G. S., Siqueland, L. and Diamond, G. M., 2003)

- Risk factors for depression are the primary "problem states" that therapists target with specific treatment strategies or tasks.

- Parent "problem states" include: criticism/hostility, personal distress, parenting skills, and disengagement.

-Adolescent "problem states" include: motivation, negative self-concept, poor affect regulation, and disengagement.

-Intervention tasks include relational reframing, building alliances with the adolescent and with the parent, addressing attachment failures and building competency.

-LGBT youth rely on the Internet and related technologies to a greater degree than their peers in order to find an accepting peer group and social support.

-Social networks offer the potential to disseminate suicide prevention or other targeted health messages to audiences of LGBT youth.

-Implement school-based awareness programs designed to heighten student awareness of adolescent suicide, increase recognition of signs of and risk factors for suicide.

- Change attitudes about getting help and publicize resources.

-Promote and implement "gatekeeper training", which teaches people who come into contact with youth - teachers, peers, school staff, and others to identify warning signs and to refer youth at risk for suicide to treatment or other services.

-Peer gatekeeping programs may be an effective intervention with LGBT youth; youth often first confide their problems to peers.

-Implement screening processes, which can include questions about mood, suicidal thoughts, substance abuse and identify high-risk youth for further assessment and treatment.

-Implement a *cultural competency model*. Cultural competence encompasses a set of behaviors, attitudes, and policies that enables a system, agency, or professional to work effectively in cross-cultural situations (Messinger, 2006)

-Many providers already use cultural competence to ensure that their services are effective for ethnic and racial minorities. Given that LGBT youth are a minority dealing with negative social forces, a cultural competence approach for LGBT people can help address service disparities.

-Training for cultural competence begins with comprehending the existence of LGBT people, learning and becoming comfortable with LGBT terminology, and developing an initial awareness of one's own biases and assumptions.

-Values clarification and empathy development are important parts of sensitivity training.

-Competency training allows participants to rehearse skills and often uses case studies and exercises in which participant groups develop LGBT-inclusive policies and programs.

-Increase transgender sensitivity with respect to homeless shelter placement and grouping based on gender identity rather than sexual identity.

-Incorporate well-designed outcome evaluations into all interventions aimed at reducing suicidal behavior and suicide risk among LGBT people

- Encourage training in LGBT suicide risk for staff and volunteers of suicide crisis lines, law enforcement, emergency care professionals, and others who work with suicidal individuals.

- Risk factors include (www.thetrevorproject.org):

- Using drugs or alcohol more than usual;
- Acting differently than usual;
- Giving away their most valuable possessions;

- Losing interest in their favorite things to do;
- Admiring people who have died by suicide;
- Planning for death by writing a will or letter;
- Eating or sleeping more or less than usual;
- Feeling more sick, tired or achy than usual;

-Advocate for legislation requiring measures of sexual orientation and gender identity to be incorporated into surveys related to health and mental health. This is in order to identify the consequences of inequities affecting LGBT people.

- Quality source in this regard is the Trevor Project; www.thetrevorproject.org;

-The website includes both Trevor Chat and Trevor Text.

- There is also a toll free number providing crisis intervention and suicide prevention services to lesbian, gay, bisexual, transgender and questioning (LGBTQ) young people ages 13-24;

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Homeless Youth Population:

Risk Factors:

-Life on the street represents risks for all homeless youth.

-Homeless and runaway youth have elevated rates of mental illness, violence, sexual exploitation, and substance abuse.

-They also have a high rate of suicide attempts: one study found that 76 percent of homeless youth reported attempting suicide at least once, and 86 percent of that group reported more than one attempt (Van Leeuwen et al., 2006)

-Common among many street youth are backgrounds associated with physical and sexual abuse, neglect, and exposure to delinquent activities such as substance use, prostitution, and petty crime.

- Youth who engage in these "deviant" behaviors often report that they do so to obtain money, food or shelter (Van Leeuwen, 2002)

- Street youth exhibit high rates of depression, drug and alcohol abuse. (Baer, Ginzler & Peterson, 2003), and sexual, emotional, and behavioral problems (Cauce et al., 2000)

-Many runaway youth living on the street, including LGBT youth, commit crimes related to their homelessness, including crimes committed while trying to support themselves on the street, such as robbery, prostitution, shoplifting, and selling drugs.

- Factors that influence the health of street youth include past and present trauma, poverty, poor access to health care and basic hygiene needs, drug misuse, loneliness and social marginalization, and high-risk sexual activities.

-As many as 1/5 transgender people need or are at risk of needing, homeless assistance; yet transgender youth face difficulties in accessing appropriate shelter assistance.

-In most shelters youth are housed by birth sex rather than by gender identity. (Ray, 2006)

-Compared to heterosexual homeless youth, LGBT homeless youth leave home more frequently and are exposed to greater victimization while on the streets. (Cochran et al., 2002)

-These youth may also experience more physical and sexual abuse from caretakers. (Whitbeck et al., 2004)

- LGBT youth may be at particular risk for homelessness due to conflict with their family regarding their sexual orientation. (Milburn, Ayala, Rice, Batterham & Rotheram-Borus, 2006)

- Being on their own without adult supervision means not only that homeless youth are likely to behave in ways that are unsafe, but also that they comprise an especially vulnerable group.

- This is reflected in the high rates of physical and sexual victimization they report. (Tyler et al., 2004)

-Research has found that homeless youth are far more likely to be victimized than their peers who are housed. (Stewart et al., 2004)

-Many homeless youth are victimized repeatedly. (Whitbeck, Hoyt, & Ackley, 1997)

- Little exists in terms of systematic analyses of street youth interventions, primarily due to the transient nature of the population and the difficulty in developing precision-based outcome measures.

Protective Factors/Best Practices:

- *Rehabilitation Approach:*

- Views the individual as needing re-education as well as protection from the horrors of street life.

- Gentler approach than the correctional philosophy, but it nonetheless maintains personal pathology as the root cause of homelessness.

- Many street youth shelters in North America adopt this philosophical approach to working with street youth, especially with the younger runaway population. (Karabanow, 2002)

Street Education Approach:

-Assumes that the best way to fight the problem is to educate and empower the children.

-Views street youth as "normal," yet forced by societal inequality to survive under difficult circumstances.

- Consideration of the political, social, and economic environment is emphasized.

-Supporters of the street education approach acknowledge that a majority of street youth come from disturbing levels of poverty and, as such, argue that the street youth phenomenon is more about structural dysfunction than personal pathology.

- Examples of this approach include such programs as Montreal's alternative street youth shelter/drop-in: Le Bon Dieu Dans La Rue: www.danslarue.com & Toronto's Street Kids International: www.streetkids.org.

-The model is to implement mobile teams of social workers and therapists, which visit youth on the streets, at drop-ins, or at shelters.

- They also implement support-groups and group therapy programs, as street youth may not want to participate in a direct therapy program in a clinical setting, due to mistrust of professionals. (Meade & Slesnick, 2002)

-There are practical considerations such as transportation, the ability to fill out forms and keeping appointments. These may preclude street youth from receiving treatment.

Peer-based Intervention Programs:

- Peer-based interventions could involve peers developing educational materials, providing outreach services, and counseling street youth. (Roberts et al., 2001)

- Youth generally develop a higher level of trust with peers as compared to formal professionals and are more likely to listen to and confide in someone their own age.

- Peer-based interventions have been successful in developing social skills, self-confidence, and commitment to school.

-Some implement *Expressive Therapy* programs that involve action on the part of the therapist and the client—such as art, music, and poetry therapy. (Boyce, 2001)

- Others conduct workshops in shelters, where youth learn basic writing and poetry skills, perform oral recitations and explore creative possibilities in a democratic and supportive atmosphere.

-This allows a venue for youth to learn to gain control over their emotions and to share their thoughts and feelings about difficult subjects.

- Toronto's Covenant House shelter and Montreal's Dans La Rue have also incorporated recreational and outdoor activities into their shelter curriculum.

Experiential Therapy:

Such activities can ultimately lead to an increase in the youth's self-esteem and confidence.

-Youths may improve their decision-making and problem-solving skills, develop successful friendships and increase self-esteem.

-Family interventions appear preferable to individual therapy in addressing adolescent emotional and behavioral problems.

- Research has specifically noting a marked reduction in illicit drug use, conduct disorders, family conflicts and the amount of time spent in institutions for those youth engaged in family interventions. (Cameron & Karabanow, 2003)

-Shelter youth, who are not reunified with their family, report significantly higher levels of hopelessness, suicide ideation, and more generalized negative expectations about the future than those reunified. (Teare et al., 1992)

-Care needs to be taken to ensure that youth are not reunified within abusive family environments that may increase the possibility of suicidal ideations or attempts.

-Implementing mentorship programs that pair a troubled youth with a caring role model provides street youth with the opportunity to build positive relationships and converse in a non-judgmental setting. (Keating, Tomishima, Foster, & Alessandri, 2002)

-Mentoring programs may also improve school attendance, decrease the likelihood of drug use, and increase employment among youth.

- Programs serving homeless and runaway youth may be more effective if they work to ensure that relevant staff members are informed about the particular risks of LGBT youth,

which include more frequent victimization, higher rates of highly addictive drug use and more sexual partners (Cochran et al., 2002)

*Case Management Approach***:**

- Recognizes the multiple and diverse needs of homeless youth. (Robertson and Toro, 1999)

- This can be a comprehensive and intensive approach that would address the unique needs of each homeless youth if it could be implemented in existing shelters and drop-in centers.

- The relationship that develops between homeless youth and their case managers could become an important resource for the homeless youth and their families.

-Youth who received intensive case management experienced improved psychological well-being and a reduction in problem behaviors after the first three months of the intervention. (Cauce et al., 1994)

- They also exhibited less aggression, fewer externalizing behaviors, and more satisfaction with their quality of life than youth who receive "treatment as usual."

-A promising service model is *Urban Peak Denver*, which provides overnight shelter as well as a variety of other services to homeless youth between the ages of 15 and 21 years.

-A case manager conducts a needs assessment and develops a case plan that includes educational and employment goals. Youth can receive shelter for as long as they are moving forward on their case plans, and those who have been discharged are followed for six months.

-According to Urban Peak's client database, which tracks the housing outcomes of youth who receive services, the percentage who experienced a positive housing outcome (e.g., moving into their own apartment, obtaining permanent supportive housing, or returning to their family of origin) ranged from a low of 48 percent in 2000 to a high of 65 percent in 2003. (Burt, Pearson, & Montgomery, 2005)

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First Nations, Metis, Inuit Youth

Risk Factors:

-Youth suicide rates in Canada's First Nations, Inuit, and Métis communities are said to be higher than those of any culturally identifiable group in the world. (Kirmayer, 1994)

-Suicide occurs roughly five to six times more often among First Nations youth than non-Aboriginal youth in Canada (Royal Commission on Aboriginal People, 1995)

-For example, in British Columbia, First Nations youth take their own lives at rates variously estimated to be between 5 and 20 times higher than that of the general non-native population. (Chandler, Lalonde, Sokol, & Hallett, 2003)

-In Canada, for Inuit under the age of 24, the suicide rates in Nunavut are ten times the national rate. (Kral et al., 2009)

-The Canadian Institute of Child Health (2000) found that young Native women were eight times more likely to commit suicide than their non-Aboriginal cohort.

In the same study, young Native men had a rate of suicide that was five times the national average.

-A study of Inuit experiences of distress and suicide found that sadness was most related to family matters, including loss of family members to death or moving away; unhappiness of family members; not being able to be with family and arguments or violence in the home. (Kral, 2003)

-Also accounting for unhappiness was losing family and friends to suicide, substance abuse, romantic relationship problems, less talking among family members, sexual and physical abuse and poverty.

-Experiences and attributions concerning suicide included Inuit youth feeling alone family problems and anger.

-Anger was most commonly associated with feelings of rejection. Youth not being cared for or being criticized by their families was a common theme concerning suicide.

-The most commonly cited background feature for Inuit suicide has been the dramatic social and cultural change experienced by the people over the last 4 or 5 decades. (Young, 2004)

-A common obstacle facing FNMI young persons is the joint necessity of constructing a sense of responsible ownership of a personal and collective past and a vision of and commitment toward one's own future prospects.

-Self-abuse and self-injuries of every description, including suicide, have recently come to be counted among the common costs of such failures in identity development. (Chandler & Lalonde, 2008)

-Cultural continuity forms a critical back-stop to the ordinary process of identity formation.

-Youth suicide rates in FNMI communities vary as a function of the degree to which particular indigenous communities find themselves bereft of meaningful connections to their traditional past, and otherwise cut off from local control of their own future prospects.

- Evidence from studies in the general population of Canada and the U.S. suggests that depression is the strongest correlate of suicidality. Many First Nations youth report depression, feelings of sadness and loneliness; for example, a Nova Scotia study found almost one quarter of Mi'Kmaq males and almost half the females aged 12 to 18 years have experienced depression and related symptoms. (The Health of the Nova Scotia Mi'kmaq Population, quoted in CICH, 2000)

-In the case of the James Bay Cree, most suffered from one or more signs of depression prior to their attempt at suicide. (Kirmayer et al., 2000)

-Western, professional mental health treatment of Indigenous peoples in North America has, in many cases, met with limited success. Top-down, outside-in treatment approaches used by government agencies have often under-valued or conflicted with the meanings and lifestyles of Indigenous peoples.

Cultural Proselytization:

- Defined as a form of Western cultural prescription of meanings of mental health and its treatment. (Gone, 2008)

- Distressed youth often do not seek out mental health services, even in cases where these are available and accessible. (Health Canada, 2003)

- Mental health services may also be perceived as too narrowly focused to be of any real help to young people in crisis who lack personal direction or they may simply be too public for self-conscious youth to access.

- The frequency with which youth suicide occurs in some First Nations may lead to complacency about the issue. (Health Canada, 2003) This normalization of suicide could, in turn, negatively affect the belief systems of the entire community and could itself become an additional risk factor.

- The experience of many First Nations youth is steeped in social disintegration and conditions associated with marginalization: physical, emotional and sexual abuse, neglect, poverty, substance abuse and deplorable socio-economic standards. (Health Canada, 1995)

-Many First Nations youth are feeling the impact of what has been termed "trans generational grief," carried from the trauma previous generations experienced in residential schools and other forms of cultural oppression. (Longboat, 1994)

Protective Factors/Best Practices:

-A study of American Indian and Alaskan Native youth suicide attempts found that increasing protective factors was more effective for reducing attempt probability than decreasing risk factors;

- Protective factors included the ability to discuss problems with family or friends, connectedness to family and emotional health. (Borowsky, Resnick, Ireland, & Blum, 1999)

Cultural Continuity Model:

Individual and cultural continuity are strongly linked, such that First Nations communities that succeed in taking steps to preserve their heritage culture and that work to control their own destinies, are dramatically more successful in insulating their youth against the risks of suicide. (White, 1998)

- Inuit who had attempted or considered suicide reported that the intervention most helpful to them as was speaking with family members. As a form of suicide prevention, speaking with and finding support from family members has, according to Inuit who made suicide attempts, saved many lives. (Kral, 2003)

-Family connectedness is thus central to Inuit well-being and important for suicide prevention.

--As well is the need to implement culturally relevant interventions in which FNMI peoples take leadership roles.

-This must include working with community leaders, including Chiefs and Councils, medicine men and women and elders, who are key resource people and gatekeepers for health and health care in First Nations communities.

-Incorporating culturally relevant definitions of mental health and illness in assessments of FNMI youth is essential as well as incorporating traditional FNMI healing methods in treatment and intervention protocols.

-Suicide prevention strategies for First Nations youth must also be congruent with cultural beliefs, norms, values and practices and must not undermine them.

-They must also be assessed in terms of their potential to preserve cultures and identities for future generations.

-*Implement a cultural competency model:*

- Cultural competence encompasses a set of behaviors, attitudes, and policies that enable a system, agency, or professional to work effectively in cross-cultural situations. (Messinger, 2006)

- Stigma associated with depression, anxiety and other mental health problems often prevents people from seeking and accepting help for treatable conditions.

- Suicide is such a mark of disgrace or shame for First Nations that they either do not report it at all or they under-report it. (Health Canada, 2003)

-The stigma attached to mental and emotional crises is a key issue that needs to be addressed. The shame and stigma attached to family problems may cause youth to keep silent and, in turn, to reach a point of desperation.

-There is wide variation in suicide rates across different First Nations communities. (Kirmayer, 1994) This variation suggests the importance of identifying risk and protective factors that account for the differences across communities.

-Training and support for volunteers in dealing with post-traumatic stress disorders is also important. (Health Canada, 2003)

The ripple effect of trauma is powerful in First Nations communities, most of which are close-knit and small in population. Every suicide has a direct effect on many community members and this may account for the tendency of suicides to occur in clusters.

-It is also common for victims to be closely related to each other and to community caregivers.

- Although some First Nations have emergency measures and plans laid out, it is often local volunteer helpers who must respond to suicide victims or victims of injuries, who are likely to be well-known to them.

-First Nations youth would be in a better position to articulate the many challenges in their lives including the reality of high suicide rates in their communities if they could become politicized around this issue. (Health Canada, 2003)

-Reconnecting youth to the emotional self, the land and spirit increases the valuing of life.

-Ideally, a suicide prevention program for First Nations communities would meet the following criteria: have proven effectiveness, reach high-risk groups, be feasible given local resources and address both immediate and basic, long-term causes.

-In remote communities, contact with health professionals may be sporadic. Maintaining long-term contact with previously hospitalized patients may be extremely helpful.

-The typical pattern of sending people out of remote communities for time-limited treatment may lead to discontinuities in care that put people with chronic problems at greater risk.

-Strategies for maintaining long-term (even if infrequent) contact between vulnerable individuals and health professionals or other helpers must be developed. (Motto & Bostrom, 2001)

-Schools should provide a health education curriculum for all students that builds basic skills useful for managing a variety of health and social issues rather than focusing exclusively on the topic of suicide.

-Curriculum would ideally enhance each student's' ability to cope with stress or distressing emotions, (esp. anger and depression), problem solving, interpersonal communication and conflict resolution. All are measures that help to build self-esteem and deal with emotional conflict and crisis. (Health Canada, 2003)

-Many young people see suicide as a natural or even heroic response to rejection. This misconception, as well as perceived stigma against seeking psychiatric help, can prevent help-seeking for emotional distress. (Shaffer et al., 1988)

-Educational materials aimed at facilitating appropriate help-seeking for major depression, alcohol or substance abuse, and family problems may help to reduce the risk of suicide.

-Knowledge of Aboriginal culture and pride in one's roots and identity can be promoted through cultural curricula.

-Younger children (under the age of 12 years) are also an important target group for primary prevention. (Health Canada, 2003) This also requires attention to and support for the family.

-Family life education, connection to traditional and cultural teachings, family therapy or social network interventions aimed at naming abuse, resolving conflicts and ensuring the emotional support of youth and children (e.g. through culturally sensitive approaches and cultural components in the school curriculum), may be more useful than an individual approach centred on the young person. (Kirmayer et al., 1993)

-Protocols can also be established with child protection authorities to respect traditional and cultural ways of dealing with family healing in today's context.

-For many youth, peers are essential sources of support and if trained as peer counsellors, can provide a bridge to professional help when needed.

- There may also be value in providing recreational and sports programs for children and young people to combat boredom and alienation and to foster peer support and a sense of belonging.

- There is a need to provide support groups for individuals and families at risk. (E.g. young mothers, recovering substance abusers, ex-offenders who have returned to the community after serving time)

-Regional crisis hotlines, based outside the community, are important to provide some degree of confidentiality. (Health Canada, 2003) Workers must have knowledge of the community in order to respond appropriately and have community contacts who are available to intervene quickly when necessary.

- Crisis centres should be based in the community or in an adjoining community to provide a safe place, "time out," and an opportunity for intensive intervention. (Health Canada, 2003)

-The latter can be staffed by lay helpers such as "big brothers/sisters," with mental health and cultural/traditional professional assistance available.

-The Honouring Life Network is a project of the National Aboriginal Health Organization, an Aboriginal-designed and controlled body committed to influencing and advancing the health and well-being of Aboriginal Peoples through knowledge-based strategies.

www.honouringlife.ca

- The website offers culturally relevant information and resources on suicide prevention to help Aboriginal youth and youth workers in dealing with a problem that has reached crisis proportions in some First Nations, Inuit and Métis communities across Canada.

-Funded by Health Canada, the Web site stemmed from a joint working group of the Indian Health Services in the United States and the First Nations and Inuit Health Branch of Health Canada.

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Youth Substance Abuse

Risk Factors:

- The use of toxic substances is a common element in those with potentially suicidal behavior and arises from ineffective coping mechanisms and depression, generating feelings of emptiness and worthlessness.

- One factor that has been consistently implicated in adolescent suicide is alcohol use; there are consistent positive correlations between adolescent drinking and suicide ideation and behaviors. (Woods et al., 1997)

- Drinking or acute intoxication may have immediate effects that increase suicide ideation or behaviors. (Light et al., 2003)

- Being under the influence of alcohol may cause young people to focus more on suicidal thoughts or may lower their resistance to suicidal impulses. (*alcohol myopia*)

- Consuming alcohol restricts one's attention to only immediately salient stimuli. (Steele & Josephs, 1990)

- Drinking may increase the extent to which a young person is influenced by others or by media portrayals of suicide, may lead to a deterioration of judgment or may increase feelings of depression.

- Longer-term alcohol use or abuse may undermine social relationships and social support, thereby increasing the likelihood of suicidal thoughts or behaviors.

- There is research to support the possibility that suicidal ideation causes drinking. Alcohol is an effective short-term anxiolytic, and suicidal ideation is associated with high levels of anxiety and stress. (Bell & Clark, 1998)

- Alcohol can also be used as a form of self-medication for distressing feelings and depression.

- The apparent effects of alcohol consumption on suicide ideation and behavior may result from the fact that young people who are sensation seekers or involved in other risky behaviors such as drug use, are more likely to drink and also more likely to think about and attempt suicide. (Light et al., 2003)

- There may also be differences by gender:

    - Alcohol use disorder *precedes* suicidal behavior among males (implying the former may cause the latter), while alcohol use disorder and suicidal behavior *onset occur at the same time* among females (implying no causal relationship either way) (Kelley & Lynch, 1999)

    - Adolescent girls are more prone to depression (Reinherz et al., 2000) and suicidality (Windle et al., 1992) than boys.

    - There is a further possibility that alcohol and other drugs represent a form of self-medication against stress and anxiety for girls more than for boys.

    - However, a cross-sectional study on 13,917 high school students reported that early alcohol use onset was significantly associated with suicidality across genders. (Epstein & Spirito, 2010)

- Alcohol consumption is positively related to knowing someone who attempted suicide, which suggests modeling as a possible pathway to adolescent suicidal behaviors. (Windle et al., 1992)

- Substance abuse among children and adolescents is an increasingly pressing contemporary issue, which causes psychiatric disorders in addition to the somatic impact.

- For acceptance in certain groups, children and adolescents have to consume certain substances or perceive the necessity to do so as a result of peer pressure.

- In a cross-sectional study on 1,261 adolescents who use cannabis, researchers found a close relationship between cannabis use and excessive drinking, plus cannabis use increasing the incidence of disruptive behaviours. (Rey et al., 2002)

- In a 21-year longitudinal study conducted on a sample of 1,265 adolescence/young adults, regular cannabis use was associated with an increased risk of other illicit drug use, increases in delinquency, depression and suicidal behaviour. (Fergusson et al., 2002)

- A retrospective analysis found that ethanol use was much more common among white completed suicides of all age groups. (Garlow, 2002)

- 50.0% of white teenage victims had used ethanol or cocaine alone, or both ethanol and cocaine, with most (41.7%) having used predominantly ethanol.

- Subjects who commit suicide with firearms are twice as likely to have used cocaine as those who used other methods. (Marzuk et al., 1992)

- An investigation of 214 cocaine-dependent patients found that at least 39% of the cocaine-dependent patients had attempted suicide more often, had a family history of suicidal behaviour, and reported significantly more childhood trauma. (Roy, 2001)

- Cocaine-dependent patients also had higher personality scores for introversion, neuroticism and hostility and had significantly more comorbidity of substance use and psychiatric and physical disorders.
- Some studies have reported an association between heroin/opiate-dependent adolescents and suicidal risk. (Drake & Ross, 2002) Heroin users are 14 times more likely than peers to die from suicide.

- They also attempt suicide more frequently than those in community samples.

- In a cross-sectional study of 108 young adult heroin-dependent inpatients, both the female and male suicide attempters were significantly younger at the onset of heroin use compared to those who had not attempted suicide. (Kalyoncu et al. 2002)

- The starting age of heroin use may be a risk factor for suicide attempts.

- In a case–control study comparing 246 opiate-dependent patients who had and had not attempted suicide, significantly more of the opiate-dependent patients who had attempted suicide had a family history of both completed and attempted suicide. (Roy, 2002)

- Three main hypotheses can be postulated to explain the escalation process in substance use and suicide. (Bukstein, 1993):

    1. Substance abuse - breakdown in personal relationships - increased suicide risk;
    2. Substance abuse - change in mood - suicidal ideation or depression - suicide attempt;
    3. Substance abuse - intoxicating effects - impaired judgement - increased suicide risk;

Protective Factors/Best Practices:

- Integrative, school-based education programs. (Reifman & Windle, 1995) An integrative approach takes advantage of the fact that many problem behaviors (e.g., suicide, delinquency, teen pregnancy) have common risk factors.

- Attempts should be made to impact a range of problem behaviors in one program.

- Prevention efforts should be focused on the underlying constructs that are risk factors for these negative behaviors such as depression, lack of social support, poor problem-solving skills, and hopelessness. (Garland & Ziegler, 1993)
-
  Substance abuse is both a problem behavior itself and a more "basic" behavior that would be an immediate target for prevention.
-
- A proper assessment is crucial, based on the evaluation of the most relevant risk factors and aimed at identifying those individuals considered to be at risk. (Pompili et al., 2012)

- The frequency of drug use, as well as environmental stressors, should be carefully considered by clinicians when approaching patients with comorbid substance use disorder and suicidal risk, because they can significantly impact an adolescent's emotional well-being.

- The presence of multiple coexisting disorders can be considered to be a strong predictor of poor outcome in substance users, increasing both the risk of suicidal behaviour and the severity of substance abuse.

- An investigation of access to lethal weapons, especially firearms, in the home is necessary. (Johnson et al., 2010)

- Four-fifths of adolescent suicides take place in their dependent's homes and most of the firearms used are owned by parents, highlighting the importance of limiting youth access to firearms. The presence of available firearms is a relevant factor in establishing the risk of suicidal behaviour.
- Adolescents often avoid bringing up their suicidal thoughts and plans, but they are more willing to discuss these if clinicians ask specific questions about any intention to commit suicide. (Pompili et al., 2009)

- Educating general practitioners, nurses and pediatricians about suicide, depression and substance abuse can have a major impact on how patients at risk are evaluated and managed. (Mental Health and Substance Abuse, 2006)

- In a qualitative study, Bergmans et al. (2009) interviewed 25 repeat substance-using suicidal patients about suicidality, substance use and service use. They also interviewed 27 emergency department staff about their attitudes when providing care to these patients.

- There was frequently a negative interaction between the two groups due to feelings of frustration experienced by the emergency department staff.

- Suicidal patients seemed not to be able to express their needs and feelings during crises; this can be ameliorated by the inclusion of social workers as part of the emergency department team when working with suicidal patients.

- It is essential that parents or guardians be involved in the evaluation and aftercare planning process, and that they recognize the seriousness of the suicidal event to increase the likelihood that they will follow through with aftercare recommendations. (Heilbron et al. 2013)

- There is increasing emphasis in ED protocols on methods of facilitating linkages to aftercare. (Heilbron et al., 2013)This is important insofar as the period after hospitalization or ED visit has been demonstrated to be a particularly high risk period for suicide or recurrent suicidal behavior. (Qin & Nordentoft, 2005)

- It is recommended that ED protocols or procedures for working with youths at elevated risk of suicide include a focus on facilitating entry into treatment and follow-up contact with youths and families. This is important to ascertain if families have followed through with aftercare recommendations or need assistance in this regard.

- One of the most effective strategies for suicide prevention is to teach people how to recognize and respond to the signals of suicidal tendencies since this increases the likelihood of at-risk youths seeking help.

- Everyone can be a source of encouragement, strength and optimism, teaching and practising problem-solving methods with the affected person and inculcating a sense of optimism. (World Health Organization, 2007)

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Youth Leaving Care

Risk Factors:

- Care leavers have been found to experience significant health, social and educational deficits including homelessness, disproportionate involvement in juvenile crime and prostitution, poor social supports and early parenthood. (Mendes & Moslehuddin, 2004)

- Many homeless youth report a history of out-of-home care placement. The percentage who report being placed in foster care or an institutional setting varies across studies, but estimates range between 21 and 53 percent. (Cauce et al., 1998)

- Of particular concern in this regard is the experience of youth who "age out" of foster care. Although these youth are expected to live independently and support themselves once they leave the child welfare system, they often lack the financial, social, and personal resources needed to do so. (Lindblom, 1996)

- Those who leave care early at 16 or 17 years, are particularly prone to homelessness. (Biehal & Wade, 1999)

- One study of homeless youth in Detroit found that a total of 17 percent of youth leaving care experienced literal homelessness. (Fowler, Toro et al., 2006) By comparison, the national five-year prevalence rate for literal homelessness among all adults in the United States was just 2 percent in 2001. (Tompsett et al., 2006)

- Just because youth were not literally homeless did not mean that they always had a stable place to live. One-third of the youth had spent time doubled up with other families or "couch surfing" among friends and relatives because they could not afford more permanent housing.

- Most commonly, youth attributed their precarious housing or homelessness to economic factors such as a lack of employment, lack of affordable housing, termination of public assistance or eviction.

- One-quarter of the youth who became homeless attributed their homelessness to problems with their families. This was the most common reason for becoming homeless immediately following exit from the foster care system.

- There was also some evidence that becoming homeless immediately post-discharge may have particularly negative effects. (Fowler, Toro et al., 2006)

- Youth who experienced homelessness after they left care reported greater psychological distress, victimization, and deviant behavior than those who did not become homeless.

- They were also less likely to have a high school diploma and less likely to have received additional schooling since leaving care.
- What is not clear is whether the youth who became homeless immediately were already more vulnerable at the time they exited, or whether they became more vulnerable as a result of becoming homeless so quickly.

- The best predictor of becoming homeless after aging out was whether a youth had repeatedly run away from an out-of-home care placement. (Courtney et al., 2005)

- Running away more than once was associated with an almost nine fold increase in the odds of becoming homeless.

- There was also a positive relationship between the odds of becoming homeless and the number of delinquent behaviors in which the youth had engage.

- By contrast, feeling very close to at least one family member reduced the odds of becoming homeless by nearly 80 percent.

- Research suggests that care leavers are more likely to use and occasionally abuse drugs and alcohol. (Saunders & Broad, 1997)

Protective Factors/Best Practices:

-Graduation from care needs to become a far more gradual and flexible process, based on levels of maturity and skill development, rather than on age alone.

-Researchers recommend use of the term 'interdependence' rather than 'independent living,' in order to reflect a notion of shared care and responsibility between young people, their families, friends, care workers and the broader community. (Green & Jones, 1999)

-Recent studies indicate that youth who have at least one positive and significant, naturally occurring mentoring relationship tend to fare better in the transition to adulthood. (Ahrens et al., 2008)

-Mentoring for foster care youth is taking a variety of forms (Britner & Kraimer-Rickaby, 2005) including traditional mode of matching youths with adult mentors who then meet regularly in person.

- Alternative formats include online mentoring, wherein mentors and youths communicate through regular email and online chat programs as well as peer mentoring programs, in which youths who have transitioned out of foster care and into independent living mentor other youth in care.

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Youth with ASD

Risk Factors:

- Our understanding about suicidal thoughts and behaviors in youth with ASD is critically important given the multitude of risk factors in this population associated with suicidality. (Storch et al., 2013)

- Social isolation, frequent bullying, and increased incidence of anxiety, impulsivity and depression are commonly reported.

- There exists in youth with ASD a particular vulnerability to suicide due to the additional burdens of depression and/or trauma history. (Storch et al., 2013)

- For these children and adolescents, suicide may seem like a viable option to relieve distress.

- Speculation exists about a potential link between ruminative thoughts associated with depression and PTSD (Post-Traumatic Stress Disorder) that may increase suicide risk in youth with ASD. (Ben-Sasson et al., 2009)

- In a sample of 350 children with autism 6–16 years of age, mothers reported depressed mood in 54% of children with high functioning autism (HFA) and 42% with low functioning autism. (LFA) (Mayes et al., 2011)
- ASD is associated with rigidity, limited cognitive flexibility, and deficits in understanding the temporal sequencing and durability of events.

- These characteristics may increase risk for becoming stuck in distressing and potentially overwhelming depressogenic thought patterns without having the perspective to understand that these states are temporary or time-limited, thereby increasing the possibility for suicide attempts.

- Suicidal threats may be one way for youth with ASD, who may have limited coping skills, to escape from an aversive experience or obtain a desired outcome. (E.g. attention, removal of a distressing stimulus, tangible reinforcers, etc.)

- More specifically, youth with ASD may make suicidal statements when they are emotionally overwhelmed and incapable of applying more effective functional communication, emotional regulation, and general coping skills to manage their distress. (Brereton et al., 2006)

- With regards to differences in suicidal thoughts and behaviors as a function of ASD diagnosis, youth with autism were the most likely to have suicidal thoughts or display suicidal behavior, whereas youth with Asperger's disorder were significantly less likely to have these problems. (Storch et al., 2013)

- These findings may reflect an interaction between psycho-social functioning and communication abilities.

- In general, youth with autism experience greater impairment in social functioning and more profound deficits in their functional communication skills relative to children with Asperger's disorder. (Eisenmajer et al., 1996)

- Adolescents with Asperger's, who may have more advanced functional communication skills, may be able to cope with distress more effectively and be less likely to display suicidal thoughts and behaviors when frustrated or overwhelmed, relative to children with autism.

- To date, little is known regarding the incidence and predictors of suicidal thoughts and behavior among children and adolescents with ASD. (Storch et al., 2013)

- Shtayermman (2007) reported that 5 of 10 (50%) adolescents and young adults with Asperger's disorder exhibit suicidal ideation.

- Four demographic variables (age 10 or older, male, Black or Hispanic, and lower socio-economic status) appear to be significant risk factors. (Mayes et al., 2013) In the above noted-study, most children (71%) who had all four of these demographic risk factors had ideation or attempts.

- The three comorbid psychological problems most highly associated with ideation or attempts were depression, behavior problems, and being teased.

- The majority of children (66%) who had six or seven of the demographic and comorbid risk factors had suicide ideation or attempts.

- The study found that ideation or attempts were also associated with behaviour problems. (disobedient, defiant, and aggressive), impulsivity, and mood dysregulation (explosive, irritable, and temper tantrums)

- Children with these externalizing problems combined with the internalizing problem of depression, are at high risk for suicide ideation and attempts.

- Teasing and bullying by peers is a common problem for children with autism and was reported by mothers of 57% of the study sample.
- Suicide ideation or attempts were three times more frequent in children who were teased than in those not teased.

- Children on psychotropic medication in an autism sample had a higher percentage of suicide ideation or attempts than children not on medication.

- Suicide ideation or attempts are 28 times greater in children with autism than in typical children, yet studies of suicide behavior in autism are almost nonexistent. (Mayes et al., 2013)

Protective Factors/Best Practices:

- It is important for clinicians to assess for the presence and functions that underlie suicidality in youth with ASD especially in the presence of significant depression and/or trauma. (Storch et al., 2013)

- Clinicians should carefully consider the functions of suicidal statements and behaviors. If it seems clear that suicidal statements are being made to obtain reinforcers or escape demands/aversive situations following a comprehensive functional assessment, replacement behaviors (e.g., asking for help, signaling when overwhelmed, etc.) should be systematically trained and shaped to provide adaptive coping strategies for the adolescent.
- With regards to treatment, psycho-social interventions for youth with ASD and anxiety have shown excellent promise, especially when individualized approaches to therapy are used. (Reaven et al., 2012)

- Additional modules focused on suicidal thoughts and behaviors (perhaps in the context of addressing depressive symptoms) may be warranted.

- Although clear treatment guidelines have been established for typically developing youth who exhibit suicidal thoughts and behaviors, it is unclear of the extent to which these approaches hold relevance for youngsters (or adults) with ASD and how they might be adapted.

- Care must be taken to avoid diagnostic overshadowing or the tendency to overlook other mental health problems in individuals with a primary diagnosis such as autism.

- All children across the autism spectrum should be screened for suicide ideation or attempts because the frequency of ideation and attempts in autism is significantly higher than in typical children, and does not differ as a function of autism severity or IQ.

- Addressing suicide in youth relies on prevention techniques and modification of risk factors, along with therapeutic intervention once children are identified as at-risk.

Many well-known and frequently utilized interventions are available to enhance the quality of life for individuals with autism. Behavior therapy, social skills training, cognitive-behavior therapy and peer-mediated approaches are common.

- Evidence-based techniques to reduce depression and prevent suicide should be incorporated into these interventions for at-risk children with autism.

- Treatment should also include interventions aimed at alleviating comorbid problems that may contribute to ideation and attempts. These may include teasing, depression, behavior problems, impulsivity, mood dysregulation and stress and adversity related to low SES and minority status.

- Treatment should be tailored to meet the needs of diverse populations, given apparent racial and economic differences in suicide ideation and attempts.

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Appendix Two: Group Feedback – January 21st 2015

Four questions were asked during the group feedback session, which followed a presentation of the major themes of the scan report. Each group was comprised of 7-8 individuals and each was assigned one question to address.

The responses are noted below:

Group One Question:

How can we effectively foster and create a culture of shared responsibility for crisis management and suicide prevention? Please be as specific as possible.

- Dedicate staff to create and implement a support strategy;
- Improved coordination of resources across regions and sectors;
- Include full participation of consumers – clients, families, etc. in the planning process;
- Have a common and shared vision of what 'shared responsibility' means;
- Create a collaboration-based work plan to achieve goals/vision;
- Create shared protocols, including MOU's with guidelines regarding responsibilities, roles, common language etc.
- Establish defined leadership to enact the changes desired;
- Ensure that the leadership committee is held accountable to the process and that it leads to a sustainable strategy;
- The strategy must include significant investment, so be prepared to contribute;
- Leverage the strengths/partnerships that already exist in the community;
- Ensure the participation of each member organization;
- Consider 310 COPE as a possible hub for development of a strategy;

Pearl Comments: (the most critical outcomes of the conversation)

- Create a vision; form a strategic plan; create protocols and guidelines; ensure leadership and sustainability of the process.

- Put a dedicated staff in place to do the work and ensure the participation of all sectors.

Group Two Question:

Does the concept of prevention resonate or generate ideas in terms of how to get at these issues earlier and more effectively as a community?

Comments:

- Find the connection between information sharing and the risk assessment phase; is there a threat or risk of sharing too much information?

- Begin data collection, conduct some research regarding what works from a prevention point of view;

- Determine which the best prevention practices beyond crisis identification are alone.

- Identify the risk level for crisis or suicide using a common risk assessment tool that will also identify where the youth is on the scale in terms of a continuum of needs.

Group Three Question:

Is there a need for greater engagement with the non-professional areas of the community in partnership or others that have not played a role?

- Who are the non-professionals? How do we categorize them?

- Education & awareness of the risk of suicide needs to be taken to the general population in order to generate greater interest from non-professionals alone in this conversation;

- Media Campaigns are now trying to do this i.e. Bell's Let's Talk.

- Place a public and open focus on Suicide Prevention with areas for conversation such as:

    - Address youth culture (keeping secrets)

- How do we increase the number of adults that youth connect with?
- Share more broadly the use of Safety Plans
- Address the stigma issue;
- Promote peer support;

- Create outreach opportunities within the workplace;
  - Lunch & Learn at various businesses
  - Connect with EAP programs on this topic

- Pay attention to children and youth who are not yet identified or receiving formal services (under the radar, high anxiety, poor behavior, perfectionist, etc.);

- Pay attention to specialized groups as well whom we understand are at higher risk for suicide, e.g. youth within the ASD, LGBT communities;

- Identify groups who want to be engaged in the conversation but currently are not; e.g. Francophone Boards of Education;

- Offer outreach to diverse cultural groups who are also dealing with suicide issues;

- Engage a wide range of community services and focus on the need for:
  - Understanding
  - Recognition
  - Dealing with Barriers (Language, stigma, capacity, education

- Recognize the need for community-wide ownership of this issue and spread this message; "*By the community, for the community, in the community.*

- Provide stronger orientation and education regarding the topic of suicide prevention. Include areas such as:
  - Getting access to help
  - Greater use of <u>existing</u> vs. specialized services to meet needs (One Stop Shopping)
  - Develop a greater understanding of cultural norms

- The answer is yes – we need a village approach, not just a therapeutic response
  - Formal services are not sufficient
  - Use all resources – i.e. social media

Pearl Comments: (the most critical outcome of the conversation)

- Yes there is a need to engage the non-professional community.
- Silos aren't working and everyone needs to be engaged by orientation and education.
- We need to capture those who are not yet captured in this conversation.
- We need to recognize cultural differences but still work together and engage the community.
- We need to use all research and communication tools available, including social media to get the message regarding suicide prevention out to the full community.
- We need more corporate partners like Bell.

Group Four Question:

How do we build greater knowledge and support for the needs of the identified specialized populations within the report?

- Consider using the ASD Partnership & MHC as a lead group in this regard; Mandate the existing Crisis Response Working Group to do so;
- Identify more clearly the local individuals and communities from the specialized groups identified in the research within the report;
- Identify all red flags within the community where greater risk is apparent;
- Commit to the development of common risk identification and assessment tools used across agencies/sectors; (Are there different tools to risk identity based on different specialized groups?)
- Create the Leadership group noted in the presentation as well as ask for a contact per agency;
- Increase awareness directly with student and families vs. professional staff, where the focus of training seems to have been for the past several years.
- Commitment to get all staff trained using ASIST–shared understanding/language;

Pearl Comments:

- It is acknowledged that not all special populations have been identified in the report who also may be at a higher risk for suicide than the norm; e.g. international students, immigrants from various countries, etc.

- There is a need for a common risk assessment tool within these groups.

- We need a vision of what success would look like for York Region in this area;

- We need to work smarter as organizations and collaboratively with each other on this matter;

- Working with a crisis response should be done in collaboration by leading with a compelling vision;

Appendix Three - Interview Sources:

1. Wendy Leve, Manager, Child & Adolescent Mental Health, Southlake Regional Health Centre, Project Co-Chair

2. Christine Simmons-Physick, Program Director, Community Mental Health, Central, Kinark Child & Family Services, Project Co-Chair

3. Neil Walker; Janette Seymour, Kerry's Place, York ASD Partnership

4. Barb Urman: Family Services York Region, (supporting the LGBTQ Community)

5. Jordan Toth; BM Consultant, York Behavioral Support Services, Mackenzie Health Centre

6. Michelle Cassidy: Mental Health Lead, York Region District School Board

7. Dean Rokos: Executive Director, The York Centre for Children Youth & Families

8. Mike Brathwaite: Executive Director, 360 Kids

9. Dr. Giuliana Malvestuto-Filici: Psychologist, York Catholic District School Board

10. Teresa Hughes, Conseil Scolaire Viamonde, Windsor Ont.

11. Dr. Marie-Josée Gendron, Psychologist, Conseil Scolaire de District Catholique Centre-Sud, Toronto, Ont.

12. Nadia Martins, Communications Liaison, Conseil Scolaire de District Catholique Centre-Sud, Barrie, Ont.

13. Theresa Hughes, Mental Health Lead, Conseil Scolaire Viamonde,

14. Frances Donovan: Central East Autism Program Director, Kinark Child & Family Services

15. Sylvia Pivko: Executive Director, Blue Hills Child and Family Centre, Chair ASD Partnership

16. Gail Hamelin: High Risk Suicide Prevention Protocol, Simcoe County, Kinark Child & Family Services

17. Angela Cummings: 310 -Cope Worker; Social Worker, Kinark Child & Family Services

18. Steffanie Pelleboer, Clinical Director, Blue Hills Child & Family Centre

19. John Clarke/Melissa Sweet: York Behavioural Support Services (Mackenzie Health)

20. Karen Hicks – Canadian Mental Health Association, York Region

21. Dr. Naila, Budd, Executive Director, Social Services Network, York Region

22. Shannon Crate: First Nations |Georgina Island

23. Janet Wilson, Mgr. Child & Adolescent Department, Markham Stouffville Hospital

24. Paul Steadman, Out-Patient Social Worker, Markham Stouffville Hospital

25. Tina Mistry, Lead Manager, Kinark Child & Family Services

26. Carrie Dinsmore, Crisis Response Program Supervisor, 310 -COPE

27. Shannon Reisbury, Jennifer Phillips, York Regional Police

28. Kathleen Janse: Charge Nurse, Child & Adolescent Mental Health In Patient Unit, Southlake Regional Health Centre

29. Heather Wheaton: Crisis Services, Child & Adolescent Mental Health In-Patient Unit, Southlake Regional Health Centre

30. Carm Bain: Urgent Clinic Counsellor, Southlake Regional Health Centre

31. Louisa Leung, Manager of Addiction Services, York Region

32. Carolyn Johnson: Children's Case Coordinator – York Support Services Network (YSSN)

33. Dagmara Woronko, Literature Review Researcher, York University

34. Darlene Fluney, York Regional Police

Family Members:

1. Cenza Cacciotti, Kinark Child & Family Services, Family Member
2. Brenda Wynne, Family Member
3. Cindy Hartman, Family Member, Parent Advocate, York ASD Partnership
4. Liz Cohen, Family Member
5. Jackie Buchanan, Parent Advocate, York ASD Partnership
6. Susan Pearce, Family Member