



LITERATURE REVIEW
AND
SUMMARY REPORT OF
EXISTING EVALUATION TOOLS AND PROCESSES

FINAL

**ALBERTA TAKES ACTION ON COMMUNITY HELPERS
COLLABORATIVE EVALUATION PROJECT**

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Alberta Health Services

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TABLE OF CONTENTS

SECTION 1: INTRODUCTION AND CONTEXT 3

1.1 CONTEXT OF THE LITERATURE REVIEW 3

1.2 COMMUNITY HELPERS 4

1.3 REPORT OUTLINE 5

1.4 LITERATURE REVIEW METHODOLOGY 6

SECTION 2: YOUTH MENTAL HEALTH 7

2.1 THE INCIDENCE OF YOUTH MENTAL ILLNESS 7

2.2 YOUTH SUICIDE IN CANADA AND ALBERTA..... 8

2.3 SUICIDAL BEHAVIOUR 10

2.4 RISK AND PROTECTIVE FACTORS..... 11

2.5 MENTAL ILLNESS, STIGMA, AND HELP-SEEKING BEHAVIOUR OF YOUTH 14

SECTION 3: MENTAL HEALTH PROMOTION..... 17

3.1 INTRODUCTION..... 17

3.2 COMMUNITY CAPACITY BUILDING..... 18

3.3 YOUTH-ADULT PARTNERSHIPS..... 20

3.4 FIRST AID PROGRAMS 21

3.5 LAY HELPING MODELS 23

 3.5.1 *Natural Helpers®* 24

 3.5.2 *Other Youth and Young Adult Peer Helping Programs*..... 28

3.6 GATEKEEPER PROGRAMS..... 29

3.7 SCHOOL-BASED INTERVENTIONS..... 31

SECTION 4: FORMATIVE EVALUATION..... 32

PROGRAM IMPLEMENTATION AND DELIVERY: BEST PRACTICES 32

4.1 PROGRAM IMPLEMENTATION PLANNING AND COMMITMENT TO PROGRAM..... 33

4.2 PERSONNEL 35

4.3 ORGANIZATIONAL STRUCTURE..... 36

4.4 SCREENING AND SELECTION OF COMMUNITY HELPERS..... 36

4.5 HELPERS’ TRAINING 38

4.6 ON-GOING SUPPORT AND SUPERVISION 39

4.7 COMMUNICATIONS..... 40

SECTION 5: SUMMATIVE EVALUATION 42

SECTION 1: INTRODUCTION AND CONTEXT

1.1 Context of the Literature Review

In 2004, the Alberta Health Services – (AHS) introduced a new mental health plan for Alberta, *Advancing the Mental Health Agenda: A Provincial Mental Health Plan for Alberta*. A comprehensive plan, it identified three broad service priorities (AHS 2004, p. iii):

- Support and treatment – provide assessment, treatment, rehabilitation, and community support for families and individuals;
- Risk reduction – reduce the risk of mental illness and optimize mental health by decreasing factors that negatively affect well-being;
- Capacity building – identify, maintain, and strengthen factors that promote mental health and well-being across government, in communities, and with individuals and their families.

Part of the first service priority is the recognition that “mental health services are primarily oriented toward treating people with mental illness rather than preventing mental illness or promoting good mental health” (AHS, 2004, p. 5). The third service priority, capacity building, is intended to increase the sense of community inclusion, the ability of families and clients to participate in their communities, and the capacity of volunteers and communities to support people with mental illnesses.

The second service priority, risk reduction, explicitly identifies a strategy of public awareness to reduce the stigma of mental illness that may prevent people from seeking help. This priority area also includes a specific and immediate action step to “establish a province-wide suicide prevention strategy” (AHS, 2004, p. 31).

A CALL TO ACTION: The Alberta Suicide Prevention Strategy

In 2004, the Alberta Health Services- (AHS) introduced a new mental health plan for Alberta, *Advancing the Mental Health Agenda: A Provincial Mental Health Plan for Alberta*. The Provincial Mental Health Plan calls for the development of a province-wide suicide strategy. In response, *A CALL TO ACTION: The Alberta Suicide Prevention Strategy* was launched in September 2006 lead by AHS in collaboration with a broad range of stakeholders including: provincial and federal departments; regional health authorities, community/not-for-profit agencies; researchers; and survivors. The *Community Helpers* program was one of three children’s mental health initiatives funded by Alberta Health & Wellness in support of the implementation of *A CALL TO ACTION and Positive Futures -- Optimizing Mental Health for Alberta's Children and Youth: A Framework for Action (2006-2016)*.

The purpose of *A CALL TO ACTION* is “to prevent and reduce suicide, suicidal behaviour, and the effects of suicide in Alberta over the next 10 years” (AHS, 2006a, p. 13). *A CALL TO ACTION* identified fifteen potential at-risk groups. The *Summary of Available Data and Evidence on Groups at Potential Risk for Suicide* (AHS, 2006b) was developed, summarizing the data and the research literature for each of these identified groups. A review of this summary led to the identification of the six priority groups for Phase I Implementation Planning: Aboriginal Peoples; individuals affected by the aftermath of suicide behaviour or a suicide death; individuals diagnosed with a mental illness; middle-aged men; previous suicide attempters; and school-aged teens and young adults.

Eight goals have been identified in *A CALL TO ACTION*. They are as follows:

1. Secure targeted and sustainable funding to implement the *Alberta Suicide Prevention Strategy*;
2. Enhance mental health and well-being among Albertans;
3. Improve intervention and treatment for those at risk of suicide in Alberta;
4. Improve intervention and support for Albertans affected by suicide;
5. Increase efforts to reduce access to lethal means of suicide;
6. Increase research activities in Alberta on suicide;
7. Improve suicide-related and suicidal behaviour-related surveillance systems in Alberta;
8. Increase evaluation and continuous quality improvement activities in Alberta for suicide prevention programs.

One of the programs implemented under *A CALL TO ACTION* is *Community Helpers*. The *Community Helpers* program contributes to two of the above-stated goals. The *Community Helpers* program addresses aspects of Goal 2 of *A CALL TO ACTION*. It will help to enhance mental health and well-being among Albertans by reducing the stigma attached to accessing mental health services or other suicide prevention supports. In addition, the *Community Helpers* program provides a model for community capacity building around the issue of youth mental health promotion. This model can serve to promote and maintain individual and community wellness. The *Community Helpers* program also helps to address Goal 3 as the program is designed to improve intervention and treatment for those at risk of suicide by increasing the appropriate and timely access to treatment services. The *Community Helpers* program also helps to address the needs of school-aged teens and young adults, one of the priority groups for action, and those who interact with them.

1.2 Community Helpers

One of the programs implemented under *A CALL TO ACTION* is *Community Helpers*. It was developed in Edmonton, Alberta by Concordia College under the auspices of Canada's "Stay-in-School" initiative (Redekopp & Reid, 1993). It is based on *Natural Helpers*® developed in the state of Washington and was further revised in West Carleton, Ontario (Austen, 2003). The focus of *Community Helpers* is to identify and support the natural helpers that youth already access when experiencing a mental health problem. The current *Community Helpers* program builds on these earlier initiatives.

When people are in distress, they tend to seek out members of their close social network – friends, family, co-workers – for advice, support and/or comfort (Redekopp & Austen, 2008). *Community Helpers* builds on this understanding and works with local agencies to train coordinators who then train helpers in their community. School-aged teens and young adults between 15 and 24 years old are asked in a survey to name adults and peers to whom they turn for advice, support, and/or comfort. These helpers are invited to take training to increase their helping skills as well as their knowledge of mental illness and suicide and of the formal mental health community. The coordinators provide ongoing support by establishing or maintaining networks with service agencies, the formal mental health community, and community stakeholders as well as engaging in activities to increase community capacity.

In keeping with the goals and objectives identified in *A CALL TO ACTION*, *Community Helpers* has three key objectives (AHS, 2006A):

- Reduce stigma attached to accessing mental health services or other suicide prevention supports.
 - *Community Helpers* provides training on mental health issues and helping skills. As helpers' knowledge about mental illness and suicide increases, common misconceptions are dispelled. The links between stigma and knowledge of mental illness, and mental health help-seeking is discussed further in Section 2.5.
- Provide a model for community capacity building around the issue of youth mental health promotion that serves to promote and maintain individual and community wellness.
 - *Community Helpers* becomes a “catalyst for capacity building as it highlights existing assets and strengths in the community” (Redekopp & Austen, 2008, p. 1). The community agency coordinators receive training and support in extending their inter-agency network to community-based and/or youth-serving agencies, members and organizations in the formal mental health community and other interested stakeholders. Capacity building is discussed in Section 3.2.
- Increase awareness of appropriate treatment services for school-aged teens and young adults.
 - *Community Helpers* builds a bridge, through the training of helpers and capacity building, between the informal social support of adolescents and young adults and the formal mental health community. As both the informal and formal mental health communities become aware of each other, more awareness of appropriate treatment services occurs.

These objectives align with two of eight goals of *A CALL TO ACTION*: to enhance mental health and well-being among Albertans and to improve intervention and treatment for those at risk of suicide in Alberta (AHS, 2006a).

A key component in both the *Provincial Mental Health Plan* and *A CALL TO ACTION* is the commitment to continuous quality improvement. Evaluation of initiatives like *Community Helpers* is central to continuous quality improvement. Part of the evaluation process is a review of the literature. The literature review helps to develop a best practices evaluation strategy that includes both formative and summative evaluations¹.

1.3 **Report Outline**

The remainder of this report discusses the results of the literature review. Section 2 begins with an overview of youth mental health, and youth suicide and suicidal behaviour. It discusses mental illness as a risk factor for suicide as well as other factors associated with higher risks of suicide. It ends with a discussion of mental illness and stigma and how this adversely affects help-seeking behaviour of youth.

Section 3 discusses mental health promotion in general. *Community Helpers* is a mental health promotion program based on certain models. These include the lay helper, community capacity, and youth-adult partnerships. Each model is presented in its best-practice form. Examples of programs or program

¹ A formative evaluation assesses how well an initiative is delivered and what is required to deliver it. A summative evaluation assesses the outcomes of the initiative.

elements with evidence of effectiveness then illustrate each model. Strengths and weaknesses of each model are discussed.

Section 4 discusses key aspects of program delivery/implementation and evaluation, and ends with recommendations for implementing, sustaining, and evaluating *Community Helpers*. It includes a summary of tools that may be useful in evaluating *Community Helpers*.

1.4 **Literature Review Methodology**

A literature search was conducted using the internet, PsychInfo and MedLine databases. The following keywords, singly or in combinations, were used:

- Aboriginal
- Adolescents; youth; young adults
- Children's mental health;
- Canada; Alberta;
- Community capacity; social capital;
- Community helpers; lay health advisors; natural helpers; peer helpers;
- Development (adolescent);
- Gatekeeper training;
- Mental health; mental illness;
- Prevention; promotion;
- Psychological autopsies;
- Questionnaires; instruments;
- Stigma;
- Suicidal behaviours; suicidal ideation; suicide attempts;
- Suicide;
- Youth-adult partnerships

Relevant references from articles were also acquired and databases were searched using names of researchers known in Canadian children's mental health. Relevant websites, such as the Centre for Suicide Prevention (CSP), were found using the internet search engine, dogpile.com, and searches of these websites were conducted in order to identify relevant documents. Tools for evaluation were searched using the above relevant keywords in the Health and Psychosocial Instruments Database.

The review has five primary objectives. First, it will provide a current portrait of youth mental health, suicide, and suicidal behaviour. Second, it will discuss the risk and protective factors of suicide and suicidal behaviour. Third, it will examine types of mental health promotion that are relevant to *Community Helpers* and that are intended to mitigate risk and enhance protective factors. Fourth, it will look at the implementation and evaluation challenges suicide prevention initiatives have encountered and overcome. The fifth objective is to develop the basis for an evaluation framework for *Community Helpers*.

SECTION 2: YOUTH MENTAL HEALTH

2.1 The Incidence of Youth Mental Illness

Mental illness and suicide are global problems. The World Health Organization (WHO, 2001) estimates that one in four people will develop a mental illness at some time in their life. Approximately 10% to 20% of youth are estimated to have mental health problems (WHO, 2007). Suicide accounts for nearly 3% of all deaths worldwide, an estimated one million deaths each year (Brown et al., 2007; Kutcher & Szumilas, 2008). Although there has been a dramatic increase in rates of suicide in the past several decades in nearly all countries of the world, Canada's youth suicide rate has fallen over the past decade (Kutcher & Szumilas, 2008; WHO, 2004).

Although Canada's youth suicide rate has fallen over the past decade, mental illness remains the leading health problem of Canadian children and youth. Estimated rates of mental illness among non-aboriginal and Aboriginal children and youth range from 14% to 23% (Waddell, et al., 2002; Advisory Group on Suicide Prevention & Health Canada [Advisory], 2003). Estimated prevalence for depression is 3.5%, for conduct disorders, 4.2%, and for substance abuse disorders, less than 1% (Waddell, et al., 2005). In Alberta, using physician billing data from the fiscal year 1995, Spady and colleagues (2001) calculated rates of mental illness among children under the age of 17. Of the 749,924 children (99% of the child population) registered with Alberta Health Services, 40,592 (5%) had a mental illness. Approximate rates of specific mental illnesses for 15-17 year old males ranged from (Spady, et al., 2001):

- 13 to 17 per 1,000 for depression;
- 4.5 to 6.5 per 1,000 for alcohol and drug problems; and
- 9 to 16 per 1,000, for conduct disorders, with the incidence peaking at age 15.

Rates of specific mental illness for 15-17 year old females ranged from (Spady, et al., 2001):

- 28 to 36 per 1,000 for depression; and
- 5 to 6.5 per 1,000 for alcohol and drug problems.

Of those children diagnosed, about 21% had more than one mental illness. Boys were more likely than girls to have more than one diagnosis. Older children and children whose families were receiving social assistance were also more likely to be diagnosed with more than one disorder. The rates calculated by Spady and colleagues, however, may not reflect the true incidence, which may be much higher since less than 25% of children and youth with mental illness obtain treatment (Waddell, et al., 2005). Reasons include insufficient resources in the mental health sector as well as poor help-seeking behaviour.

The Alberta Health Services' *Mental Health Needs of Albertans: Selected Factors and Findings* (2007) confirms Spady and colleagues' findings using data from the 2003/04 fiscal year. Specifically, among youth (15-24 years old) accessing community services, the most frequent diagnosis was of mood disorders with more females than males being so diagnosed. For substance abuse-related disorders, more females than males accessed physician services for this group of disorders.

Psychiatric disorders such as depression, conduct/disruptive disorders, and substance abuse disorders are considered significant risk factors for youth suicides. Psychiatric disorders or difficulties that are characterized by rigid cognitive styles, poor coping skills, impulsivity, aggression, hypersensitivity, and irritable and volatile moods also appear to have a relationship to suicide and suicidal behaviour (Moskos,

et al., 2005; White & Jodoin, 2003). Individuals who die by suicide often demonstrate higher rates of mental illness (AHS, 2006b). According to Kutcher & Szumilas (2008), over 90% of suicides had at least one psychiatric disorder. Kovacs and Puig-Antich (1990) calculate the range of estimated rates of mental illness to be between 15% and 92%. In a large Canadian community sample (the Canadian Community Health Survey, n=36,984 aged 15 years and older), 4% reported thoughts of suicide; of these, 37% had depression (Rhodes, et al., 2006). However, over 70% of those with depression were not suicidal and about two-thirds of those who were suicidal were not depressed (Rhodes, et al, 2006). Other mental illnesses were not examined.

Youth with impulsive behaviour, a characteristic of disruptive behaviour disorders, have also been considered to be at higher risk for suicide. Witte and colleagues (2008) hypothesized that “if impulsivity is a direct proximal risk factor for suicide attempts, those who are most likely to attempt suicide without prior planning [should] display the highest levels of general impulsive behaviours” (p. 109). This was not the case. In their large U.S. study (n=12,721), less than 10% of their sample had attempted suicide without planning it and none of them had reported involvement in other risky behaviour (Witte, et al., 2008). The youth who had the most serious suicidal behaviour (38%) – reported both planning and attempting suicide – were also most likely to have engaged in other risky and/or impulsive behaviours (Witte, et al., 2008). The authors suggest it is not the risky or impulsive behaviour *per se* that is a risk factor, but rather “an individual’s impulsivity level leads to him or her acquiring the capability for suicide (i.e., through exposure to painful/provocative stimuli) that, once in place, makes it possible for him or her to engage in suicidal behaviour should the desire arise” (Witte, et al., 2008, p. 108).

Impulsive and/or risky behaviour such as having multiple sex partners and poor sexual health practices, drinking and driving, dangerous preoccupation with body image, and drug use were higher among the group that both planned and attempted suicide (Witte, et al., 2008). Substance abuse disorders, as noted above, are considered a risk factor for suicide. The Utah Youth Suicide Study interviewed 132 contacts of 49 youth who had died by suicide. The majority of all contacts recalled the youths using alcohol while a majority of siblings, friends and relatives noticed drug use. The majority of friends indicated that alcohol and/or drug use caused significant problems for the decedent youths. Problems in school performance and with medical problems were noticed by the majority of friends, parents, siblings, and relatives; such problems may be connected with substance abuse.

The connection between mental illness and suicide has been frequently assessed. As noted, studies of youth suicide have found varying rates of mental illness among decedents. The Utah study found that 67% had received a psychiatric diagnosis. Of these, 44% had been prescribed psychotropic medication. Friends of 64% of these youth suggested the underlying cause of the suicide was untreated mental illness (Moskos, et al., 2005). Studies done on the mental state preceding suicide clearly demonstrate the high level of perturbation experienced by the individual. Depression, anxiety, variability in mood, and panic attacks were all evident (Kral, 1998).

2.2 **Youth Suicide in Canada and Alberta**

In 2003², almost 550 Canadian children and youth died by suicide. Half of these were young adults between 19 and 24. Suicide is the second leading cause of death for Canadian youth after motor vehicle collisions, a quarter of which may be intentional (AHS, 2006b; Chandler & Lalonde, 1998; Kutcher & Szumilas, 2008). Deaths by suicide may be under-reported because coroners only declare a death to be a suicide when other causes can be clearly ruled out (DeLeo, et al., 2002).

Number and Rates of Suicide for Canada and Alberta, by Age Group and Gender, 2003 ^a				
	CANADA ^b		ALBERTA ^{cd}	
All Ages:	Number	Rate ^e	Number	Rate ^e
Both genders	3,765	11.3	440	14.1
Males	2,903	17.8	331	20.8
Females	862	5.1	109	7.0
Both Genders:				
10-14 years old	27	1.3	2	0.09 per 10,000
15-19 years old	216	10.2	15	6.5
20-24 years old	306	14.0	36	15.8
Males:				
10-14 years old	19	1.7	2	1.7
15-19 years old	161	14.8	11	9.2
20-24 years old	248	22.1	29	23.0
Females:				
10-14 years old	8	0.8	0	0.0
15-19 years old	55	5.3	4	3.6
20-24 years old	58	5.4	7	6.0
20-24 years old	29	23.0		
First Nations, excluding Métis and non-status Aboriginals				
All Ages, Both Genders, 2002 ^f	n/a	n/a	32	35.6
First Nations ^g Males, 1989-93:				
0-14 years old	4	3.6	n/a	n/a
15-24 years old	126	125.7	n/a	n/a
First Nations ^f Females, 1989-93:				
0-14 years old	4	4.1	n/a	n/a
15-24 years old	35	35.0	n/a	n/a

^a Statistics are from 2003 unless otherwise specified

^b Source: Statistics Canada, 2006

^c Source: OCME, 2005

^d Source: Centre for Suicide Prevention, 2003

^e Rates are per 100,000 unless otherwise specified

^f AHS, 2006b.

^g Community Health Programs Directorate, 2005; numbers and rates were collapsed for the years 1989 to 1993.

The overall rates of suicide are slightly higher in Alberta than for Canada as a whole. But provincial rates are lower than national rates for children and youth, and slightly higher for young adults for both males and females. Two to four times as many males died by suicide in 2003 as females at both the national and provincial levels.

As with national and provincial rates, First Nations males die by suicide at a rate of approximately three times higher than First Nations females. The statistics reported above exclude Métis and non-status/treaty Indians; the numbers and rates, thus, under-report the full impact of suicide among Aboriginal Peoples. It is generally conceded, however, that the rates are at least double that of non-Aboriginal Canadians (Canadian Institute of Child Health, 2000; McNamee & Offord, 1994; RCAP, 1995).

In 1993, the Royal Commission on Aboriginal Peoples examined the issue of suicide among this population. The report opens with:

- The rate of suicide is “5 to 6 times higher among Aboriginal youth than among their non-Aboriginal peers” (p. 1);
- “Statistical analysis predicts a coming increase in the number of suicides by Aboriginal youth as the ‘population bulge’ of children now under the age of 15 enters the vulnerable years of young adulthood” (p. 2).

The RCAP also found:

...grounds for hope and ideas for change. Both spring from the activities of Aboriginal people themselves – activities undertaken to change the conditions that depress and oppress them. Commissioners have seen much evidence that Aboriginal Peoples are ... shifting their energies from decrying problems to solving them (p. 3).

The first point the Royal Commission on Aboriginal Peoples (RCAP, 1995) made regarding the primary elements of suicide prevention was the recognition that “there is a process happening across the country with people believing in themselves” (p. 111). Many positive developments in settling land claims, in attaining control over, for example, child welfare, police, and fire fighting services, and in advancing economic development have occurred in the past fifteen years. In Section 3.2, the research of Chandler and Lalonde (1998) is described in more detail, but it should be noted that suicide among Aboriginal Peoples varies not only by age and gender, but also by extent of community capacity (RCAP, 1995).

2.3 Suicidal Behaviour

The overall impact of suicidal behaviour is only partly reflected by suicide deaths. Many individuals who die by suicide or demonstrate suicidal behaviour have a history of emotional suffering. Indications of this include the greater risk of suicide among individuals affected by suicidal behaviour, indicators of self-injury, and thoughts of suicide.

Individuals affected by the aftermath of suicide are “over ten times more likely to attempt or die by suicide” (AHS, 2006b, p. 8). Individuals who previously attempted suicide are also at higher risk for subsequent attempts, with an estimated risk of 25 to 40 times higher than people in the general population (AHS, 2006b). In a Utah study, 22% of youth decedents had previously attempted suicide (Moskos, et al., 2005). The majority of friends and parents also recalled that someone the youth had known had attempted or died by suicide (Moskos, et al., 2005). That 65% of parents indicated a recent death of a friend or family member makes it likely the decedent youth was close to someone who had attempted or died by suicide (Moskos, et al., 2005). In a California study, 25% of 44 youth who had died by suicide had a family history of suicide and 11% knew a family member who had died by suicide (Nelson, et al., 1988).

According to data prepared by Information Management at Alberta Health Services, the rate of hospitalizations for a self-inflicted injury during the 2003/04 fiscal year was 71 per 100,000. Eighty-one percent (81%) of individuals discharged from regional acute care hospitals with intentional self-harm injuries also had a mental health problem or concern in their diagnosis on discharge. For youth between 15 and 19 years of age, this rate was 189 per 100,000 and for young adults between 20 and 24, it was 159 per 100,000. The rate of hospitalizations of Aboriginal Peoples for a self-inflicted injury during this period was 258 per 100,000 population (AHS, 2006b).

According to data prepared by Information Management at the Alberta Mental Health Board for the 2003/04 fiscal year, there were 193 Emergency Room visits per 100,000 population in Alberta for a self-inflicted injury. Forty percent (40%) of those who visited Emergency Rooms with intentional self-harm injuries also had a mental health problem or concern. For adolescents, the rate of emergency room visits was 590 per 100,000 and for young adults, it was 549 per 100,000. The rate of Emergency Room visits of Aboriginal Peoples for a self-inflicted injury during this period was 753 per 100,000 population (AHS, 2006b).

Suicidal ideation occurs in about one-fifth of Canadian youth (Armstrong & Manion, 2006). Suicidal ideation is having thoughts of suicide or planning for suicide. The occurrence of suicidal ideation is much higher in the U.S. than in Canada. In a large U.S. study (n=12,721), 45% of youth reported making a plan but not attempting suicide; 38% reported both making a plan and attempting suicide; and 9% reported attempting suicide without a plan. In the Utah Study of 49 youth aged 13-21 years old, 35% of decedents told their parents the method they would use and 25% used the method they had specified, but less than one-third of either friends or parents recalled whether the youth had attempted suicide (Moskos, et al., 2005). Eleven (22%) decedents had a history of previous attempts at the time of their death (Moskos, et al., 2005).

In this same Utah study, friends, siblings, and parents all recalled emotional problems for a majority of the youth. These problems included anger, sadness, and loss of interest in usual activities, including school. Anger occurred more often than sadness and was frequently volatile. This was recalled by the majority of friends, siblings, parents, and relatives, while sadness was recalled by a majority of all the contact groups in the study (Moskos, et al., 2005). Almost half of the 49 youth were socially isolated: Moskos and colleagues could find no friends to interview for half of the young women and 41% of the young men, despite excellent methodology for seeking interviewees.

2.4 **Risk and Protective Factors**

Individual psychological, biological/genetic, and intra-personal dimensions as well as socioeconomic, social and environmental factors can interact, accumulate, and contribute to an individual's risk for as well as provide protection against suicide (Gerard & Buehler, 2004; Jessor, et al., 1995; Waddell, et al., 2005; White & Jodoin, 2003). A risk factor is defined as "a condition within the youth's socialization context that potentially increases the likelihood of personally or socially unfavourable developmental outcomes" (Gerard & Buehler, 2004, p. 703). It is important to note, that the presence of one or more risk factors does not suggest that "unfavourable" outcomes or suicide will always be the result (Ramsay, 2004), as these can be countered by protective factors. Protective factors have been defined as those "variables that have their own direct effects on behaviour but that, in addition, can moderate the relation between risk factors and behaviour" (Jessor, et al., 1995, p. 923).

Individual level risk factors for suicide have generally been identified by reviewing coroners' records, medical examiners' reports and/or interviewing family and friends of the suicide using psychological autopsies (DeLeo, et al., 2002; White, 2003). Section 2.1 discussed mental illness as a risk factor for youth suicide. The relationship between self-esteem and mental health, particularly depression, has been well established in developmental and psychological approaches (Grøholt, et al., 2005). Self-esteem has several components, including self-evaluation and personal competency and mastery (Grøholt, et al., 2005). Adolescence is a normal time of developmental flux during which youth struggle to define who they are and attempt to gain acceptance and approval from peers, both parts of the development of self-esteem (Armstrong & Manion, 2006; Grøholt, et al., 2005; Halpern, 2005).

Studies of adolescent development consider why adolescents show elevated rates of suicidal behaviour. Youth with mental health problems, but without indicators of suicide, appear more able to situate themselves in their own personal history, and, presumably, in the history of their social group: they know who they were as children and the security of this source of identity enables the defining of who they are becoming (Chandler & Lalonde, 1998; Grøholt, et al., 2005). Youth with indicators of suicidal behaviour, on the other hand, are “uniquely characterized by a thorough inability to warrant their own continuity in time” (Chandler & Lalonde, 1998, p. 197) and in the absence of a depressive disorder, suicidal tendencies among these youth were associated with instability in their concept of identity (Grøholt, et al., 2005). They appear unable to connect who they currently are with who they were as children and who they might be as adults.

Jacono and Jacono (2008) note that self-esteem is a reflection of a healthy selfhood that “emerges and develops within a cultural context” (p. 50). One such stressor is a personal history that is embedded in a hostile environment. Thus, if adolescents are in unhealthy environments, the ability to develop a healthy sense of self is compromised.

Suicide is situated in social contexts. Gerard and Buehler (2004) identify four domains in which both risk and protective factors can be found: family, peer, school, and neighbourhood. They point out that if multiple stressors are simultaneously present “across several spheres of the adolescent’s world, youth might experience psychological discomfort with self and their social environment” (Gerard & Buehler, 2004, p. 703).

White and Jodoin (2003) add culture as a fifth social context. The influence of culture on self-esteem in general has been recognized by several researchers. Katz and colleagues (2002), for example, present evidence that membership in a devalued social group can have adverse effects on mental health. When individuals are members of devalued groups, they may internalize the stereotypes visited upon their group by other more economically or politically powerful groups and this may stifle or stunt the development of a healthy individual identity (Katz, et al., 2002; see also Halpern, 2005).

Table 2.1 below adapts White and Jodoin’s (2003) categorization of risk and protective factors, making additions based on the contributions of other researchers (Armstrong & Manion, 2006; Chandler & Lalonde, 1998; DeLeo, et al., 2002; Goldsmith, et al., 2002; Grøholt, et al., 2005; Halpern, 2005; Jessor, et al., 1995; Katz, et al., 2002; Kutcher & Szumilas, 2008; White, 2003).

Level	Risk Factors	Protective Factors
Individual	<ul style="list-style-type: none"> ➤ Co-morbid mental illnesses; ➤ Low self-esteem and/or identity crises; ➤ Low social status; ➤ Physical illness; ➤ Previous suicide attempts; ➤ Psychiatric disorders; ➤ Prolonged or unresolved grief; ➤ Sexual orientation; ➤ Suicidal ideation. 	<ul style="list-style-type: none"> ➤ Creative problem-solving, conflict resolution, and non-violent handling of disputes; ➤ Direct personal controls against the occurrence of problem behaviour, including personal autonomy and previous experiences with self-mastery; ➤ Good physical and mental health; ➤ Optimistic outlook; ➤ Self-mastery and sense of personal competence; ➤ Sense of humour; ➤ Strong spiritual or religious faith.
Family	<ul style="list-style-type: none"> ➤ Dysfunctional parent-child relationships; ➤ Early childhood loss or separation; ➤ Family history of suicide; ➤ Maltreatment as a child; ➤ Non-intact family of origin; ➤ Parental history of mental health disorders; ➤ Physical illness; ➤ Poor educational background. 	<ul style="list-style-type: none"> ➤ Adults modelling healthy lifestyle; ➤ Commitments to conventional institutions or to adult society in general; ➤ Family relationships characterized by warmth and belonging; ➤ Realistic expectations.
Peers and School	<ul style="list-style-type: none"> ➤ Social isolation and alienation; 	<ul style="list-style-type: none"> ➤ Acceptance and support; ➤ Healthy peer modelling; ➤ Interpersonal competence; ➤ Involvement in activities incompatible with or alternatives to problem behaviours that engage youth.
Neighbourhood and Community	<ul style="list-style-type: none"> ➤ Barriers to accessing mental health treatment; ➤ Contagion or clustering of suicides; ➤ Community marginalization; ➤ Easy access to lethal methods; ➤ Economic deprivation and/or unemployment; ➤ Isolated geographic location; ➤ Lack of proper housing conditions; ➤ Lack of social connectedness; ➤ Political disempowerment; ➤ Poor educational attainment. 	<ul style="list-style-type: none"> ➤ Availability of resources; ➤ Community self-determination and solidarity; ➤ Easy access to a variety of clinical interventions and support for help seeking; ➤ Evidence of hope for the future; ➤ Direct social controls against the occurrence of problem behaviour; ➤ Opportunities for community participation.
Culture	<ul style="list-style-type: none"> ➤ Absence of political and cultural efficacy; ➤ Breakdown of cultural values and belief systems; ➤ Membership in a devalued social and/or cultural group; ➤ Stigma associated with mental illness that leads to unwillingness to seek help. 	<ul style="list-style-type: none"> ➤ Strong cultural and/or religious beliefs; ➤ Reduction of stigma of mental illness.

White and Jodoin (2003) also identify contributing and “trigger” factors. Common precipitating factors for adolescent suicide include recent loss, rejection or disciplinary crises (Moskos, et al., 2005; White &

Jodoin, 2003). Recent loss can include romantic or parental loss. For example, in the Utah study, the majority of parents and friends suggested romantic problems were a precipitating factor of the suicide. Also, 47% of the decedents' parents had divorced in the six months prior to the suicide (Moskos, et al., 2005). In the California society, 52% of the 44 youths who died by suicide had parents who were separated or divorced (Nelson, et al., 1988).

As noted earlier, suicide rates among males are generally three to four times higher than for females. Other gender differences are also apparent. For example, suicide rates and rates of depression for rural males are much higher than for either rural females or urban males in the same age cohorts (Armstrong & Manion, 2006). Urban females, conversely, have higher suicide rates than rural females (Armstrong & Manion, 2006). The higher rates of suicide for rural males have been attributed to social and geographic isolation but this is not the case for rural females (Armstrong & Manion, 2006). Males and females also differ with regard to self-esteem and/or identity crises, with males more likely to derive self-esteem from activities that add to their social status (Armstrong & Manion, 2006). Ethnic and age cohort differences are also apparent, with suicide rates higher among young adult Caucasian and Aboriginal males and lower among adolescents and children, and black youth (Kutcher & Szumilas, 2008).

Understanding how youth attempt to cope with mental illness and/or suicidal behaviour is extremely important in developing effective interventions. "It is an important public health concern to gain a comprehensive understanding of the risk factors for suicide so that primary prevention strategies can be implemented to promote positive mental health in these particularly at-risk youth" (Rhodes, et al., p. 103, 2006).

2.5 Mental Illness, Stigma, and Help-Seeking Behaviour of Youth

Mental Illness and Stigma

"People suffering from mental illness and other mental health problems are among the most stigmatized, discriminated against, marginalized, disadvantaged and vulnerable members of our society" (Johnstone, 2001, quoted in Overton & Medina, 2008, p. 143). "Mental illness" is defined by the online American Heritage Dictionary (2000) as "any of various conditions characterized by impairment of an individual's normal cognitive, emotional, or behavioural functioning, and caused by social, psychological, biochemical, genetic, or other factors, such as infection or head trauma." Overton and Medina (2008) use the definition from the 1990 edition of *Merriam-Webster's Dictionary*: mental illness is "mentally disordered, mad, or crazy" (p. 143) and contrast it with the "broader and more current definition of mental illness" that "refers to the spectrum of cognitions, emotions, and behaviours that interfere with interpersonal relationships as well as functions required for work, at home, and in school" (p. 143). They note that this definition is the one underlying the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders*, the definitive reference used most frequently in North America.

Mental illness is still stigmatized, but perhaps not so much as it was in 1990 – dictionaries are generally considered valid representations of how people use the language. Advocacy groups, physician associations, and governments have actively addressed stigma for much of the past twenty years and since dictionaries are reflections of how people use the language, perhaps these efforts have been effective. As with so many other issues in mental illness, however, considerable work remains before people with mental illness are not "marginalized, disadvantaged and vulnerable members" of society. This may, perhaps, be one reason why youth are so hesitant to seek help.

To this end it is important to recognize recent initiatives aimed at challenging stigma. On their website,³ the Canadian Mental Health Association presents 10 ways to challenge stigma. Most recently (September 2008), the Mental Health Commission of Canada (MHCC) introduced the *Anti-Stigma Campaign*, a major, national 10-year anti-stigma and discrimination reduction campaign. This campaign will be the largest systematic effort to reduce the stigma of mental illness in Canadian history. In rolling out this campaign, MHCC will work closely with the broad mental health community of consumers, stakeholders and professionals to create a focused and well-orchestrated strategic plan. The Commission will serve as a catalyst, mobilizing and focusing the actions of others. At the same time, it will help build a research knowledge base that will be shared with mental health scientists around the world.⁴

Stigma was noted as a risk factor for suicide in Table 2.1. In the Utah study (Moskos, et al., 2005), more than two-thirds of parents reported that the decedent perceived 'seeking help as a sign of weakness or failure'. A barrier identified by more than 70% of parents, siblings, friends, and relatives was that the decedent 'believed that nothing could help' them, as opposed to other possible barriers such as the family being unable to afford mental health care. Less than half of the youth had received mental health treatment, despite 67% having been diagnosed with a mental illness.

Stigma and Help-Seeking

Underlying stigma is an ignorance of mental illness. Inability to recognize signs of mental distress influences help-seeking behaviours. Davis Molock and colleagues (2007) conducted a focus group of 42 high school-aged African-American youth who attended one of two Protestant churches in a major metropolitan area in the eastern U.S. to assess help-seeking behaviour in the context of a hypothetical suicide crisis. They hypothesized that help-seeking is affected by the recognition that there is a mental health problem. The participants were asked to read a vignette about a young man experiencing several stressful events and ends with him creating a situation in which injury or death was a likely possibility, a suicide caused by forcing a violent reaction by another ("victim-precipitated suicide). After, they participated in a focus group following a set of structured questions.

One of the findings was the general inability of the youth to recognize signs of depression and suicidal behaviours. The youth from this community recognized examples of concrete problem behaviours but did not recognize these as risk factors for suicide. They "either believed that peers with serious suicide intent would not disclose their intentions or that it was best to avoid the topic since they were unsure of how to ascertain the warning signs of suicidality" and suggest that a "suicide prevention program for African American adolescents should have an educational component to increase awareness of the prevalence as well as the risk and protective factors associated with suicidal behaviours" (Davis Mollock, et al., 2007, p.57 and p. 59). But this recommendation is certainly generalizable to youth of all ethnic groups: suicide prevention and mental health promotion need to be age-, as well as culturally- and linguistically-appropriate.

Most of the participants in Davis Mollock and colleagues' (2007) study said they would seek help on behalf of a suicidal youth and they understood that a person expressing suicidal intentions needs immediate help. They were uncertain who to approach. This uncertainty plus the inability to recognize warning signs adversely impacts help-seeking behaviour. Few of the participants selected mental health professionals as helpers and most felt that adults, including teachers and parents, would respond by minimizing or over-reacting to the situation, giving unsolicited advice, were themselves part of the stress of the situation, or were poor listeners. Some chose peers because peers were better listeners and less

³ http://www.cmha.ca/bins/content_page.asp?cid=284-683-1549-2352-2354-2402&lang=1 accessed March 23, 2009.

⁴ <http://www.mentalhealthcommission.ca/English/Pages/AntiStigmaCampaign.aspx> accessed March 23, 2009.

judgemental, but they noted that peers might not be able to handle suicide crises as well as adults. While they were suspicious of mental health professionals, they would be open to interventions by such professionals if they were sponsored by an organization they trusted, like their church. Other marginalized groups, like women with “high behavioural risk factors,” also are more open to such interventions when sponsored by trusted organizations (Tessaro, et al., 2000).

Canadian youth face the same uncertainties regarding who to approach in mental health crises. Youth report that they need mental health services which are accessible and confidential (Armstrong & Manion, 2006). The use of professional mental health services in Ontario was less than 2% for both males and females with mental health concerns (Youth Net, 2001). This may be due to a combination of factors, not least of which is the low number of psychiatrists and paediatricians knowledgeable in children and youth mental health throughout Canada.

Collaborative and innovative mental health care delivery models have been implemented to make the best use of scarce mental health resources. These include shared care and telehealth, where psychiatrists and psychologists provide consultation to general family practitioners in the treatment of mental illness. Efforts, then, have been made in Alberta as well as Canada, to increase accessibility. Since the family doctor is often the provider of the treatment, such delivery models also increase anonymity and confidentiality.

Many youth (32% of males and 46% of females) would reach out to friends in a mental health crisis, but almost as many would not speak with anyone about a mental health concern (48% of males and 31% of females) (Youth Net, 2001). It is not unreasonable to suggest that the adolescent search for identity and acceptance is a powerful barrier to seeking help for an illness that is still regularly referred to in derogatory terms that label the sufferer as somehow different. It is also not unreasonable to suppose that Canadian youth, like adults, lack knowledgeable about mental illness and are unable to recognize signs of mental crisis.

SECTION 3: MENTAL HEALTH PROMOTION

3.1 Introduction

The intention of mental health promotion is to reduce risk factors and enhance protective factors. Optimal mental health can be obtained by helping individuals manage their mental and emotional health, by increasing each person's ability to deal with their social inter-relationships, and by developing and maintaining healthy communities (Saxena & Garrison, 2004). Prevention is related to promotion. Prevention, however, focuses on the causes of disease and not on the determinants of health (Herrman, 2001).

Mental health promotion and illness prevention interventions can be delivered at three levels: universal, targeted, and indicated. Hill and colleagues (2007) and Offord and colleagues (1998) both note that strategies for promotion and prevention need to combine efforts at all three levels to promote mental health and prevent mental illness. Interventions can target risk factors for mental illness in general and for suicide in particular, at the social/cultural, intra-individual, and individual levels.

Levels of Intervention

Universal interventions are delivered at the level of larger social/cultural groups, such as schools or entire communities. They attempt to reduce or modify risk factors in a population. They attempt to reach large numbers of youth with varying degrees of risk, from no-risk to high risk. As such, they avoid stigma and labelling. Primary prevention interventions may be difficult to evaluate because the overall effect may be small (Offord, et al., 1998; Waddell, et al., 2005). With regard to suicide prevention, universal interventions seek to reduce suicide by improving the protective factors of large proportions of the population (Advisory, 2003). For example, a risk factor at the neighbourhood/community level (Table 2.1) is barriers to accessing mental health treatment; the protective factor is availability of resources and easy access to a variety of clinical interventions. A media campaign publicizing suicide prevention lines provides access to some resources, such as suicide help lines. Such campaigns also work to reduce the stigma of mental illness and suicide by emphasizing that the person suffering is not alone.

Targeted interventions are delivered to specific at-risk populations. They may require a screening method to identify the at-risk population, problematic in many areas of mental health as efficient and effective screening tools are lacking. Since at-risk populations must be identified prior to receiving treatment, secondary prevention interventions may increase stigma and labelling. Another disadvantage of these is that they do not consider risk factors that distinguish one community from another and may ignore community-level protective factors (Offord, et al., 1998; Waddell, et al., 2005). Counselling families with a history of suicidal behaviour or parental psychopathology or with poor family cohesion, and/or conflict and parenting difficulties are examples of targeted interventions.

Indicated interventions are delivered to populations who have sought out specialized health treatment. These interventions are limited to those who seek such help. Interventions may include psychopathology, recognizing the signs of suicidal behaviour, and preventing alcohol and substance abuse or antisocial behaviour (Burns & Patton, 2000). These interventions may increase stigma and labelling and, in mental health especially, there often are problems of compliance with treatment (Offord, et al., 1998; Waddell, et al., 2005). Tertiary suicide prevention also involves providing support and counselling to those affected by suicide, including attempters and the bereaved (Advisory, 2003).

Depending on the site, *Community Helpers* might be seen as either universal or targeted. For example, sites co-located with colleges would provide services to an entire college population, while sites co-located with agencies that have outreach programs for youth-at-risk would target this specific population.

3.2 **Community Capacity Building**

Community capacity includes the characteristics of communities that “affect their ability to identify, mobilize, and address social and public health problems” (Goodman, et al., 1998, p. 259). Characteristics of communities are increasingly recognized as contributors to program effectiveness, program sustainability, and a community’s ability to respond to future challenges (Griffin, et al., 2005; MacLellan-Wright, et al., 2007; Raczynski, et al., 2001). Raczynski and colleagues (2001) suggest that building community capacity is a “repetitive cycle of creating opportunities for community members and agencies to work together to address particular problems, to ultimately enhance capacity, and then to work together to address other problems” (p. 296). They also suggest that some community capacity is needed prior to collaborating. Braun and colleagues noted, however, that capacity building can involve “agents of change” who “help individuals and communities get involved in, gain skills regarding, and take action about an issue of importance to them” (Braun, et al., 2003, p. S20).

Several key characteristics have been identified as critical to a community’s ability to address local issues of importance (Braun, et al., 2003; Chinman, et al., 2005; Goodman, et al. 1998; Raczynski, et al., 2001; Zakocs & Guckenbug, 2007). They are:

- External or internal catalyst;
- High citizen participation and engagement in public affairs;
- Strong leadership that includes both formal and informal leaders;
- Citizens and leaders skilled in implementing and sustaining programs or gaining access to needed skills;
- Ability to acquire resources, both traditional funding and social capital;
- Strong and broad social and inter-organizational networks;
- Sense of community characterized by feelings of belonging, personal efficacy *vis-à-vis* community actions, a sense that members will have their needs met, and emotional connectedness between community members;
- Citizen understanding of the history of their community;
- Community power and values that are shared.

Chandler and Lalonde (1998) provide powerful evidence regarding the effect differences in community capacity can have. Between 1987 and 1992, suicide rates in the British Columbian First Nations youth population were as high as 137.5 per 100,000. However, over half of the communities experienced no suicides. Communities that had all six of what Chandler and Lalonde call “markers of cultural continuity” experienced no suicide. These markers include land claims negotiations, self-government, and on-reserve education, health, and police/fire services. If any of these markers were present, the incidence of suicide was reduced. When these First Nations communities achieved political and social efficacy, the stereotypes perpetrated within the non-Aboriginal Canadian society appeared to be mitigated and individual identity formation appeared to be healthier, as indicated by lower rates of suicide.

Example: Community Helpers, Ontario (Austen 2003)

Austen describes the implementation of *Community Helpers* in Ontario, the forerunner to the current Alberta *Community Helpers*. She identifies several outcomes indicating an increase in community capacity. Knowledge about the formal mental health care system and about mental health in general increased among youth and adults; helping skills also increased. Skills in collaboration increased as youth and businesses worked to develop, distribute, and input the survey identifying helpers and to determine how to manage and use funds from the Teen Assistance Fund. Skills in maintaining the partnerships and collaborating with each other on other issues of concern also were enhanced as other youth-serving agencies began to provide services at the community's secondary school. Empirical indicators were not provided as Austen's work was descriptive and not evaluative.

Example: Diabetes Prevention Initiative (Braun, et al., 2003)

Braun and colleagues assessed the community capacity building of a diabetes prevention initiative in Hawaii. The catalyst for this initiative was the higher rates of diabetes among Pacific Islanders; external funding was provided by the US Centers for Disease Control and Prevention (CDC). The Resource Center under contract to the CDC to provide the diabetes prevention initiative initially contacted local leaders and worked to gain their trust through collaborative discussions. Local leadership also helped to revise a training program on diabetes to meet the needs of Pacific Islanders.

Over a 4-year period, approximately 450 persons had completed the diabetes training. This training provided knowledge about diabetes and how it affects Pacific Islanders, skills training in problem-solving, and facilitation in expanded individual social networks. Using pre- and post-test questionnaires, telephone interviews, annual site reports, and completed training workbooks of participants, Braun and colleagues were able to assess the acquisition and transfer of needed skills, although they did not report on the results.

By the end of four years, 11 communities had formed coalitions for other purposes, an example of the "repetitive cycle" of working together to address other problems than the one that initially drew the communities together. Ongoing technical assistance to the communities was offered throughout the project by the staff of *Pacific Diabetes Today* Resource Center (PDTRC). They helped with action plans, by linking potential coalition members together, and by publicizing each community's work through the PDTRC newsletter. Although Braun and colleagues consider all these as indicators of successful community building and empowerment, they note that such initiatives should link coalitions with steady sources of funds.

Example: Mental Health Capacity Building for Children and Families (R.A. Malatest & Associates, 2007)

Malatest evaluated the implementation of five pilot mental health school-based partnerships. Key components of this initiative were intended specifically to build upon several of the characteristics of community capacity noted above. As with the Diabetes Prevention Initiative, an external catalyst – the Alberta Health Services was responsible for the implementation and funding of this capacity building initiative. The initiative built inter-organizational and referral networks by using multi-disciplinary teams and building connections with professional non-school-based helping resources to enable appropriate referrals. Within the participating schools, the teams made direct contact with parents and students to increase awareness of available services and to ensure ongoing communication, assessment, and direct service provision with and needs assessment of the targeted population.

3.3 Youth-Adult Partnerships

Youth-adult partnerships are characterized by mutuality in teaching, learning and decision making between youth and adults (Camino, 2005). Central to *Community Helpers* are youth and adult helpers, working in conjunction with program coordinators, and, possibly, other stakeholders. An unstated, but obvious, intention is to increase the level and quality of interactions between youth and adults. Several researchers have indicated that social isolation is a risk factor for youth suicide. The protective factor, then, is to involve youth in meaningful, purposive, and structured activities aimed at reducing social isolation and strengthening inter-personal connections among youth and between youth and adults (Armstrong & Manion, 2006; Moskos, et al., 2005).

Key components of community capacity building are strong and broad social networks and a sense of community characterized by feelings of belonging and personal efficacy (Goodman, et al., 1998; Raczynski, et al., 2001). Youth and adults, though, reside in different “cultures” and are isolated from and mistrustful of each other (Advisory, 2003; Bagley & Ramsey, 1993; Jarrett, et al., 2005; Zeldin, et al., 2005). Before community capacity can be built, relationships between youth and non-familial adults need to be built.

Jarrett and colleagues (2005) examined three youth-adult partnerships in youth-serving agencies to identify how such relationships developed. Using qualitative interviews, they identified three stages in the development of positive relationships between youth and adult:

- Youth-adult disconnect, where youth had negative preconceptions about interactions between youth and adult, a manifestation of the different “cultures” in which youth and adult reside;
- Interacting with adults through activities organized by the youth-serving agencies, where youth were able to become familiar with and relate positively with adults, who, in turn, fostered egalitarianism;
- Connecting with adults resulted after these positive and egalitarian experiences had dispelled the negative preconceptions.

Bringing youth together with adults in structured activities with common goals provides both with opportunities to know one another. Being nominated by youth and young adults as a Community Helper provides an initial meaningful bond for youth and adult helpers. Camino (2005) noted there are several pitfalls of youth-adult partnerships, including the assumptions that youth will do “everything of importance,” that adults need to let them do “everything” and that youth are the primary focus. Encouraging youth to be involved in a variety of activities in program implementation, recruitment, presentations, evaluation, or as members of advisory groups and seeking their opinions are some activities that lead to working relationships between youth and adult. *Community Helpers* currently builds in a “parade of professionals,” during training, where youth-friendly professionals from the formal helping community are invited to participate in a resource workshop to meet with the youth and adult helpers and provide the helpers with information about their services. It is also incumbent upon both adults and youth to remember the stated objectives of the *Community Helpers* program.

3.4 **First Aid Programs**

Mental Health First Aid

Mental Health First Aid was developed and introduced by Professors Anthony Jorm and Betty Kitchener from the Centre for Mental Health Research at the Australian National University in 2001. Since 2005 the program has been sponsored by the ORYGEN Research Centre at the University of Melbourne. It is available in other countries, including Canada.

Mental Health First Aid is based on first aid courses offered for physical illnesses. It provides training in the first response to a mental health crisis, much as CPR training provides training in the first response to a cardio-pulmonary crisis. To continue the analogy, the objective of the First Aid is to save lives. Specifically, it aims to (AHS, 2007):

- Preserve life where a person may be a danger to themselves or others.
- Provide help to prevent the mental health problem from developing into a more serious state.
- Promote the recovery of good mental health.
- Provide comfort to a person experiencing a mental health problem.
- Improve mental health literacy and decrease stigma.

Training consists of a 12-hour course over four sessions. The first session introduces mental health and mental illness and covers common mental health problems, a five step model of mental health first aid, and substance use disorders. Each of the subsequent sessions covers specific categories of mental illness: depression (including suicide), anxiety disorders, and psychosis. Risk factors for each category are discussed as well as first aid responses, and treatment and resources. The steps of mental health first aid are: (1) assess risk of suicide or harm; (2) listen non-judgementally; (3) give reassurance and information; (4) encourage person to get appropriate professional help; (5) encourage self-help strategies.

Master Facilitators are trained by the program founder Betty Kitchener at the Centre for Mental Health Research, Australian National University. These facilitators teach instructors in a five day course to provide the 12-hour training to members of the general public. Instructors must meet specific selection criteria to be eligible for the training. These include: demonstrated knowledge and/or experience in the field of mental health and mental illness; knowledge and/or experience in delivering training/teaching effectively to adult learners; experience in networking with community partners; knowledge of the range of mental health services; good interpersonal and communication skills; good knowledge about mental health problems; positive attitudes towards people with mental health problems; and enthusiasm to reduce stigma and discrimination associated with mental illness. In addition to meeting specific criteria, instructors require reference letters. Instructors also receive support from Mental Health First Aid. Trainers receive certification when they have successfully delivered three workshops.

The program has been extensively evaluated in controlled tests, uncontrolled tests, and in a qualitative study (Jorm, et al., 2004; Kitchener & Jorm, 2004; Kitchener & Jorm, 2002). Evaluations have consistently shown improvements in knowledge about the disorders covered in the course content, increased agreement with professionals regarding appropriate interventions, decreased social distance, increased confidence in providing help to others, and an increase in the amount of help actually provided. Additionally, former participants retained training effects 19-21 months post-training (Jorm, et al., 2005).

Applied Suicide Intervention Skills Training (ASIST)

ASIST was developed in Alberta in 1981 and implemented in 1985. It is a curriculum-based suicide intervention workshop that includes components on attitudes toward suicide, knowledge of suicide and risk factors, and skills training in five sections. According to its website, suicide intervention is viewed in the “same way people view CPR or basic first aid,” while the ASIST program is intended for “front-line caregivers/gatekeepers of all disciplines and occupational groups” (LivingWorks, 2008). It was recently revised in 2003. Section 1, Preparing, “sensitizes participants to evidence that suicide is a serious community problem” (Ramsay, 2004, p. 11). Sections 2, 3, and 4 (Connecting, Understanding, and Assisting) include “first aid” knowledge to enable participants to provide “first aid” care. Section 5, Networking, is a section on the importance of self-care, community resources, and collaboration and networking.

It is offered in a 2-day skills-building workshop format. A half-day “TuneUp” is also offered to graduates of the 2-day course. The training prepares people to:

- Identify people who have thoughts of suicide.
- Understand how your beliefs and attitudes can affect suicide interventions.
- Seek a shared understanding of the reasons for thoughts of suicide and the reasons for living.
- Review current risk and develop a plan to increase safety from suicidal behaviour for an agreed amount of time;
- Follow up on all safety commitments, accessing further help as needed.

ASIST training is offered in Alberta through the Centre for Suicide Prevention. In other provinces/territories across Canada, and in other countries, ASIST training is provided through LivingWorks Education Ltd.

Trainers for ASIST participate in a 5-day course that covers coaching, independent study, group presentations, lectures and seminars. A selection/application process is also in place, as with Mental Health First Aid. Suggested skills include: a strong interest in the subject of suicide; a flexible attitude about suicide; good interpersonal communication and helping skills; suicide intervention experience; established presenter and small group facilitator skills; knowledge and application of adult learning principles; ability to work collaboratively with other Trainers; and the commitment to deliver a minimum of 2 ASIST workshops a year (Centre for Suicide Prevention, 2008). ASIST trainers receive certification when they have successfully presented three workshops (Centre for Suicide Prevention, 2008). ASIST requires two trainers per session and also places restrictions on the size of the group being trained (not to exceed 15). It expects its trainers to adhere to the curriculum, as ASIST is a standardized program and meant to be delivered in a standardized fashion. It also provides support to trainers (LivingWorks, 2008).

Several evaluations of ASIST have found consistent evidence that participants experience increases in knowledge and awareness of issues surrounding suicide, increases in confidence and competence in first aid skills, in networking capabilities (AskClyde, 2007; Cornell, et al. 2006; Lander & Tallaksen, 2007; Todd, 2005). In a comparison between ASIST and QPR in a school-based setting, (see Section 3.6), training effects were greater for ASIST and trainees reported referring significantly more students to mental health services as well as questioning more students about suicide and making more safe plans (Cornell, et al. 2006).

3.5 Lay Helping Models

One of the key components of community capacity is the social and other networks within it. Lay helper models explicitly rely on and seek to enhance the social networks of those involved in the initiative. These models have been implemented for a wide variety of health issues and in communities traditionally marginalized by the health care system or society as a whole. The existing social network of helpers is a central feature of such models and several studies report on the “importance of strong social ties and supportive social relationships in influencing health-related behaviours, and both mental and physical health” (Tessaro, et al., 2000, p. 603).

Such programs are based on the observation that people usually seek out members of their social networks for advice, support, and/or comfort. Lay helping models recruit such members and provide them with knowledge about specific mental or physical illnesses and in helping skills. Communication, decision making, and problem solving are usual components of the training; many programs also provide information about making referrals to formal professional helpers. They not only tap into these members’ social networks, but they create another one as well. Helpers provide support for other helpers for their own problems and to debrief about the help they have provided others. Lay helping models also build upon assets, instead of being focused on disease (Froh, 2004).

Identification and Recruitment

Lay helpers are identified through a number of ways. The most usual is by nomination: members of the target population are asked to nominate people they already turn to for help. These people are then invited to be trained as lay helpers. Several other identification/recruitment methods have been tried in lay helper programs.

Bishop and colleagues (2002) report on a study of lay helpers in five North Carolina counties. The program was designed to disseminate information about breast cancer to a high-risk group – African-American women. Helpers were to be identified by community members, but the program deviated in several ways. The coordinators felt some pressure to meet funding timelines and invited their relatives, friends and acquaintances to training sessions. Some women who had been identified by community members brought friends with them to training, while other women came uninvited. These latter women felt excluded by the nomination process. The program had an advisory group whose primary function was to identify natural helpers, but some of the women it nominated did not meet the criteria established to identify natural helpers.

Tessaro and colleagues (2000) studied lay helpers in the workplace, in another North Carolina study. This program targeted working class women with the intention of changing health behaviours commonly related to increased morbidity and mortality. They used three identification methods. The first was by nomination via a baseline survey; the second was by eliciting recommendations from management to ensure all social networks were included; and the third was by self-identification. More women than expected were trained as natural helpers and the authors suggest one reason was because of the inclusive recruitment method.

D’Augelli and Vallance (1982) surveyed two communities in Pennsylvania prior to implementing a lay helpers program. The intention of their research was to test a training model in mental health promotion they referred to as a “pyramid” model, but what has come to be referred to as “train the trainer.” In such models, a small group are trained to train others in the curriculum. Participants were identified in the community survey, where the question, “about how often are you sought out by someone needing personal help?” identified 64 lay helpers.

The peer nomination process appears to have good validity and reliability. Froh (2004) suggests that the high correlation between student and teacher nominations indicates good validity, while comparisons with peer ratings and peer rankings demonstrate both better validity and reliability for the nomination method. He also identifies several strengths of the peer nomination process in school-based lay helper programs: (1) peers may be more perceptive of certain skills than adults; (2) peers may be exposed more frequently and under more diverse circumstances than adults to certain skills; (3) when responses are pooled, as they are in the nominating survey, biased nominations from individuals are reduced; and (4) peer nominations are based on how peers behave under normal circumstances and not on how they behave in social situations with adults.

Benefits accrue to both helpers and helpees. On the part of the helper, increases in self-esteem and emotional growth, growth and enhancement of interpersonal skills and psychological well-being, and the development of leadership skills are all possible benefits. Helpees benefit from having access to current information, to professional helpers through the referring capabilities of helpers, and to a sympathetic and possibly less threatening ear.

Lay helping models have been used in a variety of settings, with a variety of populations, and to address both physical and mental health promotion.

Evaluations of the registered *Natural Helpers*® program are discussed first, followed by generic lay helper models.

3.5.1 *Natural Helpers*®

The *Natural Helpers*® programs discussed here have several features in common. Program goals include teaching effective ways to help others, positive ways of self-care, and ways to contribute to a safe and supportive school environment. Identification of helpers is accomplished using a survey distributed to the school population; students are asked to name two people to whom they turn for help. Nominated peers are invited to a training session, usually conducted as a 3-day off-school retreat that lasts a total of about 25-30 hours. Training continues throughout the school year, typically on a weekly basis.

Helping and listening/communication skills form the core of the training. Information is generally provided on how and when to make referrals to professional helpers as well as specific knowledge-based information about an issue of concern. Natural helpers are also taught self-care techniques such as setting limits. Specific skills include:

- Active listening, that avoids advising, analyzing, reassuring, and close-ended or “why” questions in favour of more facilitating probes such as paraphrasing, asking clarifying questions, open-ended questions, reflections of feelings, being empathic, demonstrating genuine care, providing alternatives, and silence;
- Empathetic understanding or identifying the feelings that accompany the helpee’s distress;
- Accepting others as unique individuals worthy of respect;
- Recognizing when friends need help and specific warning signs of, for example, substance abuse or suicide;
- Using the “Helping Skill,” a “specific set of steps used to assist a person with a problem that helps that person find his or her own solutions” (Froh, 2004, p.4)

- Having the ability to know how and when to refer serious problems to professional helping resources; and
- Exercising self-care and expressing helping limits.

Natural helpers form a social bond with other helpers that begins during the training retreat and continues over the course of the year. Follow-up sessions are considered crucial in maintaining and strengthening this bond, in providing continued support from adult coordinators, and in presenting updated training or training on new topics.

Example: Natural Helpers®, Michigan (Michigan State University Extension, 2008)

The *Natural Helpers®* program was implemented in 1979 in Michigan. The program was evaluated over a two-year period from 2003 to 2005. The goals of the evaluation were to compare the two training methods (retreat and series) and the impact of the program. The evaluation included 345 students and 93 staff from six schools.

Four instruments and a focus group were used to gather evaluation data. All the instruments adapted questions from surveys designed for *Natural Helpers®*. The *Training Evaluation Questionnaire* compared the training effectiveness of retreat and series training. The other three instruments and the focus group were used to assess the impact of the program on the school community.

How training was delivered did not affect learning and both methods had evidence of effectiveness. Pre- and post-test scores demonstrated increases in knowledge and skills in all areas of training. The authors point out that this is the first time the mode of delivery for training had been evaluated. Although there were increases in knowledge and skills regardless of the mode of delivery, a stronger relationship between trainer and helper may develop with training delivered in a series mode.

The program had several impacts on students in the school: over 90% of students from the general population (n=144) reported that the natural helper they spoke to about a concern had good listening skills, understood their problem, and helped them make their own decision. The majority (68%) of *Natural Helpers* reported referring students to professional helping resources and 53% of students who sought their help reported being referred to someone else. This indicates that natural helpers are aware of their limits and do not assume inappropriate responsibilities. The majority (70%) of school staff (n=93) reported that natural helpers are effective in helping other students.

Staff members attributed the program with contributing to a safe and supportive school environment:

- 74% reported it had made a positive difference in the school;
- 80% recommended continuing the program; and
- 74% would recommend it to other schools.

In addition to helping students and contributing to a safe and supportive school environment, the helpers provided relief to school counsellors by providing help for not-so-serious problems.

Example: Natural Helpers®, New York (Froh, 2004)

Froh evaluated the acceptability of and efficacy in meeting program goals of the *Natural Helpers®* program in New York State. Participants included 1,023 students from two high schools, 3 administrators, 21 teachers, 29 parents, 14 coordinators, and 22 school psychologists. Only one of the schools had a *Natural Helpers®* program. Froh points out that although statistical significance has not been demonstrated for the *Natural Helpers®* program, clinical and practical significance has.

One of the objectives of the evaluation was to examine the effects of being a natural helper on the helper him/herself. His data is the first to examine these effects. He also examined the effects the presence of the program has on the school environment and members of that environment such as teachers. As with the effects of being a natural helper, little other data exists on school climate. He discusses the lack of research on the effects on the helpees, but his evaluation did not research these effects. As D'Augelli and Vallance (1982) suggest, assessing the quality of the help is difficult because data collection may disturb the informal nature of the helping interaction.

Froh used several instruments to assess the program's effectiveness. These include:

- *Demographic Sheet* collected demographic information about the participants. The parent form asked parents about their child's level of commitment to the program.
- *Statements About Schools Inventory* evaluated perceptions about current and ideal school climates.
- *Positive Peer-Helping Norms Survey* included items on positive helping norms.
- *Program Acceptability Survey* evaluated the acceptability of the *Natural Helpers*® program.
- *Leadership and Personal Development Inventory* assesses if students in organizations are provided with the means to become leaders and acquire personal development.
- *Acquisition and Maintenance of Skills Survey* is the parent evaluation form and assessed parent perceptions of their child's ability to acquire, maintain, and apply skills learned in *Natural Helpers*®.
- *Personal Growth Survey* ranked peer-helping programs like *Natural Helpers*® against other scholastic activities, like sports and music, on students' personal growth and development.

The results were favourable. *Natural Helpers*® met its program goals of (1) providing a safe and supportive school environment; (2) teaching students adaptive strategies for coping with problems; and (3) engaging in positive self-maintenance. Additionally, the program provided training that enhanced student skills in leadership and their sense of personal efficacy and taught them values consistent with education in character-building.

Acceptability of the program, however, was not so favourable. In fact, the more likely one was a student or a coordinator (from a sample that included students, administrators, teachers, parents, coordinators, and school psychologists), the less likely they were to accept the program. Froh suggests this requires more research, especially given qualitative data that suggests students, in particular, accept the program.

Example: Natural Helpers®, Washington (Aaby, 1987)

Aaby interviewed 52 coordinators and trainers of Washington State schools to examine strengths and weaknesses of the program. Respondents had been involved with the *Natural Helpers*® program from 6 months to 9 years. Among the strengths, respondents noted the following: enhanced self-esteem due to being nominated by the student's peers; bonding of natural helpers as they trained and provided support for each other; promoting the value of knowing one's limits; and enhancing the potential to use helping resources. The primary weakness was a lack of follow-up sessions.

Aaby points out that the authors of an early *Natural Helpers*® program (Akita & Mooney, 1982) recommended a minimum of four follow-up sessions. The intention of these sessions was to continue with training on issues identified in the school as issues of concern; to strengthen the bonds that emerged during the initial training sessions; and to remind students of their limits.

Example: Modified Day One Natural Helpers, Maine (Substance Abuse and Mental Health Services Administration, 2007)

The Day One Natural Helpers program was established in 1985 in Maine. By the 2006 school year, about 450 youth natural helpers and 40 adult helpers in 20 schools had been trained. The training follows the same content as indicated above, but uses adventure-based experiential learning activities as well as role playing and small group and didactic discussions.

Details of the evaluation are lacking. Day One has contracted the services of an evaluation firm to develop and implement a comprehensive evaluation plan, but reports on a “recent evaluation.” Results include:

- 80% reported increased knowledge of listening and communication skills;
- 50% reported increased knowledge of available resources;
- 80% reported increased bonding with an adult facilitator;
- 50% of students reported feeling more supported within the school by having a natural helper available;
- 100% of students referred by a natural helper received professional treatment.

Example: Modified Natural Helpers, Southwestern U.S.A. (Robinson & Morrow, 1991)

Robinson and Morrow report on an evaluation of a modified *Natural Helpers*® program; the modification included *Peer Power* as the philosophical basis and structure of the program combined with the *Natural Helpers*® format. As with *Natural Helpers*®, the high school was polled and students asked to indicate the names of two students to whom they would go if they needed help. They were also asked to indicate two faculty or staff to whom they would go if they needed help. To increase ethnic diversity, the list of natural helpers was categorized by ethnic and sub-cultural group and those with the highest number of votes were invited to the initial training. Of a 1,972 student population, 27 students were invited to participate and 8 accepted. A school counsellor, a teacher, and a program director from the sponsoring agency also attended training. The program started late in the school year.

Training occurred over a 3-day weekend retreat and was conducted by the two doctoral students who had developed the program. Prior to training, participants were asked to complete a pre-test on communication skills, using a 10-item questionnaire developed by Tindall and Gray (1985) for use in their *Peer Power* program. Participants were also asked to evaluate their strengths as helpers. Strengths included: the ability to listen, to give unbiased advice, to avoid judgments, to see both sides of an issue, to offer alternatives, and to help with relationship problems. Finally, participants were asked to indicate what they wanted to learn from the training. The training was both didactic and experiential. The components portions stressed personal growth, acceptance of diversity, self-assessment, micro counselling skills, crisis management, and setting limits, while the experiential components used role-playing and a trust-building exercise to reinforce the didactic components.

Two follow-up sessions with the doctoral students gave the helpers opportunities to assess the impact of their training. At the first follow-up, two weeks after the training retreat, participants completed a post-test of their communication skills. At both follow-ups, helpers discussed the situations they'd been involved with and received both support and advice, especially as regarded “clients” who needed to be referred to formal helpers. Of these initial 8 helpers, 5 continued into year 2 of the study and were joined by 13 more peer helpers. Weekly supervision by the doctoral students commenced and at these weekly

sessions, helpers were responsible for submitting written reports of helping incidents; peers could report on these verbally at the sessions and/or discuss personal concerns.

Improvements in communication skills were found for all participants and scores were significantly higher at post-test than at pre-test. Students were asked to record types of concerns they helped with and the gender of the helpee. The female counsellors reported almost three times more helping interactions than male counsellors even though males outnumbered females by 11 to 7.

At the first follow-up for the second year helpers, two weeks after the training, helpers were asked to complete a subjective evaluation of the training. The most satisfying components included: experiencing intimacy with others, learning about people, interacting with the doctoral students, and being actively involved. The most important components included: a respect for diversity within the group, the importance of listening and effective questioning rather than giving advice, improved relationship skills, and the ability to handle troublesome situations. Helpers were asked to identify which skills learned in training had been used the most often. In order of decreasing value, these skills include: active listening, communication skills, nonverbal cues, being non-judgemental, and asking questions rather than giving advice. A 1-year follow-up telephone interview with 6 peer counsellors indicated all were still informally providing help, with two “helping” in college and two planning to enter helping professions.

3.5.2 *Other Youth and Young Adult Peer Helping Programs*

Example: High school peer counsellors for students experiencing divorce (Sprinthall, et al., 1992)

Sprinthall and colleagues developed a psychological education program that focused on the psychological development of participants. It included systematic reflection and a balance between role-taking and reflection; training extended over one semester as a seminar. Training in peer counselling also occurred over one semester and included skills training and practice. The training for divorce group leaders incorporated material about the issues involved in divorce. The training was co-led by a counsellor and a teacher.

Students were recommended by teachers, counsellors, and other students on the basis of their maturity and ability to relate to others. Of the 24 peer counsellors, 10 co-led groups of students from divorced families. This latter group of students was identified by counsellors and then divided into five groups of eight pupils for group work on family disruptions. Both groups of students also volunteered to participate in the study. All instruments were assessed pre- and post-test. Both peers and helpees were assessed using the Loevinger Sentence Completion Test- Short Form that measures stages of development of the self-concept. Peers also were assessed using a measure of principled reasoning, the Rest Defining Issues Test. Helpees were assessed using the Nowicki-Strickland Locus of Control Scale, which measures the amount of control with which respondent believes they have over aspects of their lives. All three instruments have good reliability and validity psychometric properties.

Peers gained psychological maturity, exhibited greater self-awareness, and improved in perspective-taking capacity. The relationship between peers and the schools' adults improved with the latter being “extremely impressed by the resourcefulness, the insight, and the responsibility exhibited by the peer counsellors. Peers, too, changed their attitudes toward the adults and saw them as “genuine resource educators who not only helped them with the skills but also were responsive to them on a personal level.” Helpees showed a movement away from self-protectiveness and toward individuality, an elementary inner life psychologically, and a greater awareness of self in relation to others. They also showed improvements with regard to their locus of control toward the self and away from other-directedness.

The authors expressed their initial concern that peers would be unable to handle the complex issue of divorce and included a counsellor in the early sessions to observe and respond to distress, if need be. It was unnecessary and the authors attribute this to the ongoing support the peers experienced both within the seminar meetings and in the training.

Example: College peer counsellors in the treatment of young adult eating disorders (Lenihan & Kirk, 1990)

The PACT program addressed eating disorders in a midwestern college in the U.S. It recruited undergraduate students registered in a paraprofessional psychology program and gave them clinical experience. Peer counsellors were recruited based on the following criteria: (1) junior, senior, or graduate standing; (2) completion of specific courses in helping skills and crisis intervention; and (3) a clinical interview that assessed attitudes toward eating, health styles, and personal adjustment. They attended a 25-hour training course at the beginning of the semester. Training included readings and lectures on issues related to eating disorders, components of good health and good nutrition, and a review of helping skills and ethics.

They were matched with clients with eating disorders by program coordinators in conjunction with program supervisors. Coordinators were nominated by the peer counsellors at the end of each semester. They provided training; conducted weekly progress meetings for ongoing support and monitoring of peers; served as a liaison between peers and supervisors; maintained records and collected data; and served as the first resource for concerned peers.

Peer counsellors provided support and companionship to clients. They were expected to maintain daily contact and spent an average of 15 hours per week with their client. They also provided specific “therapy prescriptions,” including: monitoring nutrition; helping with meal planning and shopping; role playing new relationship strategies; practicing planned alternatives to negative cue-response patterns; training in positive stress responses; or conducting computer-aided nutritional analyses. Clients were also treated in small group psychotherapy and/or individual counselling. The peer component is one component of a broad therapeutic approach.

Lenihan and Kirk (1990) provide data on changes the client experienced between the start and end of the intervention, which lasted a semester in most cases. The PACT Program Change Scale rated the degree of client change in self-confidence, relationship with parents, self-control, and eating disorders and was completed post-intervention. The mean scores of 75 clients (+1.54 of a possible +3.00 top score) and 69 peer counsellors (+1.73) showed productive changes in these behaviours. Additionally, self-report measures of changes in eating behaviours showed improvement on binges, purges, and skipped meals between pre- and post-intervention. The authors concluded that the program “appears to be influential in encouraging client change” (Lenihan & Kirk, 1990, p. 334). The support of the peer counsellors broke the social isolation of youth with eating disorders and augmented the insights gained in group therapy. They also provided support to the overtaxed mental health system as their clients did not require ongoing monitoring by mental health care professionals.

3.6 **Gatekeeper Programs**

Gatekeepers are individuals in a community who have contact with large numbers of community members as part of their usual role as, for example, teachers and police. Gatekeeper training involves increasing gatekeepers’ awareness and knowledge of mental illness and suicidal behaviours to better identify individuals at risk of suicide, improving gatekeepers’ skills and attitudes toward mental health

intervention, and providing gatekeepers with referral information for treatment and/or support services for at-risk individuals (Kalafat & Elias, 1995; Klingman & Hochdorf, 1993).

There have been several studies demonstrating improvements in gatekeeper knowledge of suicide, commitment to awareness, and intentions to intervene with at-risk individuals (Eggert, et al., 1997; King & Smith, 2000; Knox et al., 2003; Tierney, 1994; Turley & Tanney, 1998). Mann and colleagues (2005) suggest that gatekeeper programs that focus on training community or organizational populations that have contact with vulnerable or at-risk individuals are among the most promising methods for improving suicide rates. According to this review of such programs, community or institutional gatekeeper programming can be effectively implemented for a variety of populations, including religious personnel, first responders, pharmacists, community caregivers, and staff in institutions such as schools, prisons, and the military.

Example: Many Helping Hearts (Stuart, et al., 2003)

Some programs contain both gatekeepers and peer helpers and combining the two approaches has been recommended as part of a comprehensive suicide prevention strategy in schools. Stuart and colleagues studied the efficacy of providing gatekeeper training to peer helpers. The results of this study suggest that peer gatekeeper training can result in increased knowledge about suicide and improved skills for responding to suicidal peers both immediately after training and 3 months later.

In the province of British Columbia, a peer gatekeeper training program named *Many Helping Hearts* was offered to students in eight schools. While the eight schools already had peer helping programs in place, *Many Helping Hearts* was the first program to offer suicide risk assessment training. Students were trained during two half-day sessions approximately one week apart, and a follow-up session three months later. Training was provided by the Suicide Prevention Information and Resource Centre's coordinator. The skill-based training sessions were based on a variety of training techniques and included: (a) active listening skills, (b) self care and setting limits, (c) crisis theory, (d) signals of suicide, (e) suicide risk assessment, (f) role-play scenarios involving suicidal youth, and (g) community resources. Training was provided to small groups of 13 students.

Results of the study show that this peer gatekeeper training method significantly changed participants' knowledge of suicidal behaviours, and skills and attitudes towards suicide intervention. Peer helpers were evaluated for changes in knowledge, skills, and attitudes toward suicide as a result of suicide-risk assessment training. The study was also used to assess the efficacy for using the SIRI-II evaluation with adolescents.

The evaluation used a repeated measures design, where peer helpers (n=37) were assessed at baseline, immediately after training and 3 months later. Helpers were evaluated for:

- Changes in skill using a modified Suicide Intervention Response Inventory (SIRI-II), that included several open-ended questions assessed qualitatively and added by the research team;
- Changes in attitudes toward suicide intervention using the Suicide Intervention Questionnaire (SIQ); and
- Changes in knowledge using eight true-and-false questions developed by the Suicide Prevention Information and Resource Center in other evaluations.

Pre-test scores differed significantly from post-test and follow-up scores for the skill, knowledge and attitude measures, although positive attitudes towards suicide prevention had declined significantly at 3 months. The report emphasized the need for skill-specific training in suicide risk assessment for young adults; training in general helping skills is not sufficient for suicide prevention in youth. Overall, this

study provided strong support for gatekeeper training of young adults (13 – 18 years) as peer helpers in suicide prevention.

3.7 **School-Based Interventions**

School-based prevention strategies include both universal programs (curriculum-based) and targeted programs (skills training for high-risk individuals). The literature suggests that awareness and education programs aimed specifically at youth have both positive and negative effects when it comes to help-seeking, attitudes, and peer support. Most school-based suicide prevention programs implemented since 1970 are curriculum-based, with a focus on increasing awareness of the problem of adolescent suicide, identifying adolescents at risk, and teaching referral techniques and resources.

Evaluation of curriculum-based programs has found minimal increases in knowledge and attitudes towards suicide remained unchanged or attitudes changed in negative ways (Garland & Zigler, 1993; Hazell & King, 1996). In addition, there is concern that curriculum-based programs do not reach populations at the highest risk for suicide, for example, high-school dropouts (Burns & Patton, 2000). Guo and Harstall (2002) reviewed ten curriculum-based programs and found such problems in methodology that they concluded that “research in the area of suicide prevention for children and youth is considered to be relatively weak” (p 31). Ploeg and colleagues, in their systematic review of nine programs concluded “there is currently insufficient evidence to support school-based curriculum suicide prevention programs” and found that some studies had harmful effects on suicide-related attitudes, hopelessness, and coping skills (Ploeg, et al., 1996 quoted in Guo & Harstall, 2002, p. 33).

Several other evaluations found negative effects in these programs with a targeted audience of general high school students, but some effectiveness with “at-risk” students. It also appears that developing programs to reduce risk factors is less successful than programs aimed at increasing protective factors.

It is generally conceded that a multi-pronged approach to suicide prevention that incorporates curriculum-based programming within schools as well as community-based programming is most effective (e.g., Advisory, 2003; Stuart, et al., 2002). *Community Helpers*, as noted earlier, is based on a school-based peer helping program. As a community-based program, the expectation is that it will provide services to at-risk populations, such as school-drop-outs, that school-based programs may exclude. It incorporates and expands upon the *Natural Helpers*® program that focused primarily on developing helping skills, social bonds and abilities to make appropriate referrals within a school environment to include specific instruction on mental illness and suicide, particularly the warning signs that require immediate attention and/or referral.

SECTION 4: FORMATIVE EVALUATION

Program Implementation and Delivery: Best Practices

Each section summarizes recommended practices as identified by the authors reviewed in this report regarding program implementation and delivery. Formative evaluations are undertaken to “help form” the program by “examining the delivery of the program or technology, the quality of its implementation, and the assessment of the organizational context, personnel, procedures, inputs, and so on” (Trochim, 2006). The following discussion of program implementation and delivery best practices includes: program implementation planning; personnel; organizational structure; screening and selection of helpers; training; establishing on-going support of both coordinators and helpers; and communications.

This section also identifies best practices, as exemplified by the American National Association of Peer Programs (NAPP) Rubric (www.peerprograms.org). This is a tool for evaluating peer-helping programs. NAPP also certifies programs that meet specific criteria including meeting the standards in this rubric. The Rubric rates each program component for each standard on a 4-point scale and provides component-specific definitions for each of the ratings: advanced (3), proficient (2), basic (1), and below basic or does not meet standard (0). Scores of “proficient” and “advanced” are both acceptable, but any component below “advanced” needs improvement. Not all components apply and when this is the case, no numeric value is assigned. The sub-sections that follow use the definitions for “advanced” programs.

Another source of best practices is the Canadian Peer Resources Network, described as “a non-profit, education corporation, specializing in the development of peer, coach and mentor programs” (Peer Systems Consulting Group Inc., 2008), and the administrative body for the North American certification board, the National Certification Review Panel. A third source is the framework developed by the Centers for Disease Control (CDC) for evaluating public health initiatives (Milstein, et al., 2000).

The Community Helpers program is a unique program. The program asks youth to identify both youth and adults that they turn to in times of need, and then trains the identified helpers, both peers and adults. Approaches differ, with some more peer specific in their focus and consequently in the tools developed. While these tools have been identified as the most appropriate to guide formative evaluation strategies, for, it is recognized and acknowledged that not all components will fit with the unique characteristics of the Community Helpers program.

Each sub-section ends with recommendations for the program, if applicable and/or recommendations for the evaluation.

In general, the *Community Helpers* formative evaluation would assess the following implementation and delivery standards using document reviews and key informant interviews with items generated from the following discussion. Where there are suitable and available instruments useful in evaluating the implementation and delivery of *Community Helpers*, these will be named after the recommendations. The instruments are described in Section 6: Summary of Existing Tools and Processes.

4.1 **Program Implementation Planning and Commitment to Program**

Program Implementation Planning

The NAPP standard suggests that program implementation planning include a rationale based on a needs assessment; clear statements of the purpose, goals and objectives of the program; and procedures that are consistent with these.

Community Helpers has clear statements of the purpose, goals and objectives, and procedures of the program. It forms part of the implementation of *A CALL TO ACTION: The Alberta Suicide Prevention Strategy*, and is intended to reduce suicide and suicidal behaviour by strengthening community capacity. It identifies and supports community members or “natural helpers” that youth already access when experiencing a mental health problem. Such helpers are identified through a nomination process where youth are surveyed and asked to name two people from their social support network to whom they already turn or would consider turning to in times of need. The program provides these helpers with an introduction to mental health issues, including suicide, and expanded helping skills.

Its objectives are to:

- Reduce stigma attached to accessing mental health services or other suicide prevention supports.
- Provide a model for community capacity building around the issue of youth mental health promotion that serves to promote and maintain individual and community wellness.
- Increase awareness of appropriate treatment services for youth and young adults at risk of suicide.

Recommendations for Evaluation:

The *Community Helpers Initiative* should:

- Identify the rationale of the *Community Helpers Initiative* for each site.
- Develop a Logic Model and Evaluation Framework.

Commitment to Program

Engaging stakeholders is a necessary part of program implementation planning. Having committed stakeholders contributes to the program’s sustainability. It is an essential first step in the *Community Helpers* implementation and a core component of community capacity building (Braun, et al., 2003). Involving stakeholders encourages ownership of the program (Robinson & Morrow, 1991) and of the process of confronting local issues and resolving them (Braun, et al., 2003).

Three broad stakeholder groups can be identified in the *Community Helpers* initiative: those involved in program support, those involved in program operations, and those affected by the program. Each member of the stakeholder group has specific roles.

Those involved in program support include:

- Alberta Health Services: provide formal technical resources and funding.
- Alberta Health Services: provide legal and technical assistance; for example, the nine geographically-based health regions that are now a part of Alberta Health Services are the signing authority for contracts with AHS and may provide help to the community-based agencies for building networks with other agencies.

- Life-Role Development Group Limited: provides training to the Program Coordinators in the *Community Helpers* model.

Those involved in program operations and/or are affected by the program include:

- Pilot sites (community-based youth serving agencies) for *Community Helpers*: provide the program with a dedicated coordinator, access to training facilities and materials, resource materials relevant to the community's needs and support from the community in the guise of helping to establish linkages with other community-based agencies.
- Community-Based Agencies: provide helping resources (e.g., may be recipients of referrals from *Community Helpers*); may provide personnel for community advisory committees and/or community capacity building and/or as presenters at *Community Helpers* training sessions.
- Program Coordinators: provide training and ongoing support to the helpers based on the training program developed by Life-Role Development.
- Youth *Community Helpers*: provide help and guidance to members of the target population, which may include youth at risk for mental health problems and/or suicide.
- Adult *Community Helpers*: provide help and guidance to members of the target population, which may include youth at risk for mental health problems and/or suicide.
- Community Advisory Groups: organized by the program coordinators with the help of their agencies and geographically-based health regions now part of Alberta Health Services. May include members from community-based agencies, youth, and other interested stakeholders. CAGs may assist in reaching the target group, may participate in portions of the training, and help ensure the program's sustainability.
- Community Service Providers: the professional helping resources who provide additional services on the recommendation/referral of the *Helpers*; e.g., local hospitals, mental health care centres, health care centres, and health care professionals (general practitioners, psychiatrists, psychologists, mental health therapists). Members of this stakeholder group may be involved in program operations by presenting materials during training sessions or volunteering for advisory groups. They are also affected by the program.

Those affected by the program but not involved in program operations are:

- Community of Youth: the recipients of the help.

Best Practice Model: National Association of Peer Programs Rubric

Program commitment is evidenced by a consistent and active involvement by program administrators, community supporters, program staff, and advisory committee members. It also entails identifying financial and logistical resources. Its components include:

- Full administrative and community support.
- Advisory committee whose members:
 - promote and support program ownership by staff;
 - reflect the community's ethnicity, gender, age, religion, and occupations (e.g., business/industry, academia, social services and government).
- Program funding for logistical support and implementation to include curricular and training resources.

Community Helpers has secured funding in place for logistical support and implementation and provides training to program coordinators to create an advisory committee, engage in other community capacity efforts, and implement the program at the local *Community Helpers* pilot site locations. Plans for program sustainability should be clearly identified along with the costs for operating the program (Robinson & Morrow, 1991). Stakeholder engagement is expected to increase as programs move from implementation to establishment/sustainability.

Recommendations for Evaluation:

The *Community Helpers Initiative* should collect information to:

- Assess the understanding and accuracy of roles and responsibilities of various stakeholder groups.
- Assess administrative and community support.
- Assess promotion and support for the program from the Advisory Committee (if used).
- Assess adequacy of funding.

4.2 **Personnel**

Natural Helpers® identifies qualifications for trainers and trains them in a 1-day course (Michigan State University Extension, 2008). Program developers of other peer helping programs discussed in this report also indicated trainer instruction was a key component of their program.

With regard to the pre-qualifications, a study of *Natural Helpers*® in Washington State in 1992-1993 demonstrated higher rates of suicide in programs supervised by non-counsellors compared with those supervised by school counsellors. The authors point out that this could be explained by factors associated with school demographics and/or funding levels, but they also indicate the lack of attention in the academic literature concerning the qualifications of trainers (Lewis & Lewis, 1996). The training models for Mental Health First Aid and ASIST are both “train the trainer” models as is *Community Helpers*: trainers are trained by skilled mentors and trained over a 5-day course. Both identify qualifications for trainers and have a certification process. The NAPP has specific standards regarding the qualifications of the trainers/coordinators.

Best Practice Model: National Association of Peer Programs Rubric

- Program Staff Qualifications:
 - Certified by the National Certification Review Panel, a North America-wide organization.
 - Demonstrate a positive rapport with population from which peers are selected;
 - Demonstrate a commitment to the peer program philosophy, and personal and professional standards of behaviour.
 - Familiar with different learning styles to include experiential and didactic.
 - Experienced in leading groups.
 - Mastery of training and supervision concepts and skills.

Recommendation for Evaluation:

The *Community Helpers Initiative* should:

- Assess and document the requirements for *Community Helpers* coordinators/trainers.
- Assess that training has been successfully completed.

- Coordinators agree that training materials are effective and useful. Training materials include manuals, handouts, and training sessions.
 - Coordinators understand community engagement processes.
 - Coordinators understand and can implement recruitment strategies and training for Helpers.
 - Coordinators have a structure in place to provide on-going support to Helpers.
 - Coordinators have adhered to the *Community Helpers* model.
- Coordinators have on-going support as provided by Life-Role Development and the provincial *Community Helpers* coordinator.

4.3 **Organizational Structure**

The NAPP standard with respect to the organizational structure is that the program has a clear structure, with clear lines of authority, responsibility, and communication that reflect the nature and purpose of the program. It is expected that this will be part of the contracts between AHS and the nine geographically-based health regions that are now a part of Alberta Health Services, and between the nine geographically-based health regions that are now a part of Alberta Health Services and Community-Based Youth Serving Agencies.

Helpers are part of this organizational structure. However helpers are recruited (see following sections), their roles and responsibilities should be clearly identified.

Recommendation for Evaluation:

The *Community Helpers Initiative* should:

- Assess and document the organizational structure, including the lines of authority, roles and responsibilities, and communication among partners and within agencies.

4.4 **Screening and Selection of Community Helpers**

Helpers are identified by nomination of their peers. Other helper programs have used other identification methods, all but one (Bishop, et al., 2002) by design. These included:

- Program coordinator identification (Bishop, et al., 2002);
- Recommendations from adult stakeholders (e.g., advisory groups, management, teachers) to ensure all social networks are included;
- Self-identification;
- Formal application process with preset criteria and a clinical interview.

Froh (2004) pointed out that the peer nomination process is valid, with congruence between peers nominated by students and teachers. Tessaro and colleagues (2000), in their North Carolinian study of working class women, suggested the higher than expected numbers of helpers was due in part to multiple identification methods. Bishop and colleagues (2002) described how a peer helping program deviated from recruitment plans because not enough lay helpers were being identified. D'Augelli and Vallance (1982) also experienced problems with recruiting lay helpers. Both the latter were community-based

helper programs, as is *Community Helpers* and it is possible that *Community Helpers* may experience a similar challenge.

Another challenge identified by Bishop and colleagues (2002) was inappropriate identification: some women who were trained did not have the characteristics of a natural helper. Lenihan and Kirk (1990) describe the identification process of their college peer helpers as including a formal screening process. The NAPP standards are silent on the nomination process, but have outlined standards for screening and selection of peer helpers.

Best Practice Model: National Association of Peer Programs Rubric

- Screening includes ascertaining the following about the applicant:
 - Concern for others;
 - Trustworthiness;
 - Helping attitude;
 - Emotional stability;
 - Effectiveness as a role model;
 - Understanding of the types of services to be provided;
 - Commitment to the program services offered;
 - Ability to converse and be sensitive to the population served;
 - Active listening skills;
 - Manageability of groups (not applicable to *Community Helpers*);
 - Possession of exemplary citizen qualities.
- Established selection criteria is distributed and include:
 - A formal application is required that clearly explains the purpose of the program, requests information based on specific selection criteria, and requires written recommendations;
 - Structured interviews are conducted to ascertain whether the applicant possesses helping characteristics and skills; is emotionally stable; understands, is committed to and available for provision of services to be provided; is able to be reflective of and sensitive to the population to be served; can effectively manage groups (may or may not be applicable to *Community Helpers*); and
 - Peers are required to demonstrate helping characteristics and skills.

Recommendations for Evaluation:

The *Community Helpers Initiative* should:

- Implement multiple strategies for recruiting Helpers⁵.
- Add a descriptor of the “ideal” helper to the Nomination Survey, for example, “Are there a couple of friends you trust, that you know are concerned about others, who help out when they can and are a good listeners? If you think, they’d be interested in helping others...” These are 4 of 11 characteristics of peer helpers identified above; others could be incorporated as per either the recommendation of AHS and/or Life-Role Development.

⁵ It has been over a decade since the *Community Helpers*’ model was implemented in West Carleton. In that period, the not-for-profit sector has been struggling to encourage volunteers to give of their time. Although Helpers are not volunteers in the traditional sense of the word (e.g., they do not volunteer themselves but are “volunteered” by others in a nomination process), they also are not paid employees. A single recruitment strategy, as used in the West Carleton model and in the original *Natural Helpers*®, may no longer be sufficient to attract enough Helpers.

- Include a self-declaration by the helper that he/she has no criminal or child welfare record, with approval of wording from legal counsel.
- Remind/apprise pilot sites that they can request police checks and/or letters of recommendation at their discretion.
- Include a formal application and a formal or informal interview process.
- Assess screening and selection process of helpers.

One of the desired characteristics, possession of exemplary citizen qualities, may exclude the very population *Community Helpers* seeks to connect with, as might including a self-declaration or requesting security checks or letters of recommendation. As a balance needs to be struck between protecting youth and reaching marginalized youth, the advice of legal counsel should be sought.

4.5 **Helpers' Training**

All the helper programs identified in this literature review provided training in helping and listening skills, decision making and problem solving, information about community resources and referral processes, and specific disorder/disease-related knowledge. A key component is the emphasis on self-care. Training length was relatively consistent, with most programs providing approximately 25 hours of training. *Natural Helpers*® or modified *Natural Helpers*® compacted this training in a retreat format. In the Sprinthall and colleagues (1992) study of peer counselling for students experiencing divorce, training extended over a school semester. Follow-up sessions were evident in all the peer programs reviewed. The NAPP provides specific aspects what training should include.

Best Practice Model: National Association of Peer Programs Rubric

- Program training provides peer helpers with the knowledge and skills needed to be effective in peer helping roles. Training should include instruction on:
 - Confidentiality and Liability Issues:
 - A recognized code of ethics;
 - Recognition of potential threats to safety and well-being
 - Awareness of ethical and legal limitations and responsibilities;
 - How to report potential threats to personal safety or the well-being of peer helpers, helpees, and others;
 - Listening and Communication Skills:
 - Active listening skills to include verbal/nonverbal and facilitative responding skills;
 - Issues related to cultural diversity;
 - Problem-Solving and Decision-Making Skills:
 - Problem solving and decision making skills;
 - Mediation techniques;
 - Additional Issues and Topics:
 - Motivational and reinforcement principles of behaviour change;
 - Social and cultural influences and differences;
 - Crisis management and conflict resolution;

- Special needs populations;
- At least 1 detrimental social, emotional, biological, and/or developmental issue impacting youth (e.g., substance abuse, venereal disease, gangs, or family relations);
- Referral resources, services, and programs;
- Training is specifically tailored and/or designed to address the nature and goals of the program:
 - Appropriate and relevant to population served;
 - Regularly scheduled teaching/training sessions;
 - Consistent and progressively sequenced from basic to advanced;
 - Uses a variety of effective, interactive, experiential teaching techniques;
 - Provides essential information about referral resources and services.

Community Helpers provides a comprehensive training program similar in intensity and delivery with other peer and other helper models. It provides training in helping, communication, problem solving and decision making skills that form the core of peer helping programs. It also provides disorder-specific information on mental illnesses and suicide as well as information on community resources and referral processes, and ethics and confidentiality. Additionally, it incorporates life skills training on issues such as career choice, which build individual capacity and resilience. As with other peer helping models, a key component is the emphasis on self-care. It incorporates most or all of the NAPP criteria for peer training and prepares individuals for their roles as helpers.

Recommendations for Evaluation:

The *Community Helpers Initiative* should:

- Assess the adequacy of training through a review and external evaluation of training modules and other training material.
- Develop a referral log for the helpers.

4.6 On-Going Support and Supervision

On-going support of *Community Helpers* coordinators is not discussed in the NAPP Rubric.

All peer helping programs incorporate on-going support; for youth-specific peer helping programs, on-going supervision is also incorporated. One of the objectives of youth peer helping programs is to form new networks of support for both the helpers and the helpees. Aaby (1987) pointed out that any dissatisfaction expressed with Natural Helpers® was with the lack of follow-up sessions. It is also through these sessions that self-care is reinforced and bonds between helpers and between youth and adults are nurtured. Robinson and Morrow (1991) recommended that support be provided for youth helpers because they also face the same uncertainties as the peers they help.

Although the literature on youth-adult partnerships is currently sparse, Jarrett and colleagues (2005) identified three stages in the development of positive relationships between youth and adults in which structured opportunities played a key role. Robinson and Morrow (1991) recommended that tasks and projects completed in collaboration with peer helpers enables them to practice their communication skills, but, less formally, when people work together, they become acquainted. The NAPP standards also include

criteria regarding structured opportunities to provide on-going support as well as standards regarding supervision.

Best Practice Model: National Association of Peer Programs Rubric

- Programs will include a variety of structured opportunities to engage in meaningful, productive, helping roles to assist the population served. Components include:
 - Practice sessions for helpers to apply the knowledge and skills acquired during training;
 - Practice critiquing conflict resolution in de-briefing sessions following specific events;
 - Enable support systems to be in place for helpers;
- Programs will provide regularly scheduled, continuous support to and supervision of helpers. Program staff:
 - Monitor, guide, and/or assist helpers and provide supplemental supervision and support as needed;
 - Put safeguards in place to protect helpers from burnout, role confusion, inappropriate assignments, or helpee manipulation.

Community Helpers is anticipated to be delivered over a number of weeks rather than use the retreat model. As such, structured opportunities for interaction among youth helpers and between youth and adult helpers, as well as ongoing support are built into the delivery of the program. As already noted, *Community Helpers* follows best practice in reinforcing the notion of the personal limitations of helpers, emphasizing self-care.

However, a key component of *Community Helpers* is its responsiveness to local needs. It is possible, therefore, that some communities may chose the retreat model. In this case, other structured opportunities will need to be developed. In particular, regularly scheduled de-briefing sessions would need to be considered.

Recommendations for Evaluation:

The *Community Helpers Initiative* should:

- Encourage communities to offer training over a number of weeks or months instead of in a retreat format.
- Encourage ongoing contact, training and support to helpers.
- Design practice sessions, including role-playing sessions.
- Provide ongoing support and implement safeguards to protect from burnout, etc.
- Assess opportunities to practice skills, and reinforce the level of on-going support, including de-briefing opportunities and other safeguards.

4.7 **Communications**

The *Community Helpers* initiative is promoted both via the internet (www.amhb.ab.ca) and in print brochures, available in public and mental health clinics. The *Community Helpers* program guide suggests it requires no promotion, but D'Augelli and Vallance (1982) found that despite “three years of publicity and activities” (p. 208), less than 10% of their targeted population (residents of two small rural communities) knew of their peer helping program.

Recommendations for Evaluation:

The *Community Helpers Initiative* should:

- Provide support to community agencies, if required, in posting information about *Community Helpers* on agency websites.
- Add links from www.albertahealthservices.ca to community agencies offering *Community Helpers*.
- Assess adequacy of resources for promotion at the community level.

SECTION 5: SUMMATIVE EVALUATION

Summative evaluations consider whether the program attained its objectives. The objectives of the *Community Helpers* program: (1) reducing stigma attached to accessing mental health services or other suicide prevention supports; (2) providing a model for community capacity building around the issue of youth mental health promotion that serves to promote and maintain individual and community wellness; and (3) increasing awareness of appropriate treatment services for youth and young adults at risk of suicide.

Several evaluation designs exist to guide summative evaluations. Studies reviewed in this report used comparison studies with and without a control group.

Methods

Quantitative methods use instruments for which a numeric value is attached to pre-determined choices; these values are scored and the scores can be manipulated using statistical analysis. The designs most effective at determining whether a change in scores is a result of an intervention use an experimental and a control group. If the intervention is effective in obtaining its objectives, the experimental group only should show improvement in their scores and a reasonable assumption can be made that the improvement is due to the intervention. Implicit in this is that instruments are administered at the start and end of an intervention. Two quantitative designs, the randomized controlled trial and pre-/post-intervention testing are briefly described below.

Qualitative methods use semi-structured interviews and/or observation. They are often used in studies of marginalized or hard-to-reach populations. Data analysis identifies general themes among participants in the interview.

Quantitative Methods

Randomized-controlled trials (RCTs) are referred to as “true experimental designs.” RCTs involve the random allocation of participants to the intervention or to a control group. Randomized allocation ensures individual idiosyncrasies are distributed similarly between the groups, and as such, limit the effect of alternative or extraneous factors on the outcome. Outcomes on variables are measured and compared between the experimental and control groups. Any differences between the experimental and control groups are attributed to the effects of the intervention, with the proviso that extraneous variables have been controlled for, a difficult criteria to adhere to outside of a controlled situation. Quasi-experiments approximate RCTs but do not require randomized allocation to the experimental and control groups. Instead, they attempt to statistically control for extraneous factors.

A hypothesis for *Community Helpers* could be that helpers who complete the training have increased skills in helping, increased knowledge of mental health and suicide, and more enlightened attitudes towards mental health and suicide than helpers who do not complete the training. Since helpers are nominated and chose to undertake the training, no random allocation of helpers to a control group is possible. Furthermore, there are serious ethical considerations that render randomization unlikely. A quasi-experimental design is possible, however.

Pre-test/post-test designs measure changes over time. The strongest design includes a control group that complete the same measures as the experimental group. As with the RCT and quasi-experimental designs, a control group offers evidence that the intervention is what “caused” changes in scores between pre-

intervention and post-intervention. The evidence is not as strong as in either the RCT or quasi-experimental designs, but much stronger than if no control group was used.

Strengths of the pre/post design include:

Assessing helpers when they first enter training establishes a benchmark against which to measure change.

- Pre-testing is especially helpful for measuring knowledge or cognitive learning or skills.
- Pre- and post-testing can be easily scored.
- Pre- and post-testing can be relatively easily analyzed using statistical procedures.

Weaknesses include:

- Pre-/post-testing offers little useful information if helpers know little or nothing about the subject matter.
- Deciding how to develop meaningfully comparable pre- and post-testing is difficult, since the pre-test may have to be so basic that any additional learning could be seen as “growth.”
- If the evaluation is not based upon a highly structured curriculum where the objectives are taught toward and adhered to across all sites in a systematic way, it may be difficult to demonstrate cause-effect between training and improved skills, knowledge, and attitudes.

Both objective 1 and 3 above could be assessed using a quasi-experimental design or pre-/post-test with a control group design. The nomination process may discover more natural helpers than can be trained and/or not all helpers who are identified may choose to participate in the training. In both cases, a naturally occurring control group may exist. Reducing stigma is possible by dispelling inaccurate attitudes and increasing knowledge. Several instruments assess attitudes toward and knowledge about mental health and suicide. These would be administered at or near the beginning of training for both participating and non-participating helpers and near or at the end of training. Participating helpers should display more positive changes in attitudes and knowledge than non-participating helpers.

The third objective is to increase awareness of appropriate treatment services. A knowledge questionnaire about community and provincial mental health services could be constructed by Malatest in cooperation with each site (because local resources vary) and administered before and after training. Again, participating helpers should display increased awareness compared to non-participating helpers.

If a control group of non-participating but nominated helpers is unavailable or infeasible, a pre-/post test design without a control group is the remaining option. Changes between pre- and post-test may or may not be evidence of effectiveness.

Limitations

A randomized control trial of *Community Helpers* is not possible. The key characteristic, random allocation of participants to the “intervention” and to a control group, can not be obtained in this program.

In school-based evaluations of Natural Helpers®, schools without the program were compared to schools with the program. For example, both the Michigan State University Extension (2008) evaluation and Froh (2004) used this kind of comparison to determine whether the Natural Helpers®, program made a difference in school climate.

However, *Community Helpers* is community-based and without a similar or “bounded” population from which a comparison group could be chosen. As noted above, a comparison group could consist of those

nominated as a helper but who declines the training. At the community level, at least one outcome (community-level suicide rates) for the pilot sites could be compared with similar communities for which no *Community Helpers* program currently exists. The communities should be matched on key demographics such as population size and composition, presence/absence of a community-level suicide prevention program, presence/absence of a strong spiritual community (number of religious organizations per capita) and estimations of community capacity; this is likely not feasible for *Community Helpers* coordinators to do given their constraints of time, funding, and knowledge.

Community Helpers is also a new program, developed specifically for Alberta and for mental health promotion and suicide prevention. It is based on school-based peer helping groups, but is community-based. This difference is sufficient to consider it a new program as the targeted population is somewhat different: youth-at-risk in the community as opposed to youth-at-risk in the school. As such, and given the above limitations, recommendations are for a mixed methods, quantitative-qualitative study. Specifically, the nature of the help that is offered through the program could be assessed via qualitative interviews with interested helpees. Only the Michigan Natural Helpers® examined this aspect of the program using an instrument based on the evaluation instruments used in the original Natural Helpers® and focus groups. Reaching the helpee population in a community, however, poses different challenges. Recruitment of helpees would be accomplished with the help of the helper and/or by publicly posted invitations to participate in this aspect of the evaluation.

The table below indicates what is measured using what types of tools from which stakeholder group.

Table 5.1. Information Sources and Measurement

Source of Information	What is Measured	Tools
Helpers	Changes in skills	Helpers' Logs – types of help given Role-playing – style of help given using coding of role-playing sessions or via a standardized instrument like the SIRI
Helpers	Changes in community capacity	Helpers' Logs – types of referrals made Social Network instrument
Helpers	Changes in knowledge	Mental Health Knowledge Instrument Suicide Knowledge Instrument
Helpers	Changes in attitudes	Suicide Attitudes Instrument
Helpees	Type of help	Brief interview or survey
Coordinators/trainers	Awareness of community resources	Social network instrument
Coordinators/trainers	Capacity building	Community Capacity Tool
Coordinators/trainers	Changes in knowledge	Mental Health Knowledge Instrument Suicide Knowledge Instrument
Coordinators/trainers	Changes in attitudes	Suicide Attitudes Instrument
Service providers (e.g., professional helping community)	Awareness of community resources, including awareness of <i>Community Helpers</i>	Social network instrument (brief/modified)

Measurement of outcomes would be undertaken by *Community Helpers* coordinators in the summative phase of the initiative, with analysis and reporting conducted by the AHS.

The Summary of Existing Tools and Practices will describe the data collection instruments and methods in more detail. But, in brief, the Helper’s Logs would provide ongoing data regarding the types of help given, including what referrals were made for what type of problems. These could be maintained on weekly or monthly time periods and submitted at regularly scheduled training and/or support sessions; helpers could also be requested to spend the first ten minutes of a session completing these. Program effectiveness could be assessed as the increase in referrals or in number of youth helped between the start and end of training.

The style of help provided by the helpers could be assessed in two ways. One is by observing a role-playing session. Role-playing sessions include two helpers, one of whom assumes the role of “helpee” and speaks with the “helper” about a personal problem. The responses of the “helper” would be categorized as per the “Helping Skill Verbal Response System” (see Table 5.2, D’Augelli and Vallance’s (1982). This is time-intensive but, as D’Augelli and Vallance indicate, possibly the most reliable method to assess the type of help given, with the exception of actually observing an interaction between helper and helpee. The latter is fraught with potential violations of the individual’s right to privacy and a logistical problem of actually being able to observe what are essentially informal interactions held outside of a facility that would have an observation room.

Helping Skills Verbal Responses	
Response	Definition
Continuing Responses	Statements that summarize the content of the helpee’s remarks.
Content	A statement which summarizes or reflects the content of the prior statement or statements.
Affective	A statement in which the helper reflects a feeling which the helpee has not yet labeled.
Leading Responses	Statements that direct the helpee
Closed questions	Questions that can be answered “yes,” “no,” or with one or two words
Open questions	Questions that cannot be answered “yes,” “no,” or with one or two words
Influence	A statement used to change the attitudes, beliefs, and indirectly, the behavior of the helpee.
Advice	A statement that provides an alternative mode of behavior (actions or thoughts) for the helpee
Self-Referent Responses	Statements concerning the helper
Self-involving	A statement of the helper’s personal response to statements made by the helpee
Self-disclosing	A statement of factual information on the part of the helper about him/herself

A second, and more viable, method for assessing type of help given is to use a standardized skills assessment instrument, such as the SIRI. This instrument posits hypothetical scenarios between a help-line counsellor or para-professional and a caller and provides possible responses. Improvements in scores between pre- and post-training would be an indication of effective training. Interviewing helpees would provide an additional source of information about the effectiveness of the help. Multiple sources of data are a recommended best practice of both qualitative and quantitative methods.

The Formative and Summative Evaluation Frameworks will identify specific outcomes, describe in detail the proposed indicators of these outcomes as well as the methods and data sources that will form the basis of the data collection plan. Specific instruments will be described in the Report of Evaluation Tools and Processes, part of the evaluation work plan.

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