Upstream Suicide Prevention Methodology for Schools through the Hidden Power of Social Networks

A Winston Churchill Memorial Trust funded learning experience to Canada and the United States – June 2015.

Dr Tim Andersen

New Zealand

Report submitted: 29 February 2016

Acknowledgements:

I would like to express my sincere thanks to the following people and organisations for their support of my Winston Churchill Memorial Trust learning experience:

- **Professor Annette Beuatrais**: University of Canterbury
- **Marilyn Bruguier Zimmerman**: Director of the National Native Children's Trauma Centre – University of Montana
- **Dr John Frederikson**: Montana Safe Schools Centre - University of Montana
- **Karl Rosston**: Suicide Prevention Coordinator – Montana State
- **Matthew Taylor**: Executive Director of Forefront – University of Washington
- **Heather Stokes**: Vice President of Strategic Development - LivingWorks Education
- **Mark LoMurray**: Executive Director and Founder of Sources of Strength
- **Scott LoMurray**: Deputy Director - Sources of Strength
- **Donnie Wetzel**: American Indian Youth Development Coordinator – Montana Office of Public Instruction
- **Jenny Fowler**: Youth Suicide Prevention Programme with the Confederated Salish and Kootenai Tribes of the Flathead Reservation
- **Alan Woodward**: Executive Director – Lifeline Foundation for Suicide Prevention
- **Tania Papalii**: Programme Lead, Resilience – Northland District Health Board
- **The Onerahi Lions Club** (Generous donation to my travels)
- **The Ministry of Education**

Contents

Executive Summary

This report contains reflections and conclusions based on key learning experiences and new connections that I made through a Winston Churchill Memorial Trust Fellowship to the United States and Canada in June 2015. The purpose of my visit was to seek a deeper understanding of the land scape surrounding school based suicide prevention in communities with high proportions of indigenous youth.

My travel itinerary involved visits to three locations, *The World Congress on Suicide Prevention* in Montreal Canada, attendance at a *Sources of Strength* train the trainer event in Denver Colorado, and work with the *Safe Schools Programme* and the *Native Children's Trauma Institute* at the University of Montana.

Through interaction with the above experiences, and the generous people who gave me their time, I gained valuable learning experiences to inform school based suicide prevention in New Zealand. Importantly I discovered a new way forward to support a more proactive response to school based suicide prevention – that described as 'upstream suicide prevention' which is captured in Sources of Strength methodology.

I discovered a powerful intersect between upstream suicide prevention methodology and the hidden power of social networks to positively influence norm behaviour amongst youth through the notion of connectedness. The dynamic has strong potential to create a contagion of hope, strength and help seeking behaviour amongst social networks, which differs from suicide contagion which has negative and fearful connotations.

Connectedness within a school context is associated with an increased likelihood of positive wellbeing outcomes for youth. Promoting school connectedness as a proactive suicide

prevention strategy to reduce risky behaviours, including suicidal behaviours is what I recommend we put more emphasis on within the New Zealand education context.

Personal connections made through this venture are many and varied. New networks and relationships were developed across all phases of my itinerary and have remained active since my return to New Zealand. An example of this lies in my connection with Mark and Scott LoMurray from Sources of Strength. This relationship facilitated a visit from Mark and Scott to New Zealand in early 2016 which allowed them to share the Sources of Strength Methodology with a multi-agency group in Whangarei which was very well received. My relationship with key people from the University of Montana like Marilyn Bruguier Zimmerman and Dr John Frederickson provide important points of reference for the future. A connect with Alan Woodward - Executive Director of Lifeline Foundation for Suicide Prevention in Australia provided access to interesting research on a school based suicide prevention approach using SafeTALK methodology.

New connections like those described above have provided me with strength, hope and a new perspective for the future as I continue to engage in this important work. Prior to my travels a long engagement with reactive suicide prevention approaches frustrated me because operating in accordance with a risk response methodology felt like I was always waiting for the next tragedy to intervene. I sought a new way of thinking and operating in the field of school based suicide prevention and I have found something that excites me. I see strong potential for the implementation of upstream school based suicide prevention methodology in the New Zealand education context.

Introduction

The 2012 year started in a typical sort of way for me in my role with the Ministry of Education in Northland, New Zealand - the hopes and dreams for a good year to follow. I was in my third year as District Manager at the Ministry of Education – Special Education, a government department funded to provide support to schools and early childhood facilities for students with special education needs. The agency and services I was responsible for was situated in the Te Tai Tokerau region, a geographical area in the very north of the North Island of Aotearoa New Zealand (NZ). While the Tai Tokerau region is known for its beauty, rich culture and history, it is also one of the most economically deprived areas in NZ with a disproportionate number of health, social and educational problems.

One of the services my staff and I were responsible for was the delivery of support to schools who encountered 'traumatic incidents' (Ministry of Education, 2010). These are unplanned events like accidents or natural disasters that disrupt the operation of a school (Brymer, Pynoos, Vivrette, & Taylor, 2002). Little did I anticipate that in 2012 the Traumatic Incident service would be called on to support schools with trauma related events, more severe and intense than the district had ever encountered before. One of the major trauma events that schools and the surrounding community encountered in 2012 was a wave of imitative at risk behaviour known as suicide contagion (Erbacher, Singer, & Poland, 2014) which spread amongst youth, many of whom were still attending school, and contributed to a cluster of deaths by way of suspected suicide. The 2012 academic year also saw the emergence of a number of significant sexual abuse disclosures within the schooling sector. The 2012 academic year was one of the most emotionally taxing periods of my career to date.

The emergence of two suicide clusters tracked a pathway of anxiety, trauma and grief across communities in Tai Tokerau. At the time I described the emotion and unpredictability of the

events as comparable to a marauding dragon with its head cut off – an uncontainable beast that arose again and again after multiple attempts to slay it. While seemingly managing suicide risk in one part of the community – it would suddenly arise in another. In total 19 youth between the age of 10 and 25 died by way of suspected suicide in 2012 - 9 were aged 17 years and under. In addition to those who died, there was also a related spike in serious suicide attempts and other suicidal behaviour, in particular amongst Māori who are indigenous to Aotearoa New Zealand (Northland District Health Board, 2015).

Not being absolutely sure how to respond to the events described above, local government and non-government groups met to discuss a response. Something needed to be done to stem the flow of risk and death. A collaborative response was initiated by a small group who represented local Police, Education, Mental Health, Social Services and Māori health providers. The inter-agency group initially used genograms to identify and track contagion across communities and manage risk through sharing information and apportioning local support. After a short period of time the Ministry of Health provided funding for a local Suicide Prevention Co-ordinator, initially for one year– this person joined the group. As an observer I had never witnessed cohesive collaboration and information sharing like it in my local community. The disappointing aspect was that it took a series of tragedies to motivate this level of response.

Although it is not the purpose of this report to tell the story of how this suicide prevention response evolved and its related outcomes, it is important to note that the inter-agency group and process now referred to as FUSION remains in place to this day, and operates within the context of the Te Tai Tokerau Suicide Prevention Plan (Northland District Health Board, 2015). The Fusion group, of which I am now a permanent member, shares and responds to information relating to suicide risk within the Tai Tokerau community daily, and has strong governance over it to ensure its accountability and sustainability. The rates of youth suicide

have reduced in the area although it would be unwise to attribute this solely to the FUSION response as causal relationships to the reduction in deaths are many and varied.

A global phenomenon

Suicide is a global phenomenon. Over 800,000 people die by suicide every year. Suicide is the second leading cause of death in 15-19 years olds (World Health Organisation, 2014). Each year approximately 500 New Zealanders die by suicide and many more attempt suicide, hence many people are affected or experience suicide bereavement. New Zealand's youth suicide rate in 2011 was the second highest amongst countries that are part of the Organisation for Economic Cooperation and Development (OECD). Māori youth suicide rates are 2.4 times higher than non-Māori youth. (Ministry of Health, 2016). A visiting expert on teenage health to New Zealand gave a glowing report card, with one exception – the high youth suicide rate. Professor Robert Blum was impressed with New Zealand's approach, but said our high youth suicide rate was not good enough (Rutherford, 2015).

A schools role in suicide prevention

Suicides are preventable and communities play a critical role in suicide prevention, they can provide social support to vulnerable individuals and engage in follow up care, fight stigma and support those bereaved by suicide (World Health Organisation, 2014). Schools are often described as the hub of a community – certainly this is how they have been viewed historically in New Zealand. But where are schools situated in regard to suicidal behaviour?

Schools become directly involved in a suicide response when a student, teacher or related community member is at risk or dies by way of suspected suicide. On this basis schools have a very important role in youth based suicide prevention because youth are legally required to be enrolled at school until at least 16 years of age. By default, and becasue of the law around

school attendance, schools provide a formal set of eyes on a significant proportion of the population, five days a week, 40 weeks of the year. Schools are in a vital position to maintain a close watching brief over the emotional wellbeing of our school aged youth. This notion is supported by the U.S Surgeon General who made the point that "prevention of youth suicide should be addressed where youth spend the majority of their day – at school" (Erbacher et al., 2014, p. 6). Schools with high proportions of Māori students play a particularly vital role in suicide prevention in the NZ context when statistics relating to suicide amongst Māori youth are considered. Schools need to be supported in the field of suicide prevention and should not be expected to engage in this work on their own.

Where this project sits within the context of suicide prevention in NZ

After 2012 I have had opportunities to work in other communities around NZ in the field of youth suicide prevention. These opportunities were largely bought about because of the tragic experiences I had been involved with in 2012. In 2013 I was seconded to the *National Practice Leader – High Risk Issues* role with the Ministry of Education. The role involved advising and supporting the education community across New Zealand in regard to child abuse protocol, vulnerable children, traumatic incident support, and school based suicide prevention. I had the opportunity to speak at a number of conferences on the themes above; more so in the field of school based suicide prevention. I have had the opportunity to work with many schools and community groups, and at a policy and ministerial level. I have delivered many workshops to support the roll out of the school based resource kit – Prevention and Response to Suicide (Ministry of Education, 2013).

My observations from these experiences led me to the conclusion that within the field of school based suicide prevention in New Zealand, the responses generated for schools are largely reactive and within the realm of what is described as 'intervention' or 'postvention'.

A specific suicide prevention response is delivered as a consequence of concerns around a student's wellbeing or as a direct response to a suicidal event. I do not intend to sound critical of this situation because a skilled intervention and postvention response should always be accessible for a community when events like these occur. "The aftermath of attempted or completed suicide is a devastating and sometimes frightening issue, if not handled well, the postvention strategies employed may actually contribute to the spread of suicide, so consideration of best practice is essential" (Youth Line, 2014, p. 1). Within this context the questions that have become important to me are:

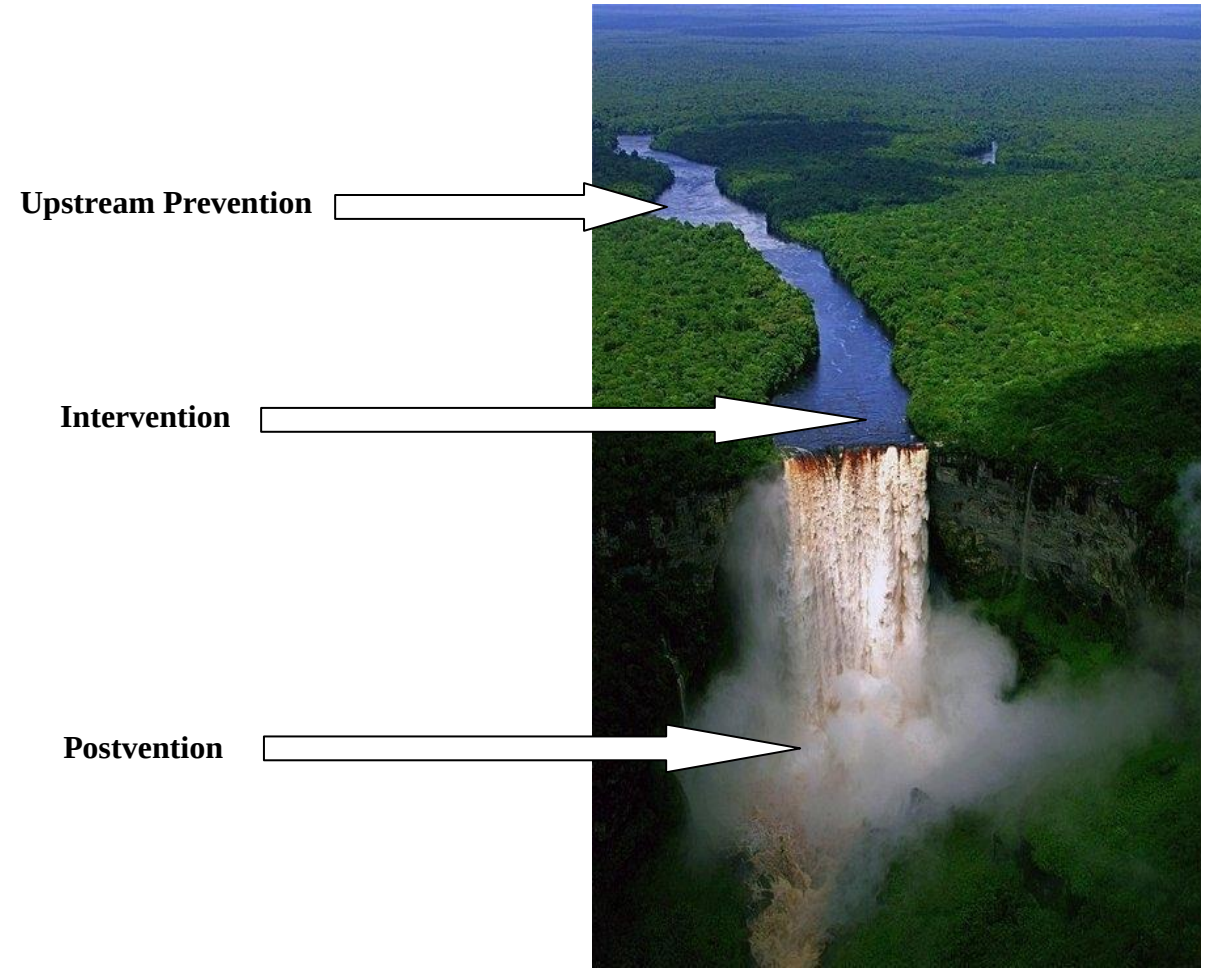
- What does school based suicide prevention look like when it is viewed from a proactive perspective?
- Can school based suicide prevention be more than a reactive response to a suicidal event?
- What is the current thinking around school based suicide prevention for schools with high proportions on indigenous students?

The relevance of the river and the waterfall

Here in lies the relevance of the visual of the river and the water fall on the front cover of this report. The meaning embedded in the visual has been informed by my Winston Churchill Fellowship learning experiences, and in particular the *Sources of Strength* suicide prevention methodology that I learned about while I was away. The visual captures what I now view as the three components of suicide prevention, and where my specific field of interest lies. As illustrated in Diagram 1 below, the water fall represents a *postvention* response to an actual suicide related event – an attempt or death. The rapids and the part of the river before the water fall represent an *intervention* response to an overt risk of a person's involvement in suicidal behaviour. The smooth calm water above the rapids represent *upstream prevention* or the efforts and strategies to instil hope, strength, resilience and help seeking behaviour in

our youth when the ‘waters are clam’ in their lives. Upstream prevention aims to help youth avoid ever needing to engage in the two downstream responses. Upstream school based suicide prevention is where my interest lies.

Diagram 1. Continuum of intervention to suicidal behaviour



The questions that led me to apply for the Winston Churchill Memorial Trust Fellowship (WCMT) are thus associated with wanting to know about what other countries and schooling systems were engaging within the field of upstream school based suicide prevention. The key supporter of my WTMC application was Professor Annette Beautrais from the University of Canterbury, Christchurch, NZ. Professor Beautrais works and teaches in suicide research and prevention and has many contacts that she was able to link me to in order to form an itinerary so I could visit these people, and address my questions of interest.

Travel Itinerary

On being awarded the WCMT fellowship I had the privilege of travelling to the United States and Canada in June 2015. My travel itinerary involved three phases:

I. Attendance at the World Congress on Suicide Prevention in Montreal Canada 16-20 June 2015
II. Attendance at a Sources of Strength train the trainer event in Denver, United States from 23 – 26 June 2015
III. Work with the Safe Schools Programme and the Native Children Trauma Institute at the University of Montana.

The following reflections and conclusions are based on key learning experiences I gained through interaction with the itinerary described above, and the wonderfully generous people who allowed me their time. The learning experiences are referred to throughout the following report which is separated into six parts:

A. Rates of suicide
B. Suicide causality
C. Post-vention as prevention?
D. Upstream suicide prevention – 'calm water' intervention
E. The hidden power of social networks
F. School based suicide prevention for indigenous youth

A). Rates of suicide

The first stop on my WCMT travel itinerary was to the *World Congress on Suicide Prevention* in Montreal Canada 16-20 June 2015. An introductory conference session by Dr Shekhar Saxena, director, department of mental health and substance abuse of the World Health Organisation helped me to understand where suicide sits within the context of other causes of death globally. Dr Saxena shared some interesting but disturbing facts. There is one death by way of suspected suicide every 40 seconds around the world. For each suicide death, there are 20 others that attempt. Death by suicide out numbers that of malaria and breast cancer. Suicide is the second leading cause of death amongst 15-29 year olds, and the leading cause of death for females 15-19 years. 75 percent of suicides occur in low – middle income countries. Decreasing access to methods of suicide (i.e. guns or pesticides) reduces rates of suicide. There is an apparent increase in suicide during an economic crisis in particular amongst males 15-24. Reducing risk will only go part of the way to reducing suicide rates – we must address protective factors. The leading method of suicide is by way of ingesting pesticides, followed by hanging and firearms. Military deaths by way of suicide have outnumbered combat deaths over the past 12 years in Canada. Indigenous people groups, and indigenous males are more vulnerable than others (Saxena, 2015).

Suicide rates amongst indigenous people groups

Relevant literature I was given by Dr John Frederikson of the Montana Safe Schools Centre at the University of Montana revealed alarming rates of suicide amongst indigenous people groups. Statistics for American Indian and Alaskan Native communities show higher rates of suicide than any other race dating back to 1955. American Indian and Alaskan Native suicide rates for ages 19 and under were highest in the Tucson, Aberdeen, and Alaska areas. These areas had rates that were five to seven times higher than overall U.S. rates. Northern areas

such as Aberdeen, Alaska, Bemidji, and Billings all had suicide rates higher than the 95th percentile of all state rates (Barnes et al., 2005). Montreal conference presenter Gerald McKinley (2015) of the Centre for Mental Health and Addictions in Toronto spoke of first nation's communities in Ontario who had experienced a disproportionate burden of suicide in their population under the age of 18. Despite accounting for approximately 1% of the total population in that age group, the first Nations youth of these communities represent over 20% of annual suicides. In the NZ context 2013 data shows that the suicide rate for Māori was 1.6 times the rate for non-Māori or 15.8 deaths per 100,000 Māori population compared to 9.7 deaths per 100,000 non-Māori population. The rates for Māori males and females were 1.4 and 2.2 times the rates for non-Māori (Ministry of Health, 2015).

The relevance of my venture

Dr Saxena's presentation, and the other information presented above reinforced to me early on in my travels the relevance of my WCMT application. The following series of questions and responses became increasingly relevant during the Montreal conference and now provide a simple but strong rational for why this venture and the related report is important for the New Zealand education system, and the district I live:

- Is suicide a major problem globally? *Yes.*
- Who is more at risk than others? *Youth who live in low socio-economic conditions.*
- Which groups specifically? *Indigenous youth - males in particular.*
- Can we prevent suicide? *Yes.*
- Where can we reliably connect with and monitor the wellbeing of our youth to at least the age of 16 year? *School.*
- Is an intervention / postvention response enough on its own to reduce suicide rates? *No* - we must also address protective factors.

In the next section I present further information gathered on my journey that helped me understand some of the causal relationships of suicide that I had not considered before my travels.

B). Suicide causality

Gaining a statistical perspective of the rates of suicide globally as described in the section above is important, but so was understanding more deeply some reasons why people find themselves in such a dark and impossible place that the decision to end one's life becomes a consideration, or indeed an outcome. I am not in any way suggesting that what is described below attempts to define all of the reasons why people make a decision to end their lives. This would of course be impossible - the reasons are many, varied and often unknown. I did however gain access to new information which broadened my perspective on the notion of suicide causality.

Learning about Adverse Childhood Experiences - University of Montana

My encounter with Dr John Frederickson from the *Safe Schools Programme* at the University of Montana deepened my understanding of suicide causality. Dr Fredrickson understood my cause and directed me to many relevant resources – one of particular interest was the Adverse Childhood Experiences (ACE) Study. The ACE study provides an evidenced based perspective on why the life trajectory of a healthy, innocent new born child can end up in such a hopeless situation later in life that death is preferred over life.

The ACE study is one of the largest studies of its kind ever completed to examine the health and social effects of adverse childhood experiences over the life span. It is situated within a growing body of literature that suggests there are universal social and cultural forces that influence suicidal behaviour, such as alcoholism and substance abuse, untreated depression, trauma, and stressful life events (The Adverse Childhood Experiences study, 2016).

The ACE study gathered information from over 17,000 patients participating in routine health screening who volunteered to participate in the study. The data reveals strong evidence of the health, social, and economic risks that result from childhood trauma.

ACEs are factors that children have been exposed to that include recurrent emotional, physical and sexual abuse, substance abuse, and mental illness. The study shows that ACEs are common and are strong predictors of what happens later in life in terms of health risks and disease. ACEs are a leading determinant of a nation's health and social well-being.

The number of ACEs determines a person ACE score. A score of 3 suggests that the child was exposed to 3 ACEs. As an example, the 3 ACEs might include having an abusive father, being a victim of sexual abuse, and having a mother who had mental health problems. An ACE score predicts health, social, and economic risks as the child grows into adulthood. For example, a higher ACE score suggests a higher probability that a person will smoke, and how heavily they will smoke. A higher ACE score also suggests a higher probability that someone will develop a dependency on alcohol. In regard to the field of mental health and suicide prevention, ACE scoring suggests that there is more than a 60% probability that a person with an ACE score of 4 or more will experience chronic depression. When prior suicide attempts are matched with ACE scores there is a 31 - 50 fold increase in adolescents who attempt suicide when they have an ACE sore of 6 or more.

Insights into historical trauma from the Montreal conference

The notion of adverse childhood experiences explained through the ACE study would appear to have a strong relationship to the notion of 'historical trauma' which was described in a conference session in Montreal titled: *Historical trauma in indigenous societies: theoretical approaches, and implications for youth suicide prevention*. Historical trauma or 'soul wound' as I heard it described, is the intergenerational transmission of trauma experience,

and is considered to be a social determinant of health in First Nation's communities. In this conference session Gerald McKinley (2015) described on page 14 above presented a relationship between people who have been exposed to historical trauma, and mental health problems. People who have been exposed to historical trauma are more likely to experience early onset of depression, a family history of depression, and greater incidents of suicide attempts. It is believed that understanding the intergenerational embodiment of historical trauma will aid in suicide prevention.

Conference speaker Amy Bombay (2015) of Dalhousie University presented an example of historical trauma related to the Native American Indian people's experience of being placed in Indian Residential Schools (IRS). American Indian Residential schools were boarding schools established in the United States during the late 19th and early 20th centuries to educate Native American children and youths according to Euro-American standards. Children were often immersed in European-American culture through appearance changes. The children were forbidden to speak their native languages, and traditional names were replaced by new European-American names. The experience of the schools was often harsh, especially for the younger children who were separated from their families. The children were encouraged or forced to abandon their Native American identities and cultures. There was a cumulative impact of trauma experienced by children in the IRS, the more generations of a family exposed to IRS trauma – the more intense the effect of ongoing trauma. This risk appears to grow as the ex IRS students get older.

Conference speaker Jack Hicks (2015), Professor of Child and Family Studies at Carleton University – Ottawa described another first nation's people who have experienced intense historical trauma, high rates of adverse childhood experiences and cumulative adversity in childhood and youth. For the Nunavut people of Northern Eastern Canada there is a very strong correlation between a reduction in their power, control, independence and autonomy

through their re-location into residential schools and new communities, and an increase in deaths by suicide – in particular amongst males.

Related research I considered after I returned from my travels stressed that each first nations tribe or people group needs to be considered separately in reference to suicide prevention and intervention, and that unwarranted generalizations must be avoided (McIntosh & Santos, 1981). When self-report surveys were conducted on three culturally distinct tribes, no single correlation of suicidal ideation (plans of taking their own life) was common to all three tribes (Novins, Beals, Roberts, & Manson, 1999).

In the next section I move to discuss suicide prevention and some of the key learning experiences I gained on my travels. I firstly discuss the notion of 'postvention as prevention'.

C). Post-vention as prevention

A number of times during the conference in Montreal I heard the phrase 'postvention is prevention' when applied to the notion of preventing a person or persons dying when they or others have presented a risk or actual involvement in suicidal behaviour. I understand the notion of 'postvention as prevention' as I work in this mode of operation almost every day in my role in suicide prevention in my own community. At the same time I also consider the words of Dr Saxena at the Montreal conference (described on page 13 above) who said that reducing risk of suicide will only go part of the way to reducing suicide rates – we must also address protective factors. By protective factors I refer to those attributes that increase the likelihood of positive wellbeing outcomes for people which include self-control, healthy family functioning, cultural engagement and school connectedness. "In particular, close and caring family relationships are associated with reduced youth participation in a number of potentially risky behaviours, including suicidal behaviours" (Ministry of Education, 2013, p. 19).

As I engaged in my travels around the Canada and the US I thought more and more about the notion of post-vention as prevention, where governments apply their funding within the field of suicide prevention, and what is possible from proactive prevention perspective. From my experience I am confident that the district that I work operates one of the most responsive suicide prevention and suicide risk management systems in New Zealand. Those of us involved are often asked to comment on the systems and processes we operate in other areas of the country. The fact that the FUSION process operates a reliable and responsive service for the community is great. It has in all likelihood been responsible for saving lives although it is hard to claim causality.

Proactive and reactive and suicide prevention

FUSION is not a suicide prevention method in the sense that I view pro-active suicide prevention now I have returned from my WCMT travels. FUSION is a system that reacts to a suicide related risk that has been communicated to a help agency in a time of crisis. This illustrates the distinction for me between a reactive and proactive suicide prevention response. The former responds to risk, the latter aims to embed protective factors in people's lives in order to help them cope with the ups and downs of life. In my view we need a more balanced focus on proactive and reactive suicide prevention within our communities. Proactive suicide prevention is discussed in more detail the next section.

D). Upstream suicide prevention – 'calm water' intervention

Two examples of upstream school based suicide prevention programmes that I discovered while at the Montreal conference were *Zippy's Friends* (Partnership for children, 2016b) and the *Passport Skills for Life Programme* (Partnership for children, 2016a). Both programmes are universal mental health promotion programmes for primary aged students that are designed to promote emotional wellbeing and skills to cope with everyday challenges and

interpersonal relationships. In relation to the river and water fall diagram described in page 10 above, these are 'calm water' interventions. They are proactive measures to help our young people prepare for the inevitable storms of life. It was however my visit to Denver, Colorado to take part in the *Sources of Strength* training that gave me access to the most powerful learning experience related to upstream suicide prevention while on my travels.

Sources of Strength

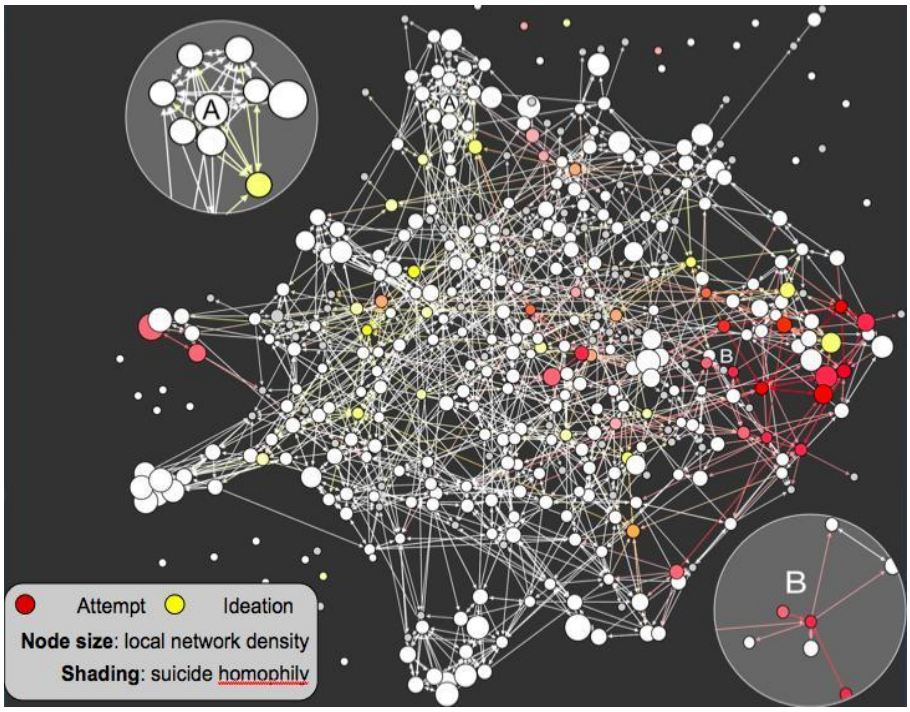
Sources of Strength (SOS) is built on a universal school-based suicide prevention approach designed to build socio-ecological protective influences across a full student population (Sources of Strength, 2015). Attending the SOS training radically changed my view of suicide prevention methodology – and introduced to me the notion of upstream suicide prevention. Prior to attending the SOS training the word 'contagion' initiated a negative and fearful reaction in my mind. Personal memories of the terrible year that our community experienced in 2012 revolved around the word contagion – the spread of fear and anxiety, potential death - the 'dragon with its head cut off' as discussed on page 7 above. To me the word contagion was associated with a risk and reaction response. While a risk and reaction response is indeed an appropriate action when suicide contagion is evident, the SOS training introduced me to a different way of thinking about the notion contagion. SOS view contagion from an opportunistic perspective, using social networks as a medium to carry positive messages amongst people in a pro-active manner.

SOS promote the utilisation of existing social networks (i.e. a school, church or youth group) to spread messages of hope, strength and help seeking behaviour. It is instigating contagion, but from a different mind-set. It involves proactive steps that are strategically developed to make a positive change in the way young people think and behave. Youth leaders, including at-risk adolescents, are trained to influence and change the norms and behaviours of their

peers by conducting well-defined messaging activities with adult mentoring. The purpose is to modify the norm behaviour propagated through communication within peer groups to alter perceptions of what is typical behaviour, and of the social consequences for positive coping behaviours (National Register of Evidence Based Programs and Practices, 2016).

What I observed as 'norm behaviour' in some parts of the youth network in Tai Tokerau in 2012 looked similar to that depicted in Diagram 2 below. Diagram 2 is associated with some preliminary findings from SOS related research that is in the process of being completed by Professor Peter Wyman and colleagues at the Department of Psychiatry, University of Rochester School of Medicine (Sources of Strength, 2015). In regard to diagram 2, the darkness of the red dots indicates the extent of closeness of suicidal youth to other suicidal youth. The size of the node represents the number of friends in local peer friendship groups. Isolates are small, while students in tight clusters of close friends are large.

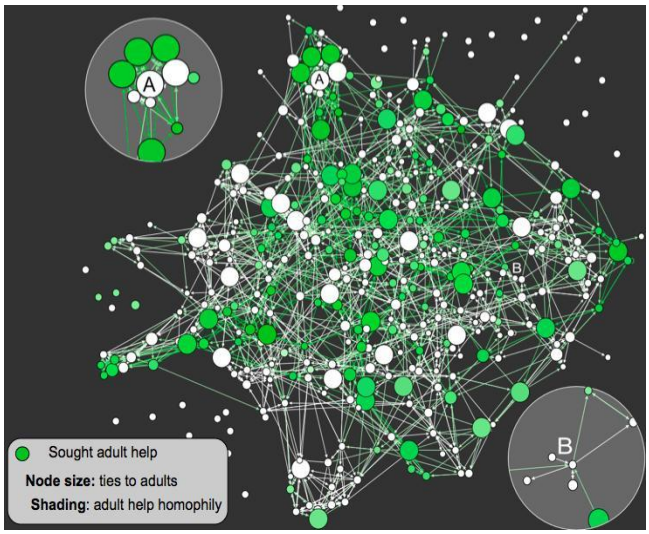
Diagram 2. Social network slides – Proximity of youth to other suicidal youth.



While Professor Wyman has made it clear to me in my communication with him that he does not want to imply causality through these findings at this point to determine if suicidality spreads or if risky kids connect with each other (Personal Communication), the diagrammatical representation reminds me of what I witnessed amongst the youth network in Tai Tokerau in 2012. I observed close associations between groups of youth and the at risk behaviour they were involved with. I observed that this phenomenon appeared to spread amongst parts of the social network through various mediums of communication, and that social media in particular was a significant carrier of these messages.

As an upstream suicide prevention methodology, SOS is suggesting that as an alternative to at risk behaviour, strength, hope and help seeking behaviour can be instilled and spread with strategic intent amongst social networks when youth have close ties to trusted adults and through friends. This is illustrated in diagram 3 below where the green dots represent students. The green dots indicate students who sought help in the last year. The sizes of the dots represent how close the students are to friends who have trusted adults in their lives. More help seeking behaviour is associated with having more connections to trusted adults both directly and through friends (Sources of Strength, 2015).

Diagram 3. Social network slides – Proximity of youth to other youth with trusted adults.



Evidence suggests that SOS training improves the peer leaders' adaptive norms regarding suicide, their connectedness to adults, and their school engagement. Trained peer leaders in larger schools were 4 times as likely as were untrained peer leaders to refer a suicidal friend to an adult. Among students, the intervention increased perceptions of adult support for suicidal youths and the acceptability of seeking help. Perception of adult support increased most in students with a history of suicidal ideation. SOS is the first suicide prevention program involving peer leaders to enhance protective factors associated with reducing suicide at the school population level (Wyman et al., 2010).

SOS has been listed on the US National Registry of evidence based programmes and practices since 2012. SOS has been implemented in 13 states across the US. It also has been implemented with indigenous people groups in the Salmon River Tribe, Spirit Lake Nation, Three Affiliated Tribes, Tohono O'odham Nation, and Turtle Mountain Nation. These implementations represent approximately 130 peer teams, with 3,000 peer leaders, working with approximately 25,000 adolescents and young adults (National Register of Evidence Based Programs and Practices, 2016).

SafeTALK

SafeTALK is another upstream suicide prevention programme that was introduced to me by Alan Woodward – Executive Director – Lifeline Research Foundation - Australia who I met at the Montreal conference. SafeTALK is a training package designed to help participants better identify people at risk of suicide and improve help-seeking and can be delivered to persons 15 years and over. On this basis SafeTALK can be used with school aged students. It might be said that SafeTALK has a slightly more overt focus on 'suicide' as an apparent risk than SOS which appears to be more focused on the promotion of protective factors and coping behaviour. Related research forwarded to me by Alan Woodward has been completed

on the use of SafeTALK in a school environment by Orygen – The National Centre of Excellence in Youth Mental Health in Australia (Robinson et al., 2015). The findings showed that:

- The SafeTALK program was found to be effective in terms of increasing knowledge of suicide risk and warning signs, willingness to help others and likelihood of seeking help for suicide-related thoughts and behaviours
- The program was acceptable to young people and had no iatrogenic effects
- Of this sample 31% had previously experienced suicidal ideation at some point in their lives, just over 25% had experienced these thoughts in the past month, and nearly 14% had made a past suicide attempt
- A significant proportion had not sought help for these problems, mainly for reasons associated with stigma; these students were subsequently linked into the school wellbeing team.

Orygen commented that concerns have been expressed across the suicide prevention sector that delivering suicide prevention workshops directly to young people may have harmful effects. For this reason universal school-based interventions like SafeTALK have not been widely taken up in many countries, and efforts have largely focused upon the development and evaluation of gatekeeper training programs for school staff. Orygen claim that even though the study is small and uncontrolled these findings suggest that delivering these types of program may be safe and worthwhile. Additional benefits included the early identification of young people at risk who had not otherwise come forward to seek help (Robinson et al., 2015).

As it happens, while in Montana I had the opportunity to meet with Heather Stokes, Vice-President of Strategic Development at LivingWorks – the organisation that promotes and provides training for the safeTALK programme internationally. It was valuable to have an

opportunity with Heather to gain a more in-depth understanding of safeTALK and other programs like ASIST and suicideTALK of which I knew little about prior to my travels.

Youth Aware of Mental Health

While at the Montreal conference I also became aware of material promoting the *Youth Aware of Mental Health* programme (YAM) which also seems to fit in the category of upstream youth based suicide prevention. YAM is an evidenced based programme for 14 – 16 year olds which promotes increased knowledge and discussion about mental health and the development of problem-solving skills and emotional intelligence. YAM offers a hands-on approach to mental health issues such as stress, crisis, depression and suicide allowing the personal experiences of the participants to influence the programmes content and discussion. (Youth Aware of Mental Health, 2014).

Instances of upstream suicide prevention methodology are used in a NZ context. An example of an upstream suicide prevention programme is seen in the development of 'Matanui', an education play and workshop programme specifically written for schools in Tai Tokerau after the suicide events of 2012. The play aims to empower youth and their communities to build community resilience. Each play performance is followed by a workshop and introduction to community support networks. The Matanui Programme has impacted positively on youth, family, school teams and community support networks (Penney & Dobbs, 2014).

In the next section the dynamics of a social network, of which upstream suicide prevention programmes like SOS, safeTALK and YAM and the Matanui programme seek to utilise and embed positive thinking within is discussed in more depth.

E) The Hidden Power of Social Networks

At the SOS training Mark and Scott LoMurray presented with a fascinating TED Talk by Nicholas Christakis that gave evidence of the power of what being embedded in social networks means to us in both a positive or negative sense, and how social networks affect us (Christakis, 2010). This information provided an important learning moment for me where I gained a deeper understanding of how emotional contagion (described below) evolves through social networks.

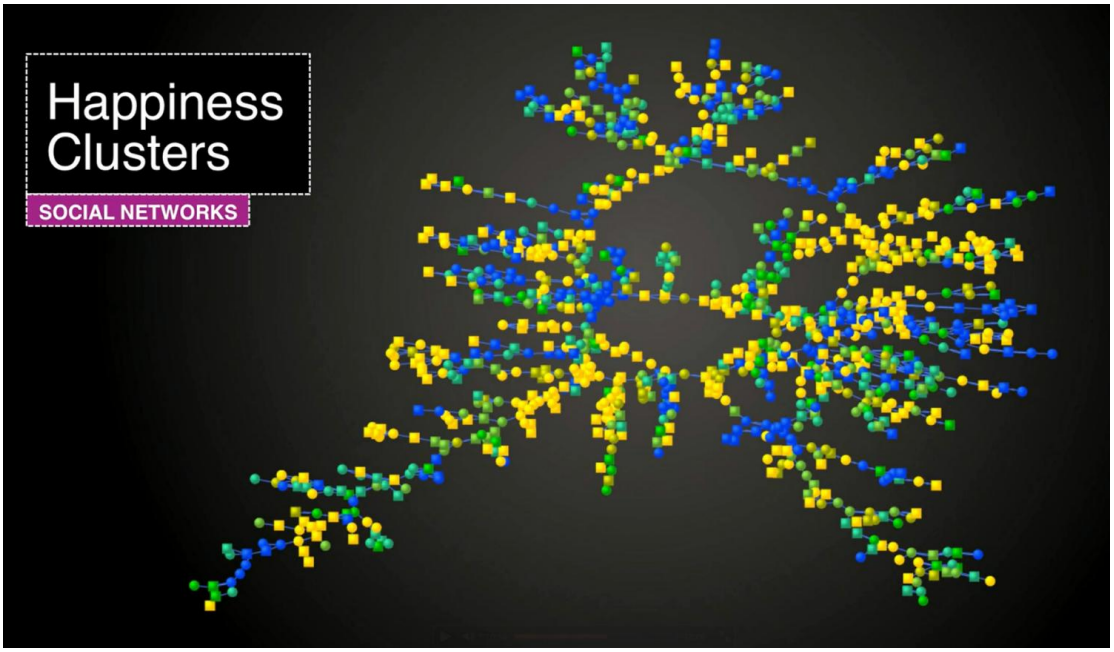
In his presentation Nicholas Christakis used the theme of obesity to illustrate the power of influence within social networks. Christakis showed that if your friends are obese – there is a higher chance that you will also become obese depending on how close you are to other people in your social network who are obese. If your close friend is obese – there is a 57% chance that you will become obese. Christakis shows how ideas spread and cluster within social networks through the process of induction and homophily, and that social networks have a memory and are essentially living things.

Christakis then turns his attention to the spread of emotions within social networks. When we have emotions we show them – others can read them and copy them. Christakis describes this as 'emotional contagion' and uses the term 'emotional stampede' to describe the spread of emotions in a sustained way over time.

Diagram 4 below is from the Christakis presentation and shows an example of the connections between people within social networks. Blue are sad people, yellow are happy, and green are in between. The network shows people are clustered into smaller networks with people of like – happy people are more likely to be clustered with happy people and vice versa. The network also shows that that happy people are situated in the middle and edge of

the network while sad people are on the outside. Christakis suggests that whether you are happy or not is somewhat dependant on whether or not you occupy a 'happy cluster'.

Diagram 4. Happiness Clusters within social networks.



What is the point here? How does this help us understand some of the problems that occur within communities like Tai Tokerau in 2012? Christakis suggests that social networks have value – a kind of social capital. He suggests that it is the pattern of connection between people that determines the different properties of the network and that it is the ties between people that makes the "whole greater than the sum of its parts". It is the architecture of the social network around us (i.e. people losing weight, gaining weight, becoming happy, becoming sad, getting rich, becoming poor etc.) that affects us. Our experience of the world depends of the structure of the world and the social networks that we reside in. In this sense behaviour is better understood by reference to the collective rather than the individual.

The work of Christakis helped me to gain a greater understanding of the suicide context that evolved in Tai Tokerau in 2012, the 'emotional stampede' of negativity and risk taking behaviour amongst a social network of youth. As a positive and proactive way forward from

the 2012 experience, Christakis suggests that the spread of good and valuable things are required to strengthen and nourish social networks, and social networks are required for the spread of good and valuable things. Where SOS is situated within this conversation is as an evidenced based upstream prevention tool to help schools organise and promote a process to strengthen their social network with strength, hope and help seeking behaviour.

In the next section I reflect specifically on school based suicide prevention for indigenous youth within the context of what has been discussed in sections above.

F). School based suicide prevention for indigenous youth

As I reflect on the Montreal conference and the overwhelming theme of concern which highlighted unacceptably high rates of suicide amongst indigenous people groups, I found it interesting the obvious absence of indigenous people leading work to address this problem. It was obvious to me and others that the researchers that were talking about the work they were doing to reduce suicide amongst indigenous people were mostly not indigenous to the people they were researching. This fact was overtly highlighted by a first nations conference participant from Australia in a session titled *Suicide Prevention with Indigenous People* where all but one presentation from the NZ group *Waka Hourua* were delivered by non-indigenous people.

I was also surprised at the lack of cultural input and guidance into the structure of the World Congress on Suicide Prevention from local Native American Indian people considering the conference was held in their community. From a NZ perspective I have come to expect that Māori play an equal role in matters such as these. Symbolically speaking, the lack of input from indigenous peoples at the conference said a lot to me about where indigenous people sit in the conversation around suicide prevention globally. While it might sound harsh - it

appeared to me that indigenous people groups were identified more for the problem presented rather than as part of the solution or way forward.

Reflecting on my cause as a Pākehā

Within the context that I observed at the conference described above I reflected on my own cause as a non-indigenous male attempting to understand more about suicide prevention amongst indigenous people to help reduce rates of suicide amongst Māori youth. Historical accounts of Pākehā researchers working in Māori communities are generally not positive (Smith, 2012). New Zealand is only one of many lands colonised by Britain and other European powers in the period of European global expansion, beginning in 1492 with Christopher Columbus, and peaking in the 19th century at the height of the Victorian era (Smith, 2012).

Today, the four 'settler nations' of Australia, Canada, New Zealand and the United States, collectively termed CANZUS, share many characteristics in common, including a history of colonisation by Britain (Bell, 2014). In each of these countries, the British colonisers set out to assimilate or 'civilise' the indigenous populations, using overt methods (Simon & Smith, 2001). Under colonisation, 'the educational and wider social experiences of the indigenous Māori in New Zealand have been characterised by consistent inequality and disadvantage' (Bishop, 2003, p. 221). As a result of the colonisation process by which New Zealand was established as a modern Western nation-state, Māori became embedded in political economies constituted from structurally dissimilar groupings that result in an unequal distribution of material, social, and political power (Smith, 2005). This situation it would seem was replicated in many other colonised countries.

Within the context of suicide prevention I heard it said from an audience participant in a conference session on *Historical Trauma in Indigenous Societies* that suicide was historically

not part of the local tribe they were associated with – it is seen as a consequence of colonialism. While there was no evidence presented to substantiate this claim, the question was asked whether the notion of historical trauma is acknowledged and addressed enough in national suicide prevention strategies as a risk for suicide. There was a related plea amongst many in the group to 'indigenise national suicide prevention programmes'.

In the context of the discussion above the responsibility that falls on me as a Pākehā who shows an interest in the field of indigenous youth suicide prevention presents a significant challenge to ensure that whatever is suggested or initiated in the form of 'help' is done with and not to indigenous people, and in particular Māori. It is also important for schools and those working in the field of school based suicide prevention to understand the context in which mental health related concerns and suicidal behaviour is situated for indigenous people groups.

The Montana experience

The place where I connected most closely with work around school based suicide prevention for indigenous youth was in my visit to Montana and specifically the University of Montana where I connected with the *Safe Schools Programme* and the *Native Children Trauma Institute* at the University of Montana. It was at the University of Montana that Marilyn Bruguier Zimmerman, Director of the National Native Children's Trauma Centre took me under her wing for 4 days and introduced me to key people who worked in the field that I was interested. Marilyn is of the Nakota / Dakota tribe. I am deeply indebted to Marilyn for the time she took to help me and shown me around.

Montana itself is steeped in natural beauty and wide open spaces. It is the third largest state in the US. With its beauty, it also has its problems from a suicide perspective – the rates are

very high when compared to other parts of the US. Montana shares with Wyoming the nation's highest rates of suicide (Taylor, Anderson, & Bruguier Zimmerman, 2014).

While in Montana I had the privilege of meeting with Karl Rosston who is the Montana State Suicide Prevention Coordinator. Karl told me that 20 people / 100,000 people die by way of suspected suicide each year in Montana as opposed to 13 people / 100,000 nationally. The rate of suicide amongst men is 35 / 100,000 while the rate of suicide amongst Native American Indian people is 26 / 100,000. Karl told me that high gun ownership (63%) and a staunch, masculine attitude toward mental health problems are key reasons for the high rates of suicide in general. Isolation and alcohol abuse are key contributes to the high rate amongst Native American Indian people who mostly live on reservations many hundreds of miles away from most major cities on poor quality land, and in low cost housing.

It was interesting to note that one of the suicide prevention strategies that Karl had initiated in the state of Montana was a mass production and free distribution of gun locks. This strategy falls in line with an accepted suicide prevention methodology which shows that removing access to the means of making a suicide attempt (i.e. the ability to use a gun) reduces rates of suicide. Karl asked me about the process of gaining a gun licence in NZ. Karl seemed in awe of the tight gun ownership legislation that we have in NZ. It is much easier to take ownership of a gun in the state of Montana, which presents an ongoing problem for Karl in his attempts to reduce suicide rates.

The Montana Behaviour Initiative

In regard to the high rates of suicide on Indian reservations, the National Native Children's Trauma Centre and the Safe School Programme has a specific focus on supporting American Indian and Alaska Native communities across the U.S. Amy Foster-Wolferman and Rob Henthorn from the University of Montana talked to me about the Safe Schools Programme

and specifically the *Montana Behaviour Initiative* (MBI). MBI is an initiative that has been operating in the state of Montana for the past 21 years, and is implemented in 70% of the schools. The reason I was interested in MBI was because its equivalent in New Zealand education context is the *Positive Behaviour for Learning – School Wide* (PB4L-SW) programme which was introduced to New Zealand 6-7 years ago (Ministry of Education, 2011). The theory that underpins MBI and PB4L-SW is *Positive Behaviour Support* (Carr et al., 2009).

From a 'safe school' and suicide prevention perspective MBI uses a three tiered approach to plan systems and processes to support the wellbeing of the students in school. When supported by accepted suicide screening tools, MBI schools utilise tier two of the intervention structure (the layer that focuses on supporting students with moderate social and emotion needs) as a way of tracking needs associated the students emotional wellbeing. It also supports adults to understand what at-risk behaviours to look for in students through specific professional learning and development programmes like ASIST and SafeTALK.

The implementation of MBI has gone well in many schools across Montana, over many years. Having been personally involved in the implementation of PB4L-SW in NZ I viewed this as an impressive achievement. When I asked about the key reasons why the implementation of MBI had been so successful the response was that of passionate and influential leadership from one individual in particular, and the input of high quality expertise at MBI conferences that were held for schools.

When I asked how the implementation had gone in schools situated in Indian reservations where the vast majority of Native American Indian people live, the answer was – "not well". Why? The problem in reservation schools is a very high turnover of staff and teachers in these isolated communities, and a lack of resources or proximity to services. The staff that

teach in the schools are often not indigenous to the community they are working in, and there is often a lack of trust between school and community. I was told that it takes 5 times the effort to gain a strong level of MBI implementation reservation schools. These types of barriers were also endorsed by Donnie Wetzel – a man of the Blackfeet tribe who Marilyn introduced me to. Donnie is an American Indian Development Coordinator for the Office of Public Instruction in Montana. He works in the field of youth suicide prevention in Indian reservations and described the rate of suicide among Native Americans as an epidemic. Donnie expressed that he was frustrated with the staffing problems in the schools, so he was now putting his energy into the youth themselves in the hope that it would make a bigger difference.

From a systemic perspective I found the reasons given for why the MBI initiative was not working well in areas where it appeared to be needed most as relevant to my own community in NZ. The Tai Tokerau education community also struggles with an isolation factor which presents barriers to accessing services, and contributes to a high turnover of school leadership and teaching staff.

Suicide Prevention on Native American Indian Reservations

While talking with team members of the Native Children's Trauma Institute at the University of Montana I was told about rural communities that had been through suicide cluster experiences like that which I have described of my own community above. One community in particular was located in the Fort Peck Indian reservation where 28 school aged and young adult Native American Indians died by way of suspected suicide between 2006 and 2010 – 14 were aged between 10 – 14 years. The community placed itself in a state of emergency as a result of this situation and therefore qualified for specific funding grant to develop a plan to address the problem.

I had the privilege of spending time with Native Children's Trauma Institute team members like Marilyn Bruguier Zimmerman who were part of the intervention that supported Fort Peck. It became clear to me from those I talked to that that the community was still being closely monitored and supported some five years later, and there had been no suicides in this community during that time. I was able to formulate an understanding of what had been done through the funding that was provided to support the community.

Suicide prevention and psychological first aid training was provided for school staff members, as well as suicide risk screening and school staff mentoring for selected students. More than one hundred adults were trained in the ASIST programme. School staff identified students who were closest to the initial suicide victims. Therapy, self-care plans and mentoring programmes were put in place for them. The mentoring programme was based on asking the students which staff member they felt closest to and could talk to if they had a problem, therefore linking students to trusted adults in order to form strong connections for them within their social network. The staff members who were identified by the students were asked if they would review the student's self-care plan with the student three times during the school year.

There remains a strong relationship between the Native Children's Trauma Institute team and key support people living in the Fort Peck community. I was invited to attend a regular phone conference meeting between them. This was a meeting to take stock of the current needs, help solve problems that had arisen, and provide encouragement for those working on the ground.

While at the University of Montana it was also suggested that I connect with Montana based Family Therapist Debra Klemann regarding an intervention in a school where 15 students died by way of suicide. On a phone call to Debra she described the types of programmes that

had been put in place. The programme that Debra herself had written called *STAR – Students, Trauma and Resiliency* (Klemann, 2001), was designed for use within the classroom providing lesson plans for teachers. STAR was written to provide students with the tools to mitigate the effects of exposure to potentially traumatic events. STAR is written using the principles of Cognitive Behavioural Therapy.

After I had completed the conversations described above I reflected with Dr John Frederickson of the Safe Schools Programme in Montana about the key factors that made the difference in why there had been no suicides in Fort Peck in the last five years. John indicated that it was about relationships and connections, and that for those involved in supporting the community it almost had to be more than a job. He also indicated that in life fear and greed motivate, and that there still remains a fear of not wanting to go back to what occurred five years ago – therefore people keep working hard to ensure it is not repeated. I identify with this motivation as it feels very similar to the work we are involved with in Tai Tokerau – of not wanting to go back to that place in 2012.

In addition to that described above, I also had the privilege of meeting Matthew Taylor at the Montreal Conference. Matthew is currently Executive Director of Forefront Suicide Prevention at the University of Washington, but was previously a staff member at the University of Montana, and had worked in the field of suicide prevention on Indian reservations. Matthew presented at the Montreal conference on the theme of *Response, Resilience and Recovery in Northern Plains Tribes: Strengthening Community in Response to Suicide Clusters*. I had initially been linked to Matthew by Professor Annette Beuatrais, and had been in touch with him prior to leaving NZ. We planned to meet in Montreal. Matthew talked to me about his work and shared a lot of relevant articles – one of which he co-authored is cited on page 30 above and is based on the theme of suicide prevention in rural, tribal communities. Matthew also has a high level of expertise in the field of *Psychological*

First Aid which is a highly relevant methodology to inform responses to suicide attempts, death by suspected suicide, and other trauma related events. I greatly appreciated the time Matthew gave to me.

On my last day in Montana Marilyn Zimmerman organised to take me to the Salish and Kootenai tribal area on the Flathead reservation to meet Youth Suicide Prevention coordinator Jenny Fowler. Prior to the visit I had heard a lot about the reservation land that had been apportioned to Native American Indian people during the process of European colonisation, and the deep feelings of injustice and historic trauma that were associated with this. From what I can gather the Native American people were basically shifted as far away from European society as possible, and given poor quality land and limited resources to make do. These decisions were a product of racist policies that were unfortunately typical of those developed by European settlers in the countries they colonised. Even in 2015 I saw very few Indian people in the cities and towns I visited. The only time I saw gatherings of Indian people was at a 'pow wow' that Marilyn took me to once we had reached the reservation. A pow wow is an event where related family groups come together to re-connect and take part in cultural rituals – similar I imagine to Māori whanau (families) gathering at their Marae (communal or sacred place) for a specific event.

If I had not been with a local person I would not have known when we had arrived in the reservation. There was no specific sign or gateway as such. According to Marilyn the Salish Kootenai reservation was not at all typical of most Indian reservations in that it was only a relatively short distance from a main city (1.5 hours), and the land was of good quality.

The conversation with Jenny Fowler was interesting in that a lot of what she had to say about the suicide prevention work with her people had strong links with a thread I noticed had started to weave its way through my journey and the experiences I had accumulated – that of

connectedness. Jenny talked of a gap in connectedness amongst her people where generations had lost touch with their elders and the traditional ways which have strong historical and spiritual associations to being Native American Indian. Jenny mentioned that at one point in their history the elders thought the white ways were better. They now believe a disconnect with their spiritually is a key reason why there are such high suicide rates amongst their people. Jenny also talked about the notion of historical trauma as a descriptor of the journey that her people have been through and the damage that has been done.

As sad as this was to hear, Jenny clearly had a highly capable hand over the suicide prevention work that she was coordinating amongst her people. She talked about an *Indigenous Connectedness Programme* that is operating with the youth that connects the young people to their elders. One might suggest that this is similar to the concept of connecting youth with trusted adults as is recommended through the SOS Programme. There were also 'rites of passage' programmes created for boys and girls when they turned 13 years of age that link the young people with mentors and teach them traditional ways and experiences. Also introduced was a modern twist on traditional storytelling where youth were connected to the old stories like 'Journey to the Bison' via digital storytelling. Resilience and help seeking behaviour was also being promoted through songs and messages on the radio.

While my time with Jenny was short as people were packing up for their 5th of July holiday weekend, I really enjoyed spending time with this passionate and driven young woman who just wanted to make a difference for her people. Like a lot of what I have observed on this journey, the success of a project or piece of work comes down to passionate people who stubbornly stand up for what they believe and fight for it year after year. On reflection it would have been great to have more people like Jenny at the Montreal conference - people

who are leading work in this sensitive and complex field, and who intimately understand their own people.

Conclusion and Recommendations

I engaged in the WCMT fellowship wanting to know and understand more about the field of school based suicide prevention, to make a better contribution to the suicide prevention landscape in NZ, and to assist in some small way in reducing the rates of suicide amongst Māori youth. Reflecting on my WCMT travel experiences, I remember sitting in the SOS training in Denver on the first day feeling a little uncomfortable as the only non US based participant in the room, introducing myself with my NZ accent and talking about why I was there. I remember talking about my experiences in Tai Tokerau, and my desire to find a way to help in a NZ context.

On the final day of the SOS training I remember contributing to the 'sum up' conversation with the rest of the group. I talked about the feelings I had experienced in gaining access to a different perspective on the notion of contagion. There was a liberating aspect of this discovery, and other experiences linked to it for me personally and professionally. I have discovered a way forward in the field of school based suicide prevention that isn't purely motivated by an apparent risk or suicide related tragedy. Prior to my travels this reactive approach frustrated me because operating according to a risk response methodology feels like we are always waiting for the next tragedy. I needed a new way of thinking and operating in the field of school based suicide prevention and I have found something that excites me. I see real potential for the use of SOS methodology in a NZ education context.

As the title of this report suggests, the central theme of my WCMT learning relates to the hidden power of social networks as a foundation and facilitator of upstream school based suicide prevention methodology. As described above, a realisation of the potential of social

networks to facilitate positive connections amongst youth to promote healthy norm behaviours is a theme which became apparent during my WCMT travel experiences, and is therefore central to this report.

The theme of connectedness created through the hidden power of social networks is apparent in SOS methodology and the work of Nicholas Christakis. We see a blending of thinking here between the social capital which Christakis says social networks generate, and the strategic intent of SOS which seeks to utilise and influence the social network with plans to facilitate positive and safe connections between youth, trusted adults and their peers.

Left to their own devices youth create their own social capital through the network – positive, negative and anywhere in between. At times the social network is infiltrated by what Christakis describes as an 'emotional stampede' which upsets the equilibrium of the network – and in a worst case scenario plays out as suicide contagion. As adults working in this field it becomes our role to try to re-establish the equilibrium within the network through the promotion of connectedness, coping skills, helping behaviour and hope for the future.

As described on page 18 above, school connectedness and close and caring family relationships are protective factors associated with reduced youth participation in potentially risky behaviours, including suicidal behaviours. These notions are promoted by the NZ Ministry of Education in their suicide prevention response kit for schools. But how do schools achieve a greater sense of school connectedness? SOS seems to be the only upstream school based suicide prevention programme that provides a tool to assist schools in promoting school connectedness and help seeking behaviour to prevent or at least pre-empt stampedes of emotion amongst our youth so they are better able to deal with the storms of life when they arrive.

I was presented with an overt example of an emotional stampede leading to suicide contagion and a serious cluster of deaths on the Fort Peck reservation in Montana. As this situation and the related intervention was described to me I observed the theme of connectedness appear again in one of the key help strategies that was initiated. The youth were assisted to connect with safe and reliable people in order to restore stability and facilitate help seeking behaviour. As summed up by John Frederickson on page 35 above, relationships, connections and sheer determination from those involved in supporting the community were some of the key reasons for the nil suicide rate over a five year period since the tragedies.

I also observed the promotion of connectedness in the work that Jenny Fowler was involved with in her role as Suicide Prevention Coordinator for the Salish and Kootenai Tribes of the Flathead Reservation. Jenny and her team were promoting connectedness between youth and their elders. This work appeared to be almost trying to reverse the effects of historical trauma that her tribe and many like it had experienced as their sense of connectedness within their family networks was deconstructed when their young people were forced to attend Indian Residential Schools away from their immediate family.

Promoting school connectedness amongst our youth as a proactive suicide prevention strategy to reduce risky behaviours, including suicidal behaviours is what I recommend we do more of within the NZ education context. In my view we need a more balanced focus on what I described on page 19 as proactive and reactive suicide prevention within our communities. From what I have seen we do reactive based suicide prevention work well, particularly in a school context. In my opinion we are yet to address proactive suicide prevention in a consistent and systemic manner. This report shows that there are evidence based programmes like SOS available if we so decide to invest and engage in this work in the future.

Outside of the SOS model I believe it is entirely possible for schools to apply upstream suicide prevention methodology within their context, particularly for secondary schools that are often equipped with staffing to operate pastoral care systems for students. From a philosophical and practical perspective I believe that the notion of upstream suicide prevention would fit comfortably within a schools health and wellbeing policies and curriculum delivery. For example, promoting the notion of the 'trusted adult' in a school which has been described as a successful upstream suicide prevention method in a range of settings through this report would be a reasonably straight forward initiative to implement with minimal associated costs.

Like anything that is implemented systemically within a school it must first be acknowledged and planned for with the schools strategic intent, and purposefully led. With even a basic understanding of the notion of connectedness and positive contagion schools can implement positive messaging and help seeking campaigns across the school, particularly with the assistance of social media and cellular technology. Schools may say they do this anyway. My observations having worked in this field is that schools do embark on these types of campaigns but more often as a reaction to a concern around student wellbeing and apparent suicidal behaviour, as opposed to a proactive strategy that school embarks on in collaboration with other service agencies to build and sustain positive and healthy contagion amongst their student population. This is not a criticism – it is the reality when we do not know about or promote the notion of upstream suicide prevention within the education sector.

From my point of view my plan is to distribute this report across my networks and offer myself as a point of reference to discuss the notion of upstream suicide prevention. I am in a strong position to engage in conversations with the education sector at various levels about the notion of upstream school based suicide prevention as I am in schools on a weekly basis. I am also involved in phone conversations with schools on a weekly basis around the theme of

school based suicide prevention. I am in a strong and credible position to entertain these conversations and will do so.

To this point I have taken the key learning's from my travels and adapted old presentations that I had previously used across the country, with new material, in particular the concept of upstream suicide prevention and the power of social networks. With this adapted material I have delivered two presentations to education and social sector groups in Kaitaia and Kerikeri in October 2015. I also presented at the Teachers Refresher Course Committee conference: *Wellbeing in Schools: Growing safe and peaceful learning communities* in October 2015. I have really enjoyed sharing the proactive components of upstream prevention methodology, and have had very positive responses from the educators I have worked with. It is nice to be a part of informing and forming ongoing connections around this work, in Tai Tokerau, and across NZ.

As I conclude this report I think about the connections I have made with a number of good people in the places I visited, and who are listed on page 2 above. These people were very generous and hospitable to me and I count myself blessed to have met them. The connections I have made I have maintained since I have arrived back to New Zealand. As I write this report Mark and Scott LoMurray from the SOS team are planning to visit NZ in March 2016 to link with me, and share the fundamentals of SOS with some education sector representatives in the Tai Tokerau region.

I also think about the ongoing connections I have made in this field since I have returned from my WCMT travels. Since I have been back I have had opportunities to speak to groups about my WCMT learning experiences. I have presented to my colleagues from the Ministry of Education Traumatic Incident team in the Tai Tokerau region about my travels and learning's. I will also present to the Onerahi Lions group on the 15th of March 2016 on a

similar theme. The Onerahi Lions showed a specific interest in my venture and made a generous donation to my cause.

In concluding this report, the words of Nicholas Christakis (2010) seem to provide a relevant closure point. He says:

> If we understood how valuable social networks are we would spend a lot more time nourishing them. The spread of good and valuable things is required to sustain social networks. Similarly, social networks are required for the spread of good and valuable things like love, kindness, happiness and altruism and ideas. Social networks are fundamentally about goodness, and what the world needs now is more connections.

References

Barnes, D., Boatman, C., Bill, N., Bravehart, M., Davis, Y., Daw, R., . . . Vorpahl, J. (2005). American Indians and Alaskan native communities: Cultural contexts for suicide and psycological prevention: The national organisation for people of color against suicide.

Bell, A. (2014). *Relating indigenous and settler identities: beyond domination*. New York: Palgrave Macmillan.

Bishop, R. (2003). Changing power relations in education: Kaupapa Māori messages for mainstream education in Aotearoa/New Zealand. *Comparative Education, 39*(2), 221-238.

Bombay, A. (2015). *The association between intergnerational trauma and early onset suicidal ideation and attempts*. Paper presented at the 2015 World Congress on Suicide Prevention, Montreal.

Brymer, M., Pynoos, R., Vivrette, R., & Taylor, M. (2002). Providing school crisis interventions. In S. Brock, P. Lazarus & S. Jimerson (Eds.), *Best Practices in School Crisis Prevention and Intervention*. Bethesda: National Association of School Psychologists.

Carr, E., Dunlap, G., Horner, R., Koegel, R., Turnbull, A., Sailor, W., . . . Fox, L. (2009). Positive Behavior Support. *Journal of Positive Bheaviour Interventions, 4*(20), 4-16.

Christakis, N. (2010). The hidden influence of social networks. Retrieved 5 January, 2016, from https://www.ted.com/talks/nicholas_christakis_the_hidden_influence_of_social_networks?language=en

Erbacher, T., Singer, J., & Poland, S. (2014). *Suicide in Schools*: Taylor & Francis.

Hicks, J. (2015). *Elevated rates of historical trauma in Inuit communities: The evidence, an explanatory hypothesis, and the implications for suicide prevention*. Paper presented at the 2015 World Congress on Suicide Prevention, Montreal.

Klemann, D. (2001). STAR: Students, trauma and resiliency: A trauma intervention for use in the classroom. Missoula: The University of Montana - National Native Children's Trauma Centre.

McIntosh, J., & Santos, J. (1981). Suicide among Native Americans: A compilation of findings. *OMEGA-Journal of Death and Dying, 11*(4), 303-316.

McKinley, G. (2015). *Understanding intergenerational embodiment to aide in suicide prevention: A public health perspective*. Paper presented at the World congress on suicide prevention, Montreal.

Ministry of Education. (2010). *Managing emergencies and traumatic incidents – The guide*. Wellington: Ministry of Education.

Ministry of Education. (2011). Positive Behaviour for Learning Action Plan. Retrieved 9 November 2012, from http://www.minedu.govt.nz

Ministry of Education. (2013). *Prevention and response to suicude: A resource kit for schools*. Wellington: Ministry of Education.

Ministry of Health. (2015). Suicide facts: 2013 data. Retrieved 21 February, 2016, from http://www.health.govt.nz/publication/suicide-facts-2013-data.

Ministry of Health. (2016). Understanding suicide in New Zealand. Retrieved 22 January, 2016, from http://www.health.govt.nz/our-work/mental-health-and-addictions/working-prevent-suicide/understanding-suicide-new-zealand

National Register of Evidence Based Programs and Practices. (2016). SOS Sources of Strength. Retrieved Jan 3, 2016, from http://legacy.nreppadmin.net/ViewIntervention.aspx?id=53

Northland District Health Board. (2015). *Te Tai Tokerau Suicide Prevention and Postvention Plan 2015-2017*. Whangarei: Northland District Health Board.
Novins, D., Beals, J., Roberts, R., & Manson, S. (1999). Factors associated with suicide ideation among American Indian adolescents: does culture matter? *Suicide and Life-Threatening Behavior, 29*(4), 332-346.
Partnership for children. (2016a). Passport: Skills for life. Retrieved 26 January, 2016, from http://www.partnershipforchildren.org.uk/teachers/passport-skills-for-life.html
Partnership for children. (2016b). Zippy's Friends. Retrieved January 26, 2016, from http://www.partnershipforchildren.org.uk/zippy-s-friends.html
Penney, L., & Dobbs, T. (2014). Promoting Whānau and youth resilience in Te Tai Tokerau: Evaluation of the Northland District Health Board Youth Suicide Prevention Projet 2013. Kerikeri:Kiwikiwi Research and Evaluation Services.
Robinson, J., Bailey, E., Parker, A., Spittal, M., Pirkis, J., Gould, M., & Reval, K. (2015). Preventing suicide in schools: An evaluation of the safeTALK program in the Northern Territory. In U. o. Melbourne (Ed.). Parkville, Victoria: Orygen.
Rutherford, K. (2015). NZ must address high youth suicide rates. Retrieved October 10, 2015, from http://www.3news.co.nz/nznews/nz-must-address-high-youth-suicide-rates--expert-2015011618#ixzz3yF4Iyp6W
Saxena, S. (2015). *Global agenda for suicide prevention: saving 100,000 a year.* Paper presented at the World Congress on Suicide Prevention, Montreal.
Simon, J., & Smith, L. T. (Eds.). (2001). *A Civilising Mission? Perceptions and Representations of the Native Schools System*. Auckland: Auckland University Press.
Smith, L. (2005). On tricky ground: Researching the native in the age of uncertainty. In N. Denzin & Y. Lincoln (Eds.), *The Sage handbook of qualitative research.* (3rd ed., pp. 443-466). Thousand Oaks, CA: Sage Publications.
Smith, L. (2012). *Decolonizing methodologies: research and indigenous peoples* (2nd ed.. ed.). New York: Zed Books.
Sources of Strength. (2015). Sources of Strength trainer newsletter. Bismarck, North Dakota: Sources of Strength.
Taylor, M., Anderson, E., & Bruguier Zimmerman, M. (2014). Suicide prevention in rural, tribal communities: The intersection of challenge and possibility. *Journal of Rural Mental Health, 38*(2), 87.
The Adverse Childhood Experiences study. (2016). Linking childhood trauma to long-term health and social consequences. Retrieved Jan 16, 2016, from http://www.acestudy.org
World Health Organisation. (2014). Preventing suicide: A global imperative. Retrieved 22 January, 2016, from http://www.who.int/mental_health/suicide-prevention/world_report_2014/en/
Wyman, P., Brown, C., LoMurray, M., Schmeelk-Cone, K., Petrova, M., Yu, Q., & Wang, W. (2010). An outcome evaluation of the Sources of Strength suicide prevention program delivered by adolescent peer leaders in high schools. *American journal of public health, 100*(9), 1653-1661.
Youth Aware of Mental Health. (2014). Retrieved 7 February, 2016, from http://www.y-a-m.org/
Youth Line. (2014). Best Practice Strategies for Postvention. Retrieved November 20, 2015, from http://www.youthline.co.nz/home/SearchForm?Search=postvention