Suicide Risk Assessment With Indigenous Peoples: Exploring Providers’ Knowledge and Experiences
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Suicide Risk Assessment With Indigenous Peoples: Exploring Providers’ Knowledge and Experiences

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Safety planning is an intervention that mental health practitioners use following a suicidal risk assessment. In practice, safety planning practices in response to suicidality seldom consider the diverse needs of marginalized communities. The overarching lack of culturally relevant suicide safety planning practices is especially troubling for Indigenous peoples in Canada, who are disproportionately impacted by this issue. Despite the well-established importance of providing culturally safe mental health services, there remains a paucity of safety planning practices that are tailored to Indigenous peoples. The present study identifies key observations on how mental health providers working with Indigenous peoples in Canada establish the risk of suicide and then engage in safety planning. We conducted a reflexive thematic analysis using textual data generated from a national survey that investigated the readiness of mental health providers to intervene upon suicidality with Indigenous clients. Seven key themes were identified with respect to safety planning and include (1) a range of clinical modalities and therapeutic assumptions, (2) the quality of therapeutic relationships and skills, (3) commonalities and outliers in terms of risk assessment, (4) safety planning and risk mitigation, (5) addressing diversity and cultural safety, (6) addressing a range of ethical and legal issues surrounding suicidality, and (7) the importance of support for clients. The themes are discussed and used to generate implications for psychotherapeutic practice, policy, and research that move suicide safety planning toward culturally safe practices. The strengths and limitations of the study are also discussed.

Clinical Impact Statement
Our study provides a unique view into the suicide risk assessment and safety planning practices of mental health providers serving Indigenous clients through the Non-Insured Health Benefits mental health counseling program in so-called Canada. Through a reflexive thematic analysis of mental health providers’ descriptions of safety planning practices, we have identified and described the unique themes and patterns that these providers use to respond to the issue of Indigenous suicidality.

Keywords: suicide, suicide safety planning, culturally safe care, Indigenous mental health, psychotherapy interventions

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This study received ethics approval from the University of Toronto. Data may be made available upon reasonable request due to privacy and ethical restrictions. The data that support the findings of this study are available upon request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.
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Suicide risk assessments are a practice designed to help mental health practitioners identify and intervene with clients who may be at risk for lethal self-injury and death by suicide. Given that Indigenous peoples experience disproportionate rates of premature deaths by suicide, there is a growing call for the practices of risk assessment and safety planning to be transformed in ways that are culturally safe and contextually informed when working with Indigenous peoples (Ansloos & Peltier, 2022). The objectives of this study are to describe key themes observed related to the suicide risk assessment practices utilized by practitioners serving Indigenous clients in Canada. In this study, we make seven observations regarding the suicide risk assessment practices conducted by mental health professionals registered with the Non-Insured Health Benefits (NIHB) program in 2021 (Government of Canada, 2022). We then offer a discussion with suggestions that seek to move this practice toward a standard of culturally safe care.

**Literature Review**

**Indigenous Suicide in Canada**

Suicide is a profound public health concern that disproportionately impacts Indigenous peoples in Canada. While accounting for only 4.9% of the population in Canada, Indigenous peoples are reported to die by suicide at a rate 3–5 times the national average (Kumar & Tjepkema, 2019; Statistics Canada, 2017). In some Indigenous communities, Indigenous children and young people below the age of 15 have suicide rates 50 times higher than their non-Indigenous peers (Kumar & Tjepkema, 2019). Indigenous youth and children are dying by suicide at exceptionally higher rates in Canada compared to their non-Indigenous peers (Kumar & Tjepkema, 2019). Suicide and self-injury are the leading causes of death among Indigenous youth and adults in Canada (Kumar & Tjepkema, 2019). It is true that Indigenous suicide in Canada is a harrowing reality impacting various communities to differing degrees. However, the rates of Indigenous suicide in Canada should be interpreted with caution, as there is marked variability across community rates of suicide.

**Conceptualizing Suicide**

Suicide risk assessment is a set of practices informed by theories about suicide. When we take stalk of all theories available, most construct suicidality as a phenomenon that emerges from a complex constellation of ecological factors, which all have a varied bearing on suicidality. However, this diversity and complexity are not often reflected in suicide risk assessment practice. For example, suicides in First Nations tend to map very closely to other forms of socioeconomic inequality and are heavily shaped by social determinants of health. There is a higher prevalence in the northern and remote regions of the country. Although resources are being directed there, they are profoundly underresourced, and the systems to provide care are severely underdeveloped. This said, in the context of Indigenous suicide prevention, gaps surrounding broader contextual risk factors are noted (Ansloos, 2018; Elliott-Groves, 2018; Marsh, 2010, 2016).

**Suicide Risk Assessment**

Suicide risk assessments are a standard of practice that is mandated by the regulatory bodies of mental health care providers to ensure that practitioners are upholding their duty to intervene upon clients who may be at risk of dying by suicide (e.g., in Ontario: College of Psychologists of Ontario, 2023; College of Registered Psychotherapists of Ontario, n.d.; Ontario College of Social Workers and Social Service Workers, 2021). Various situations might invite a mental health provider to conduct a suicide risk assessment. Some examples include when an individual reports suicidal ideation, meets criteria
as having risk factors for suicide, or is experiencing significant life stressors that prompt someone to ask about suicidality (Gold & Frierson, 2020).

Assessing the risk of suicide means attempting to determine the likelihood that a client may die by suicide, and this looks different depending on who is conducting the assessment and what tools are being employed. This can be done through clinical interviews as well as structured or semistructured checklists and patient surveys (Gold & Frierson, 2020). Clinicians will also evaluate suicide risk and protective factors by reviewing a patient’s life history interview and performing a mental health evaluation (Sadek, 2019). Although the identification of risk factors is helpful, they do not always determine who will die by suicide. In some cases, someone who identifies with many risk factors may not die by suicide, whereas someone with one identified risk factor will (Carter & Spittal, 2018; Gold & Frierson, 2020). Moreover, the identification of suicide risk is not static, as risk and protective factors can change. As such, suicide risk assessments should be an ongoing process to evaluate the patient’s mental health status.

Safety Planning

Following a suicide risk assessment where the level of risk of suicide has been established, a mental health provider may then engage in a practice of safety planning that seeks to intervene upon suicide and prevent death (Stanley & Brown, 2012). Generally speaking, a range of responses are typically accepted and largely depend on the level of risk that is identified (Fowler, 2012). On one end of the spectrum, this might include working with clients to address thoughts of suicide and find coping strategies. On the other hand, where there is a more serious risk of harm, it could include directing clients to their local emergency department. How providers intervene may also be preestablished by organizations they work within as a set of protocols. And different practitioners and agencies may do assessments differently. As such, there is great variability in how providers plan for client safety.

The Need for Culturally Safe Suicide Risk Assessments

Despite the established importance of providing culturally competent mental health services (Sue et al., 2009; Zangeneh & Al-Krenawi, 2019), suicide risk assessments and interventions often take universalizing approach anchored in Eurocentric cultural assumptions and do not consider the needs of racialized peoples (Wexler & Gone, 2012). Some have theorized that dependence on these normative approaches based on the modernist assumptions of contemporary suicidology tends to universalize and flatten diversity and the contextual embeddedness of experiences of psychosocial distress (Ansloos, 2018; Marsh, 2016). Such approaches fail to anchor such practices within beliefs and practices of cultures that may have different understandings about suicide (Colucci & Lester, 2013; Wexler & Gone, 2012). Western dominance within the study, conceptualization, and intervention upon suicide is problematic given that Indigenous people are disproportionately at higher risk of suicide than non-Indigenous peoples in Canada (Kumar & Tjepkema, 2019). For instance, while mainstream perspectives conceptualize suicide as an individual/personal act, for Indigenous people, suicide is often understood as a social response to profound marginalization and ongoing trauma and therefore should be viewed from a social, political, and historical perspective (Ansloos, 2018; Wexler & Gone, 2012). These two perspectives locate the problem of suicide in two different places. Consequently, dominant approaches to suicide risk assessment and prevention might entirely misidentify the specific risks and needs of Indigenous communities. In fact, training on suicide risk assessment and intervention procedures through programs like Mental Health First Aid (Mental Health Commission of Canada, 2023) and Applied Suicide Intervention Skills Training (ASIST; LivingWorks, 2023a) has, in some contexts, been shown to increase suicidal ideation or related behaviors (Sareen et al., 2013).

Suicide risk assessment in Canada operates on an individual scale that assumes that suicide will cease to occur if enough people are trained to recognize and intervene upon it within community and clinical contexts. However, this assumption often relies on a one-on-one model that negates social, cultural, economic, colonial, and structural drivers of suicide risk. Thus, the onus to prevent deaths by suicide rests on the shoulders of the person who must ask the right questions (e.g., “Are you having thoughts about suicide?” or “How can we develop a plan to ensure your safety?”) and on
the person who must admit their ideation. These types of questions do little to acknowledge the ongoing and violent colonial context in which Indigenous people live. Nor do these types of questions invite any sense of possibility for living outside of “keeping safe,” otherwise interpreted as solely “preventing death.” Current suicide risk assessment practices embrace a “prevention-of-death framework” (Ansloos & Peltier, 2022) that is not tailored for diverse contexts. Namely, Indigenous communities, despite having some of the highest suicide rates in Canada, have no method of suicide assessment that is reflective of Indigenous worldviews.

Methodology

Theoretical Framework

The present study is grounded in a framework of social constructionism. Social constructionism focuses on how meaning is created through social interactions (Chen et al., 2011). This approach is interested in understanding how these interactions are related to various contextual factors, including social, political, cultural, environmental, and structural dimensions. A crucial aspect of social constructionism is its attention to language and how the language we use may shape our biases, assumptions, and behaviors. By examining the role of language in the construction of meaning related to suicide risk assessment and safety planning, researchers can gain insights into the complex interplay between individual experiences and broader social systems shaping these practices. Additionally, social constructionism aligns well with Indigenous orientations to research, which emphasize a holistic understanding of how problems emerge and evolve within communities. This approach allows for the exploration of diverse perspectives and the incorporation of Indigenous knowledge systems in the research process. Given our aim to understand safety planning practices implemented with Indigenous clients in the context of psychotherapy, social constructionism serves as an appropriate methodological framework.

Context of the Study

The NIHB program is a federally provided health coverage program. It provides registered First Nation and Inuit peoples in Canada health coverage for a range of services that they may not be able to access through social programs, private insurance plans, or provincial/territorial health insurance (Government of Canada, 2022). One such service that is provided under the NIHB program is mental health counseling services. This means that recognized First Nation and Inuit people within Canada may access a regulated mental health professional such as a psychologist, social worker, psychiatric nurse, or registered psychotherapist through this program. Providers in these programs may be licensed by regulatory colleges or be members in relevant associations where members are not regulated but instead may access support and resourcing. Beyond these ties, they may not be formally under supervision unless required by their regulatory body. As such, there is no quality-control mechanism for these providers outside of the self-referring service user seeking a consultation with an NIHB mental health provider. Every 12 months, an eligible client may receive up to 22 hr of counseling, including individual, family, and group services. Here, a counseling hour is defined as the service hour that is typically 50 min of session and 10 min of administration. The 22 hr allotment can be extended with justification from providers. It remains unknown how this number of service hours is decided, but it nevertheless reflects a policy decision informed by a homogenizing approach to treatment.

Mental health providers through this program are privately contracted. This means that counselors provide services through their own practice but with a written agreement from the NIHB. With thousands of mental health providers registered with the NIHB program, there is little information publicly available on the efficacy of this program and who the mental health providers are. Information regarding the training of practitioners and their preparedness to respond to the needs of Indigenous clients is not made readily available unless Indigenous clients independently research practitioners and personally question them. Within the psy-disciplines, ideas about what skills, knowledge, and practices make practitioners competent to work with diverse populations are varied.

Participant Selection and Data Collection

The data explored in the present study draw from a national survey that was approved by a
The survey was sent to contracted mental health providers registered with the NIHB mental health counseling program across Canada in the summer of 2021. Over 1,500 NIHB mental health providers were invited to participate, and the survey received 444 responses. Across our survey, the most frequently endorsed trainings in suicide risk assessment and intervention were LivingWorks ASIST (32.6% responses; LivingWorks, 2023a), Mental Health First Aid Basic (22.3% responses; Mental Health Commission of Canada, 2023), and safeTALK (10.4% responses; LivingWorks, 2023b). Of the 444 responses, 364 individuals specifically responded to the question of analysis, which was “In your own words, please describe what you believe the key components are for creating a safety plan with someone at risk of dying by suicide?” Participant demographic information is described in Table 1.

Data Analysis

Embedded within a national survey was one textual survey question that asked NIHB mental health providers to reflect on the following: “In your own words, in a sentence or two, please describe, what you believe the key components are for creating a safety plan with someone at risk of dying by suicide?” To analyze this question, the present study utilized a methodology of social constructionism. This means that the research team attended to the ways that NIHB practitioners spoke about what they believe the key components are for creating a safety plan with someone at risk of dying by suicide.

Then, reflexive thematic analysis (Braun & Clarke, 2019) of text-based survey data was employed. The analysis was separated into six different phases and conducted by two members of the research team (Dunn, McVittie). The first phase involved engaging in repeated readings of the textual responses to become familiar with the content. The responses were then uploaded to NVivo coding software. The next phase involved using NVivo to code the responses for ideas that were related to the research questions. Intercoder agreement was engaged to increase reliability. This was done by seeking consensus on what the data were perceived to represent. When disagreements occurred about coding the material, the coders sought to come to a consensus through critical discussion, a reflection of the literature review, and their own judgments as clinicians. The codes were then organized to identify overarching themes and patterns in conjunction with the principal investigator (Ansloos) to further establish consensus. To determine whether a theme was significant, its frequency and relevance to the research question were evaluated. The next phase involved reviewing the coded data assigned themes to ensure that the themes represented the content being described and vice versa. Next, descriptions for the themes were created and reviewed. The final stage involved communicating the emergent themes in writing.

Results

Our analysis yielded seven themes, and they include the following: (1) Risk assessment and safety planning involves a range of diverse clinical modalities and therapeutic assumptions;
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(2) risk assessment brought about concerns about the quality of the therapeutic relationship and importance of therapeutic skill; (3) risk assessment practices highlighted some commonalities (and outliers) in terms of approach; (4) safety planning involved a range of diverse practices (some more or less evidence-based; and some contraindicated) for safety planning and risk mitigation; (5) diversity and cultural safety were spoken about in ways that were both broad and specific to Indigenous peoples including other critical concerns; (6) a range of knowledge regarding legal and ethical issues with regards to suicide were indicated; (7) a variety of uses of the concept of “support” was spoken about in ways that were sometimes very specific, but also quite vague. Each theme is discussed, and examples are provided. The examples provided are a complete response to the question, “In your own words, please describe what you believe the key components are for creating a safety plan with someone at risk of dying by suicide.” Copy editing has occurred to improve the readability of responses.

1. Diverse Clinical Modalities and Therapeutic Assumptions

This theme refers to the range of treatment approaches that underlie psychotherapeutic care and may reflect an array of different theories and techniques for managing suicidality.

Many respondents explicitly spoke about a variety of theoretical orientations and practices that guide their interventions. Overwhelmingly, cognitive and behavioral interventions were recognized, such as cognitive–behavioral therapy and dialectical behavioral therapy. This was referenced directly, such as “For example, it depends if I use DBT or IFS,” or indirectly, for example, “I focus on strengths, creating hope, exploring supports, exploring what keeps the individual going, core beliefs, future focus, etc.” and “a plan for a step between thought and action. A phone call to part of their safety circle.”

However, other humanistic approaches, such as client-centered, also received substantial recognition. For example, “client centered safety plan where the person is supported to make an informed decision about their health” and “client-centered, holistic. Using the person’s own words and strengths.”

Other less commonly cited approaches to psychotherapy included narrative therapy, internal family systems, and mindfulness approaches. Some examples of how these orientations were spoken about are provided below:

Using an Internal Family Systems perspective, I would establish a fundamental plan for safety (i.e., check in; next session; follow up) then explore suicide from a parts perspective for the purpose of the person unblending from the suicidal ideations or plan in pursuit of them working with the part.

Understanding their world view and their “story” is paramount; their relationship with self, family, community, and spirituality. It is essential the individual be engaged to the greatest extent possible in crafting the safety plan and influencing how it is implemented. Each plan must be person-centered not system-driven.

The utility in understanding the spread of therapeutic orientations described is rooted in the knowledge that each theoretical orientation locates problems differently and makes different assumptions about how change happens in the psychotherapy process and, by extension, when the issue of suicide is presented. For example, cognitive–behavioral approaches tend to locate problems as existing within a client’s thoughts (cognitions), whereas narrative approaches adamantly advocate that the person is not the problem; the problem is the problem (White, 2007). The variety of clinical modalities observed may reflect how respondents understand how change happens when suicide is involved and, by

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Note. NIHB = Non-Insured Health Benefits.
extension, their own understandings about the logics of suicide.

2. The Quality of the Therapeutic Relationship and Importance of Therapeutic Skill

The quality of the therapeutic relationship and importance of therapeutic skills refers to how respondents described the importance, or not, of the connection between service user and their service provider and how it influences the delivery of effective and beneficial psychotherapeutic care.

On one end of the spectrum, many respondents highlighted the importance of maintaining a good therapeutic alliance through the use of common factors. Common factors refer to the necessary and sufficient conditions that produce good psychotherapy outcomes (Wampold, 2015). For respondents, this included empathy, unconditional positive regard, collaboration in care, nonjudgment, and validation. One response states, “acknowledge what they are feeling,” and another states, “empathy, support, and resources.” A final example is more descriptive in its use of common factors:

Develop a good rapport quickly; unconditional positive regard along with caring and empathy; acceptance; good suicidal assessment skills; ability and skills to develop a safety plan along with the client that is doable for client, identifying client resources and support.

Conversely, many respondents did not include comments about the quality of the therapeutic alliance and therapeutic skill altogether. Instead, these respondents focused on measuring and documenting suicidal distress and the level of risk. Within these responses, we see respondents gravitate toward “check list” approaches to suicide risk assessment and safety planning that are concerned with evaluating the level of risk of suicide and materializing a safety plan. One respondent reports, “Helping them to understand personal internal/external risks factors,” and another one states, “Identifying resources for the client, assessing the risk, contacting client’s family, if necessary.” One respondent also includes a highly descriptive list on how they evaluate risk:

- Evaluating whether client has plan, intent and means.
- Assessing risk factors (i.e.: male, chronic pain/illness, etc.). Assessing clients support system and resources.
- Safety Plan: Includes signs that client’s suicidal thoughts are getting triggered/stronger; 5–7 coping strategies (grounding, breathing, distraction techniques); Lists 3 people client can reach out to; Provide crisis lines and encourage to call 911 if safety plan is not decreasing the intent/thoughts.

In many cases, respondents paired these two approaches together, seeking to balance a good therapeutic alliance while concretely assessing risk and creating a safety plan. In one case, a respondent acknowledges that “there is a significant difference between safety planning for the purpose of documentation and actual safety planning in real relationship with a client.” This observation is important in that it points out what is awkward about risk assessment and safety planning in terms of therapist–client relationship—that it may feel like maintaining a good relationship may sacrifice a thorough risk assessment and vice versa.

3. Risk Assessment Practices and Approaches

This theme refers to the patterns observed in how respondents evaluate the likelihood and severity of service user suicidal ideation or behaviors such that intervention and safety planning may take place.

Overwhelmingly, responses to assessing risk followed a standardized pattern. This included assessing if clients had a means, method, and plan when it came to suicide. Respondents also reported evaluating the clients’ reasons for living and reasons for dying. They also assessed if there was a history of substance use and suicide for the client or their loved ones. For example, one respondent states, “To assess the risk by considering elements such as whether or not they have the means and the plans.” Two other examples are provided:

- Prior suicide attempt(s); Misuse and abuse of alcohol or other drugs; Mental disorders, particularly depression and other mood disorders; Access to lethal means; Knowing someone who died by suicide, particularly a family member social isolation; Chronic disease and disability; Lack of access to behavioral health care.

I have ASIST training and go by this model of exploring invitations, addressing if the individual has a plan and access to items associated with that plan. We identify support such as family members to assist with monitoring, accessing crisis services at a local hospital when required, accessing an elder or traditional healer and emphasizing compassion for pain with reminders no feeling is final. Compassion therapy assists with belief in self and helping the individual recognize they are not alone.

Some respondents sought to explore protective factors such as the extent and quality of the client’s social support network and their ability to implement coping skills, identify alternate forms
of distress, and explore psychological resiliency with clients such as their strengths, gifts, and hobbies. Respondents also spoke about connecting clients to culture, faith, and spiritual aspects of the client’s life. For example, “Identifying and securing ‘protective factors,’ including commitment by the person to not self-harm, identifying alternative responses to distress, and identifying supports for that person to assist them in staying safe.”

Some respondents, in their assessment of risk, sought to understand the contextual and historical realities of clients. This included asking about their stability of housing, quality of education, financial needs, experiences of racism, and food security. We view this assessment as an outlier because, epistemologically, this kind of assessment is not typically considered in Western assessments of suicidal risk. For example, “Awareness of contextual issues at play for the person at risk including strengths, history (personal, family and community), connection to others and community.” Another respondent provided a lengthy description that included a variety of contextual factors related to poverty:

Identifying current supports/people around the individual, assessing their financial, housing, and food stability to see if these stressors can be mitigated or helped, checking if they have the means to do so, informing them of all supports, crisis lines/workers/agencies in their immediate area, establishing a person they can let authorities or medical professionals know if they are planning to take their life, informing them of wellness checks by MH Nurses or police, letting them know the process and working with them step by step to determine what they do if they feel certain things or if certain things transpire around them, a plan of action.

4. Safety Planning Practices and Approaches

This theme refers to the patterns overserved in how respondents intervene and provide safety planning among clients identified as being at risk of suicide.

Several respondents indicated that they would make themselves available for clients struggling with suicide ideation outside of the typical therapy hour by inviting clients to reach out in case of an emergency. In some cases, therapists indicated that they would strive to make themselves available “at any time of day.” Some respondents also indicated that they would personally attend emergency department visits with clients. This choice might reflect the reality that many Indigenous clients living in rural settings such as reserves or in remote areas do not have access to the typical pathways of care encouraged when someone is experiencing suicidal ideation, such as going to an emergency department.

Many respondents reported that they would seek to measure a client’s suicidal behavior and their risk of death through validated measures like the Columbia Suicide Severity Rating Scale (Posner et al., 2011). For example, “calm/confidence activities, reasons for living, friends, family, professionals in their circle of support, places of safety. To assess risk C-SSRS. Plus give Coping with Suicidal thoughts documents.”

Many respondents noted that they would provide their clients with crisis lines to connect with in the event they were feeling at increased risk of suicide. Many general crisis lines were mentioned and occasionally there was mentions of crisis lines specific to suicide. For example, “to provide options and support to the client at any time of day—therapist, family, friends, crisis lines, suicide prevention line, mental health line, Emergency Room, psychiatrist, AA AN sponsor, etc.” Another respondent states, “Assessing the level of risk, ensuring that they don’t have the means to take their life if they have a plan, ensuring they have support to reach out to and services such as a crisis number or the hospital.”

Many respondents also indicated that they would contact the police if their client disclosed that they were at risk of harming themselves. For example:

Identifying current supports/people around the individual, assessing their financial, housing, and food stability to see if these stressors can be mitigated or helped, checking if they have the means to do so, informing them of all supports, crisis lines/workers/agencies in their immediate area, establishing a person they can let authorities or medical professionals know if they are planning to take their life, informing them of wellness checks by MH Nurses or police, letting them know the process and working with them step by step to determine what they do if they feel certain things or if certain things transpire around them, a plan of action.

Assessment of risk factors is first and foremost (how at risk, is there a plan, access to means, self-harming behavior, loss of hope or helplessness many factors to explore—two sentences is not enough): if there is imminent danger and/or one cannot keep oneself safe, then there are processes to follow to keep the person safe (hospital, police, engaging with next of kin, etc.). Safety plan is dependent on the situation and level of risk: notifying next of kin or family/friends that are close to the person when appropriate. Identifying coping strategies when in distress as well as supports to reach out to when strategies are not sufficient to keep safe.
Then follow up with that individual in a predetermined amount of time (as soon as 24 hr, no longer than 2 weeks, depending on the severity of the risk).

Overwhelmingly, respondents made references to completing suicide contracts with clients. Suicide contracts are verbal or written agreements between a client and practitioner that instruct a client to not kill themselves over the course of psychotherapy. For example, “Written commitment to not take their own life before next session. Have numbers of people or agencies to call prior to taking own life. Ask who is depending on you?” Other respondents sought to create collaborative contracts to stay alive:

Firstly, I would conduct a risk assessment and then inquire what safety resources the person already possesses. Their safety plan would be a collaborative effort and an agreed upon contract that outlines specific steps they take before attempting to die by suicide.

Confirming with the person that they agree not to engage in the behaviours. If they begin to think seriously to call or reach out to supports immediately. Contracts can be signed if there is a likelihood they will follow through. Add resources and supports supervision to mitigate risk.

5. Cultural Safety and Other Critical Concerns

This theme reflects the ways in which respondents name and consider diverse cultural backgrounds, belief systems, values, systemic inequalities, historical trauma, and social determinants of health as relevant to the suicide safety planning process.

Culture was often named as an important factor to consider with clients but not described. Culture was spoken about in instrumental ways in that respondents referenced Indigenous practices and tools such as medicine wheels and smudging but did not connect them to deeper understandings of wellness and spirituality. For example, “Clients require connection and hope. We need to connect, offer hope, build community, help with sense of purpose and connect with culture” and “Connecting with service providers and supporters, medical, psychological and cultural supports also need to be activated.”

In other instances, referencing culture was connected to belief systems, worldviews, and ways of knowing. Respondents indicated the importance of reflecting on teachings, decentering Western ways of knowing, and remaining curious about what indigeneity means to the client. Other respondents offered curiosity about what the experience of suicidal ideation “means” for the client and connected this meaning to curiosity about their “life story.” For example, “culturally we ask if they use smudge, or have an elder, we clean their home and send away negativity. If not, we see if they will allow a smudge” and:

A safety plan should include strategies for managing the risk i.e., identifying family members who can provide supervision and support. Also identify activities that can be soothing or offer healing such as ceremony, elders, indigenous medicine, circle process.

Several respondents acknowledged the importance of engaging in cultural humility. They engaged in this by reflecting on their own social location and the ways in which they have experienced privilege and disenfranchisement and how this implicates their ability to assess and intervene upon suicide. For example, many respondents reported the need for highly collaborative suicide risk assessments that sought to empower Indigenous clients to make choices about their mental health and wellness:

Completing a thorough assessment identifying the level and natural of risk is fundamental. Genuine empathy, care and concern with assurance of hope. Acknowledgement of the trauma and injustices of colonization. Connection with cultural beliefs and traditional ways of healing. A safety plan needs to identify individual, system and cultural supports as well as assisting with connecting to the supports. It also needs to include a commitment from the client to follow the safety plan. Lastly, follow up to ensure client safety and connection to supports.

6. Legal and Ethical Issues With Regards to Suicide

Legal and ethical issues with regards to suicide refer to the ethical and legal considerations that respondents named contending with when navigating the suicidality with service users. This could include confidentiality, third-party reporting, duty to warn, respecting service user autonomy, and the promotion of well-being in the context of power differentials.

Respondents frequently demonstrated reviewing the limits of confidentiality with clients and inviting them to share what they feel comfortable with while making visible their duty to intervene should the issue of suicidal ideation emerge. For example, “By law we need to inform people that
hurting self or another cannot be kept confidential.” This approach is in line with reducing power dynamics by explicating power and making visible the types of risk mitigation and safety planning that may be invoked.

Respondents were generally aware of their duty to report suicidality and cited when they would break confidentiality to inform a third party, such as family, emergency medical services, or the police. For example, some respondents reported informing their clients of mental wellness checks by law enforcement and psychiatric nurses as a safety planning response to suicidality. Often, self-harm was included in this grouping. It is worth noting, however, that mental health professionals are not required to break confidentiality for self-harm unless they engage in life-threatening injuries.

Finally, a very limited number of respondents also cited specific legislation, such as the Mental Health Act as a document they would reference. For example:

Assessing risk (history, means, ideation, plan, knows someone who has died by suicide), validating emotions, contracting for safety or intervening for safety if needed, making safety plan, provision of a range of resources (helpline, crisis line, family/community. Schedule the next check-in or follow up). Reference applicable legislation (e.g., MH Act).

7. Support

The theme of support refers to the diverse ways in which respondents indicated the importance of connection to others during the suicide safety planning process. This often included the provision of resources, interventions, and community and family assistance, all with the goal of promoting safety and well-being and mitigating the risk of suicide.

Respondents frequently cited making referrals to “community supports.” Numerous respondents spoke about referring clients to the emergency department, and a few referred individuals to the police. Many listed crisis phone lines for referrals, and some respondents listed alcoholics/narcotics anonymous as a referral source. For example, “to provide options and support to the client at any time of day—therapist, family, friends, crisis lines, suicide prevention line, mental health line, Emergency Room, psychiatrist, AA AN sponsor etc.” Some respondents stated that they would refer to mental health care professionals, as we assume these responses refer to existent mental health care providers elevating care from their own (i.e., a registered psychotherapist referring to a psychologist), while few respondents explicitly reported referring to psychiatrists as part of their safety planning process.

Many respondents spoke about connecting individuals to family and friends. Both responses signal the importance of relationships and connectedness. Further elaboration was generally not provided, given the brevity of responses. For example, “1. Support system including familial/friend and formal 2. access to crisis 24/7 3. A therapist/social worker assigned to the client if they go through any type of crisis services. Follow up after a suicide attempt is abysmal in Ontario.” We interpret this response as speaking to the necessary but woefully underdeveloped infrastructure for mental health care for Indigenous people in Canada, thus creating a profound burden for a small group of providers servicing many people.

Many respondents indicated that cultural support was relevant and should be consulted in the safety planning process. In most instances, descriptions of what this would entail were quite vague, and in other instances, they were quite specific, for example, engaging the knowledge and guidance of Indigenous elders and remaining curious with clients about relevant teachings and meanings for them.

Suicide is a very significant and sensitive issue among First Nation peoples, especially our youth. Culturally appropriate supports and resources, cultural and traditional services such as traditional healers, elders, and natural helpers who live and understand our worldview, perspectives, and ways of life, to effectively utilize our traditional medicines and teachings of healing. Do they have a plan and how to respond to that plan and be cautious and aware of other means, especially in remote areas of the lands and waters where opportunities can be provided?

Many respondents emphasized providing support through the therapeutic relationship with their client. Validating the client’s experience, responding in a way that is nonjudgmental, being empathetic toward the client, and engaging in active listening were all soft skills that were listed by respondents as supporting the client through their interactions with them.

Discussion

The purpose of this study was to collect information about how mental health practitioners
registered with the NIHB program and the First Nations Health Authority engage in suicide risk assessment and safety planning with Indigenous clients across Canada. Our results yielded seven different themes related to suicide risk assessments and safety planning practices. These themes uniquely capture a heuristic of safety planning practices used with Indigenous peoples seeking services through this federal mental health program.

Risk assessment and safety planning seem to employ a variety of clinical modalities, techniques, and therapeutic assumptions. This could imply that practitioners are using a range of approaches tailored to the specific needs and circumstances of each individual. The diversity of methods reflects the complexity of suicide risk, requiring different strategies for different individuals.

Risk assessment appears to bring up concerns about the quality of the therapeutic relationship and the importance of therapeutic skills. This suggests that practitioners are sensitive to how the assessment process can impact the relationship with their clients and that skilled communication and rapport-building are critical to maintaining a supportive and trusting therapeutic alliance. This is particularly important in a suicide risk assessment, which involves discussions of deeply personal and often distressing experiences. Our survey revealed that ASIST, Mental Health First Aid Basic, and Safe Talk were the most common courses taken, and this has implications for program evaluation in Indigenous mental health contexts.

There seems to be a general consensus on certain approaches to risk assessment, but also deviations or unique practices. This may reflect a balance between adhering to established protocols and adapting to the particular needs and contexts of Indigenous clients.

The safety planning process involves a range of practices, some of which are more or less evidence-based and some of which may be contraindicated. For example, while calling emergency services is a gesture that responds to concerns of risk and the desire to contain potentially lethal behavior, contact with authorities may also be experienced as deeply shameful and an extension of colonial violence. Additionally, negative interactions with police and the Royal Canadian Mounted Police among Indigenous people are well documented, and this form of action may present the possibility of further physical and psychological harm for clients (McNeilly, 2018; Palmater, 2016; Stelkia, 2020).

Furthermore, the use of safety contracts was frequently cited. This approach assumes that clients are solely responsible for their suicidal behavior and takes a largely individualistic approach to care. However, most available literature presents an unclear picture about the efficacy of suicide contracts, and many suggest they can be harmful to clients (Farrow et al., 2002; McMyler & Pryjmachuk, 2008; Puskar & Urda, 2011).

Discussions of cultural safety appear to be both broad and specific to Indigenous peoples. This suggests that practitioners are mindful of the cultural diversity among Indigenous peoples and are striving to provide services in ways that are respectful of and responsive to their cultural identities and experiences.

Practitioners have varying levels of knowledge about legal and ethical issues related to suicide. This variation underscores the importance of understanding the legal and ethical implications of suicide risk assessment and safety planning, such as confidentiality, duty to warn, and informed consent.

Engagement with the concept of support could indicate that this theme is a multifaceted concept in this context, encompassing a range of strategies and resources for helping clients manage suicidal thoughts and behaviors.

Strengths and Limitations

The primary limitation of this study is related to the research question asked. Our study collected a heuristic of what people do when it comes to safety planning. We did not invite lengthy responses to the textual survey question, and as such, we have not generated a complete picture from respondents about how they handle this matter. Nonetheless, given the task of writing a brief response, “a sentence or two,” we have collected a high-level understanding of what respondents say they do when presented with the task of safety planning with Indigenous clients. In many ways, capturing a heuristic of practice behaviours is also a strength of this study. Suicide is a key issue facing many Indigenous communities across so-called Canada, and until this program of research, there have been no data available regarding the practices of mental health providers contracted with the NIHB mental health counseling program.

Our study also did not assess the screening practices that service providers use to determine which clients are fit for their services and competency profiles. Some practitioners will not
treat or assess clients who are actively under the influence of substances, and substance use is a known risk factor for suicide. While our study did not query provider experiences around this, we note that from our anecdotal knowledge, this is likely occurring. Addressing this issue in follow-up research could prove to be important, as engagement in help-seeking behavior when suicidal, even while under the influence of substances, represents a significant juncture of care that providers need greater support in navigating.

**Recommendations**

The information collected from this thematic analysis has sweeping implications for improving culturally safe care for Indigenous clients, improving therapist education for suicide intervention and safety planning, and the need to urgently evaluate the efficacy of the NIHB mental health counseling program from the perspectives of clients. Each of these points is further discussed.

**Practice Recommendations**

Our analyses yielded five different recommendations for practice, and they include emphasizing the therapeutic alliance, engaging in holistic risk assessment practices, practicing cultural humility and safety, integrating evidence-based practices and cultural considerations, and critically engaging in ethical decision making and support practices. Each is described in further detail.

**Emphasizing the Therapeutic Alliance**

The study highlights the importance of maintaining a strong therapeutic alliance while conducting risk assessments and safety planning. Mental health professionals should balance empathy, collaboration, and validation with concrete assessment and intervention strategies to effectively address suicide risk.

**Holistic Risk Assessment**

The findings suggest that a comprehensive risk assessment should incorporate clients’ protective factors, contextual and historical factors, and cultural aspects. Mental health professionals should aim to develop a more nuanced understanding of clients’ experiences to inform appropriate intervention strategies.

**Cultural Humility and Safety**

The study underscores the necessity for mental health professionals to engage in cultural humility when working with Indigenous clients. Practitioners should reflect on their own social location and cultural backgrounds, remain curious about their clients’ worldviews, and be willing to adapt their practices to align with the cultural needs of their clients.

**Integrating Evidence-Based Practices and Cultural Considerations**

Mental health professionals should aim to incorporate evidence-based practices in conjunction with cultural considerations to provide the most effective and appropriate care for clients, particularly when working with Indigenous clients. This approach may involve reevaluating traditional practices, such as involving the police or using suicide contracts, and ensuring that culturally informed practices are included to better align with clients’ needs and backgrounds.

**Ethical Decision Making and Support**

The study highlights the importance of being aware of ethical considerations, such as the duty to report suicidality and breaking confidentiality. Mental health professionals should balance these ethical obligations with providing comprehensive and culturally safe support, including appropriate referrals and connections to family, friends, and cultural resources.

**Implications for Therapist Education and Training**

Our analyses yielded five different recommendations for therapist education and training. They include comprehensive training in culturally sensitive risk assessment and safety planning, critical examination of standard risk assessment tools and practices, an emphasis on the integration of cultural and evidence-based practices, fostering collaboration and communication with Indigenous communities and resources, and the importance of clinical
supervision in culturally sensitive practices. Each is further discussed.

**Comprehensive Training in Culturally Sensitive Risk Assessment and Safety Planning**

While all the authors of this article have had specialized graduate education in regulated mental health professions, it is striking that not a single one of us received any institutionally led graduate-level training on delivering culturally safe suicide risk assessments and safety planning. Our study reflects this broader experience among providers working in the field. Psychological education and professional training programs should provide comprehensive training in culturally sensitive risk assessment and safety planning for suicide prevention. This includes teaching students and professionals how to identify and assess risk factors, protective factors, and contextual elements specific to Indigenous clients, as well as incorporating culturally relevant interventions and supports in safety planning.

**Critical Examination of Standard Risk Assessment Tools, Practices, and Trainings**

Training programs should encourage a critical examination of standard risk assessment tools and practices, particularly when working with Indigenous clients. Students and professionals should be trained to consider the limitations and potential biases present in these tools and practices and adapt their approach to better suit the needs of their clients. Our survey highlighted the most common suicide risk assessment and intervention training programs taken by providers, and these programs should be critically evaluated to understand their efficacy for Indigenous service users.

**Emphasis on the Integration of Cultural and Evidence-Based Practices**

Education and training should emphasize the importance of integrating cultural considerations and evidence-based practices in risk assessment and safety planning. This includes teaching students and professionals how to utilize culturally informed interventions while still adhering to evidence-based guidelines and best practices.

**Fostering Collaboration and Communication With Indigenous Communities and Resources**

Psychological education and professional training should promote collaboration and communication with Indigenous communities and resources, such as elders, community support workers, and cultural advisors. This will help mental health professionals better understand the unique needs, strengths, and worldviews of their Indigenous clients and facilitate more effective risk assessment and safety planning efforts.

**Importance of Clinical Supervision in Culturally Sensitive Practice**

Psychological education and professional training should emphasize the crucial role of clinical supervision in fostering culturally sensitive risk assessment and safety planning practices. Supervisors should be well-versed in working with Indigenous clients and possess a strong understanding of cultural considerations, challenges, and best practices. Regular supervision can help students and professionals reflect on their work, address any biases or blind spots, and continually refine their skills in providing culturally informed, effective care to Indigenous clients.

**Recommendations for Policy**

Our analysis generated three recommendations for policy. They include shifting resources away from punitive risk management practices, fostering community capacity building, and increasing mental health service equity. Each is described further.

**Shift Resources Away From Punitive Risk Management and Carceral “Care”**

Policymakers should focus on reallocating resources from punitive approaches, such as involving law enforcement in mental health crises, toward more culturally relevant and effective mental health care services for Indigenous clients. This shift should prioritize community-based initiatives and capacity building to support culturally informed and therapeutic interventions.
Foster Community Capacity Building

Policies should emphasize the importance of building community capacity to address mental health issues, particularly in Indigenous communities. This can include investing in training for first responders, education workers, public safety workers, social workers, and youth workers. It should also include investments in local mental health services, training community members in culturally informed mental health care, and supporting collaboration between mental health professionals and Indigenous community leaders and organizations.

Increasing Mental Health Service Equity

In addition to community capacity building, there is a dire need for broader health infrastructure that promotes mental health service equity. An increase in gatekeeper training while failing to promote mental health service equity is a recipe for health provider burnout.

Recommendations for Research

Finally, we provide four recommendations for future research. First, the psy-disciplines would benefit from research that identifies the specific institutionally led training that service provider trainees receive with respect to suicide risk assessment and safety planning. Within this recommendation, we argue that receiving this training should be a requirement of graduate school curriculums. Second, in general, there is a need to critically interrogate and evaluate current approaches to suicide risk assessment. Third, there is a need to investigate the efficacy of culturally informed risk assessment practices. Future research should focus on evaluating the effectiveness of culturally informed approaches to risk assessment and safety planning in reducing suicidality and promoting mental health among Indigenous clients. This could involve comparing outcomes from different therapeutic modalities, examining the impact of cultural competence training on mental health professionals, and identifying specific factors that contribute to positive therapeutic outcomes. Finally, the NIHB mental health counseling program requires a comprehensive evaluation from the perspective of its clients. This kind of evaluation is commensurate with the Truth and Reconciliation Commission of Canada’s (2015) calls to action.

Conclusion

Our study provides a unique view into the risk assessment and safety planning practices of mental health providers serving Indigenous clients through the NIHB mental health counseling program in so-called Canada. Through a reflexive thematic analysis of textual survey responses, we have described unique themes and patterns of ways that these providers respond to the issue of suicide. In response, the discussion describes relevant recommendations toward therapist education and training, policy, and future research. Throughout this study, we have sought to put forth a lens of critical suicidology, to reflexively interrogate best practices for suicide intervention for Indigenous communities, and to advocate for a deeper understanding of this urgent public health concern.

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