Niagara Region Suicide Prevention Strategy

First Public Release
March 2006

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Help is Available

Crisis Lines

Distress Centre Niagara

St. Catharines – (905) 688-3711
Port Colborne / Welland – (905) 734-1212
Beamsville / Grimsby – (905) 563-6674
Fort Erie – (905) 382-0689

Kids HelpLine – 1-800-668-6868

Internet

Samaritans – jo@samaritans.org
Kids Help Phone Web Site - http://www.kidshelpphone.ca/en/home.asp

Services within the Niagara Region

Community Crisis Care

Niagara Health System (905) 378-4647

St. Catharines General Site Ext. 43230
Welland County General Site Ext. 33407
Greater Niagara General Site Ext. 54919

Niagara Child and Youth Services 1-800-263-4944

The Child & Adolescent Crisis Service is a mobile crisis intervention service responding to families, children, and adolescents in the Niagara Region. It is staffed by professionals. Crisis Services provides immediate telephone counseling and, if necessary, on-site crisis intervention in the home, school, hospital, or other community location. It operates 7 days a week, 24 hours a day for children up to the age of 18 and their families.

Canadian Mental Health Association - (905)354-4576 or (905)641-5222

Intake & Assessment - This is a self-referral service for assessment and guidance. This is the point of entry to CMHA Niagara programs

A listing of services is also available through 211

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Acknowledgments

Who Are We?

The Niagara Suicide Prevention Coalition was formed in the fall of 2003 due to concern regarding the increase in the number of suicides in the Niagara Region. The coalition has grown to include over 25 agencies and members at large.

The purpose of the Niagara Suicide Prevention (NSPC) is to build strong community partnerships that will work together to develop a comprehensive suicide prevention strategy to address the needs of all residents of Niagara and reflect the values of a caring compassionate community.

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CANADIAN MENTAL HEALTH ASSOCIATION
ASSOCIATION CANADIENNE POUR LA SANTÉ MENTALE

The United Way

DISTRESS CENTRE NIAGARA

NVCSS
Niagara Victim Crisis Support Service

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Note: All text within this document is the responsibility of the Niagara Suicide Prevention Coalition.

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- Ms. Rachel Robertson, Geriatric Mental Health Program
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- Ms. Judith Rossman, District School Board Niagara
- Constable John Gayder, Niagara Parks Police
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- Ms. Melinda Turpel, Niagara District School Board
- Ms. Manuela Welch, Niagara Catholic District School Board

Rationale

Each year, approximately 4,000 Canadians die by suicide[1]. Across Canada, suicide is the second leading cause of death among youth age ten to twenty-four years[2]. Each suicide directly impacts 6 to 10 others[3], often referred to as survivors (those bereaved by a suicide). Given that this figure includes family and friends, it can be considered a conservative estimate.

It is estimated that for each suicide, there are another 100 non-fatal attempts. Suicide affects 1 in 13 Canadians[4], taking into consideration reports regarding serious ideation, non-fatal attempts and deaths. It is a public health problem that costs Canadians over 3 Billion dollars annually[5].

The Niagara Region experienced 805 known suicides[6] from 1986 to 2004. The ratio of male to female deaths was 3.5 to 1 which is consistent with national estimates. The highest numbers for men were in the age range of 25 to 44 years, and for women in the age range 25 to 54 years[7]. There were approximately 3,374 admissions to hospitals due to a non-fatal attempt[8] from 1996 to 2001.

The problem of suicide is much more than the numbers cited above. Suicide is about intense and overwhelming emotional pain, feelings of helplessness and hopelessness, and the perception that the only way to end this pain is to end one's life. However, when a person makes the decision to end their life, the pain hasn't disappeared. It has been transferred to those around them. The impact can be felt throughout the community and lasts for years as those affected begin their own painful search to answer many questions, the most troubling being "why". Citizens and Services in the Niagara Region are thus motivated to develop prevention, intervention and postvention strategies at the community, provincial/territorial and national level.

In the latter half of the last century the idea that suicides are preventable achieved growing acceptance. Many industrialized countries have developed, or are developing, national suicide prevention strategies[9]. Canada has lagged behind in this respect, although the Canadian Association for Suicide Prevention / L'association canadienne pour la prévention du suicide released a blueprint for a national strategy in October of 2004[1] (available at www.suicideprevention.ca).

The absence of a national, federally sponsored strategy makes the development of community-based initiatives even more important. Notwithstanding a national strategy, community-developed and driven initiatives are necessary. Those at the community level are in the best position to understand local strengths, resources and needs.

The following strategy is a culmination of work by the Niagara Suicide Prevention Coalition over the past two and one half years – but it is not a final product. It is a living document that reflects what we know about reducing suicide and its impact within communities. It also casts an eye toward a continued expansion of our knowledge through time, experience and sharing of lessons learned among all communities.

As with all such strategies, there is one simple and primary goal:

To reduce suicidal behaviour and its impact.

Process

Development of this strategy relied on a number of sources of knowledge including:

- A review of the literature on national and community based suicide prevention strategies
- A public survey of the Niagara region made available through the internet on experiences with suicide, available services and suggestions for a community-based strategy
- A planning meeting held on December 6, 2005, with representation from services across the Niagara Region
- Feedback from four community meetings across the Niagara Region regarding the first draft
- Review of the first draft by those across Canada with knowledge in suicide prevention, intervention and bereavement/postvention

There are seven broad components[10] within the general literature on suicide prevention strategies including:

- Public Awareness
- Media Education
- Access to Services
- Means Reduction
- Training
- Evaluation/Research
- Community Development

This strategy addresses six of these components. They are organized under **Suicide Postvention**, **Intervention** and **Prevention.** While the order often cited in the general literature is prevention, intervention, and postvention, they are presented in reverse order to reflect that communities are motivated into action with an increase in awareness of the problem. It is the impact of loss, grief and trauma associated with suicide that motivates communities to work towards reducing the number of suicides and minimizing the impact. "Community Development" is beyond the scope of this document and requires attention to geographical, economic and social concerns. Every activity and response to serious social and public health problems like suicide contribute to the overall development and health of the community.

It is important to recognize that postvention, intervention and prevention are not mutually exclusive. There is considerable overlap. Effective work in one area will have positive consequences for the others.

> *Note: It is not the intention of this strategy to suggest that one approach will work with every community, nor to offer a "cookbook" procedure. In the development of all goals, objectives and activities, consideration should be given to practices that take into account community diversity. Diversity includes age, sex, gender identity, sexual orientation, ethnicity, culture, faith communities, language and often these groups constitute communities within communities. Communities, regardless of their defining characteristics, are encouraged to see how the goals and objectives of the regional strategy can be adapted to their particular realities and strengths.*

The format for each section (postvention, intervention and prevention) consists of a short discussion of that topic, presentation of the six components with applicable goals and objectives. A list of resources is included at the end of this publication. Terms used throughout this publication are defined below.

The Niagara Suicide Prevention Coalition will develop a work plan upon acceptance and publication of this strategy. This work plan will consist of identifying those objectives that have been met or are underway, those that can be developed in the short term and those that will require long term development. A large part of the work surrounding this strategy will consist of coalition members and others advocating for the necessity of this strategy and the implementation of its objectives.

There are already many within the Niagara Region providing valuable services. The objectives in this strategy can be met by cooperative planning within and between services.

This work plan will consist of an annual "report card" to monitor progress, make revisions to reflect what we have learned, and list the work the coalition still has to do.

It is our hope that other communities across Canada will continue to work and share information and knowledge about their efforts so that we all benefit.

Terms

Over the years there have been efforts to adopt and clarify terms that are more accurate and less stigmatizing for describing suicidal behavior and its impact.

Survivor – refers to someone who is grieving a death by suicide, not someone who has made a non-fatal attempt.

Died by, or death(s) by suicide - is preferred over *"committed suicide"*, a throwback to when suicide was a criminal offence, or describing a suicide as a *"successful suicide"*.

Non-fatal suicide attempt - rather than a *"failed"* suicide attempt. Those that experience a non-fatal attempt can often interpret this as one more thing they have "failed" at, increasing hopelessness and the risk of another attempt.

Para-suicidal - has been used to describe suicidal behavior that has a low risk of death and may occur more frequently.

Self-injury - refers to behaviors such as shallow cutting that are not necessarily suicidal in intent.

Suicidal Ideation - while many people have some thoughts about suicide at some point in their lifetime, ideation refers to a more persistent rumination about death and suicide.

Gatekeepers – refers to those who work in the human services, and who are in a position to identify possible risk for suicide (e.g. teachers, police, medical personnel, etc.)

Defining the Six Components

Public Awareness	Information and activities that increase public knowledge about suicide and its impact. Awareness includes resources and services that address postvention, intervention and prevention, as well as information on how to help and support those at risk and those bereaved by suicide.
Media Education	Providing information to media regarding the problem of suicide, the impact of media stories on suicide, and use of media to educate the public.
Access to Services	Identification of services that respond to suicide risk and bereavement including crisis, counseling, therapy and support. Includes the development of community algorithms for identification and referral, workplace policies and procedures on managing suicidal behavior and its impact. Emphasizes the adoption of "Standards of Care" by all service providers in dealing with those at risk, and those bereaved. Also includes supervision and support of those who work with those experiencing suicidal behavior and its impact. Services need to be timely (minimal or no wait periods) and available (geographically, phone/internet and outreach).
Means Reduction	Recognizes that given the ambivalence inherent in suicidal behavior, making it difficult to acquire means may help to prevent a suicide. Strategies are internal (those which the person can personally acquire, ie. pills, rope, firearms, etc.) and external (suicide magnets such as buildings, bridges, cliffs, waterfalls, etc.).
Training	Identification of skills required to work with those experiencing suicidal risk or grief. Focuses on increasing knowledge and skill sets for volunteers and professionals.
Evaluation/ Research	Evaluation of Niagara Region Suicide Prevention Strategy including outcome measures for objectives and activities listed. Conducting research into those factors that contribute to suicidal behavior, and the impact of suicide on individuals, families and communities. Research is based on the six broad themes put forth by the Canadian Institute for Health Research agenda on studying suicide. These include: • Data Systems: Improvement and Expansion • Evidence-Based Practices • Mental Health Promotion • Multidimensional Models for Understanding Suicide-Related Behaviors. • Spectrum of Suicide Behaviors, including Suicide Attempts • Suicide in Social and Cultural Contexts

Postvention

Discussion:

Postvention addresses the need to minimize the impact of a death(s) by suicide. There is a twofold purpose for doing so:

1. To address the potential complications of the grief process due to the often traumatic nature of suicide deaths
2. To minimize the risk for cluster and contagion effects. *"Cluster"* refers to the occurrence of a number of suicides within a specific time and/or area. *"Contagion"* refers to the harmful modeling effects that suicide has that can influence others[11]

"Postvention" includes all supportive responses:

- initial discovery of the body
- involvement of first responders
- death notification
- funeral and mourning practices
- support
- development of tragic events response protocols and teams
- counseling, therapy and aftercare for survivors[12].

Grief and Trauma

Many of the experiences of grief after a suicide are similar to those following death by other causes. The set of experiences that are unique with suicide are:

- Increased risk of Post-Traumatic Stress Reactions (PTSR) and
- Post-Traumatic Stress Disorder (PTSD)

Trauma reactions are due to the "sudden" nature of the death, the violence involved and the state of the body, the nature of the relationship with the deceased, and many other factors. Trauma reactions can be perpetuated, as it is often the family and friends that are left to clean up after a suicide.

PTSR refers to a set of symptoms such as increased anxiety and fear states, reliving the trauma, and avoidance. These symptoms usually decrease over time, while PTSD is

a clinical disorder that is much more chronic in appearance and time. Many of those affected will experience PTSR rather than full-blown PTSD. However, without proper supports after a suicide, there is an increased risk for developing PTSD.

Complex and Complicated Grief Reactions

Many have reported that the quality of grief responses is different for suicide than for death by other causes[13]. For example, it is normal to have "regrets" after any death. They may include:

- "I wish we had more time together"
- "I wish some part of our relationship had been better"
- "I wish I had done more of this", or "less of that"

With suicide, many experience the same type of "regrets", and add one more sentence to it, "Because if I had, they might still be alive today."

"Regrets and the cause of death often become confused[14]. Recovering from suicide bereavement often involves understanding that "regrets" and the "cause of death" are two separate issues. The same dynamic can be seen with blame.

It is now recognized that many professionals can also be survivors after a suicide[15], particularly with the degree of responsibility that is placed on the role of parent, teacher, doctor, therapist, etc.

Cluster and Contagion Effects

Death by suicide can be a negative powerful model of behaviour and problem solving when the person affected by the loss lacks effective coping skills and resources.

Over the years, concern has been expressed regarding the link between media portrayals of suicide and the increased risk for suicidal behavior[16]. While the bulk of this concern has been focused on the news media (newspapers, radio, television), it also includes plays, music, and even public awareness presentations. It is not the existence of suicide prevention presentations, but how they are presented that can sometimes contribute to contagion effects.

Contagion effects are more likely to occur when audience members identify with the victim.

Risk for contagion is higher when:

- stories include methods for suicide
- stories are sensationalized or romanticized
- explanations are simplistic (e.g. teenager fails exam, kills self) and do not reflect the complex nature of suicide
- where it is suggested directly or indirectly that the suicide was an inevitable outcome

Risk is also increased where there is an absence of information on risk signs, how to help, and lists of resources within the community.

Many associations have developed and distributed media guidelines in an effort to educate media, and to provide accurate information about the problem of suicide. Links to a number of these sets of guidelines are in the Resources section in the appendices.

Finally, the risk for complicated grief reactions, and contagion is increased when there is a lack of helpful response and available supports for those affected by suicide at home, at school, in the workplace and in the community.

Homicide Suicide

Although cases of homicide/suicide occur far less frequently than either suicides or homicides, they can be considered *low frequency – high impact* events in the life of a community. Each year across Canada there are forty cases of homicide/suicides. The vast majority of these involve a history of domestic violence with men killing their partners and themselves[17].

The presence of shame and blame experienced by survivors in homicide/suicide situations is often more profound, with feelings of failure to protect the victim, and blame extended to the families of the offender. While there is a tendency for media to view homicide/suicide differently than suicide, many of the same concerns regarding impact and contagion are present. This concern is warranted as many stories are highly sensationalized, and contain little information about risk signs or community resources for help and support[18].

Postvention (PO)

Goal – Minimize the impact of a death by suicide on individuals, families and the community.

Public Awareness (PA)

Objectives

PO/PA 1.1 Identify and/or increase print, audio/visual and internet resources that provide education regarding the impact of suicide on those who are bereaved.
PO/PA 1.2 Identify and/or increase presentations and information that address bereavement and recovery issues.
PO/PA 1.3 Identify and publicize services that address tragic event responses, crisis, counseling, therapy and self-help groups.

> **Comment:** *Use of Survivors who are further along in their own recovery can be immensely helpful to the recovery of others, particularly those who are recently bereaved. Many times after a suicide, those who are bereaved can feel as if they have lost any future. It is helpful to hear stories as to how others recovered, and particularly outreach services, using Survivors who can demonstrate that it is possible to recover and develop a quality of life.*

Media Education (ME)

Objectives

PO/ME1.1 Increase the number of educational opportunities for media about the impact of suicide on individuals and communities and the possibilities for prevention.
PO/ME 1.2 Integrate materials on bereavement, contagion and recovery in the development of a comprehensive media package on suicide.
PO/ME 1.3 Increase media stories on the impact of suicide on individuals, families, the community and ways in which to support those who are grieving.
PO/ME 1.4 Distribute and encourage the adoption of media guidelines on stories about suicide in order to minimize contagion effects.
PO/ME 1.5 Honour responsible reporting about suicide and highlight positive examples at regional meetings and conferences.

Access to Services (AS)

Objectives

PO/AS 1.1 Identify and/or increase services for those affected by suicide.
PO/AS 1.2 Identify and/or develop community Tragic Events Response Teams.
PO/AS 1.3 Identify and/or develop policies and protocols for responding to traumatic deaths including suicide, in educational facilities, workplaces, hospitals, and among first responders.
PO/AS 1.4 After-care procedures should include services that provide help in clean-up and restoration after a suicide.
PO/AS 1.5 Identify and/or develop “Standards of Care” in working with those impacted and/or bereaved by suicide.
PO/AS 1.6 Identify and integrate practices that respect sexual and gender diversity.
PO/AS 1.7 Identify and integrate practices that respect language, ethnicity, cultural and religious diversity.
PO/AS 1.8 Develop specific policies and protocols to deal with the aftermath of homicide/suicide.

Means Restriction (MR)

Objectives

PO/MR 1.1 Where possible, discourage retention of the means for suicide (e.g. keeping a firearm that has been used in a recent suicide).
PO/MR 1.2 Track/Monitor methods used and integrate into intervention and prevention strategies.

Training (TR)

Objectives

PO/TR 1.1 Provide opportunities for Survivor input regarding those issues that need to be addressed through training.
PO/TR 1.2 Identify and publicize training packages and opportunities that address bereavement, grief and traumatic grief due to suicide.
PO/TR 1.3 Increase the percentage of counselors and therapists who have training in trauma and grief, particularly in connection with deaths by suicide.
PO/TR 1.4 Identify, or where needed develop training and standards for tragic events response teams.

PO/TR 1.5 Increase training opportunities for gatekeepers in trauma and traumatic grief, suicide bereavement and support.

Evaluation/Research (ER)

Objectives

PO/ER 1.1 Develop outcome measures for all objectives.
PO/ER 1.2, Identify relevant research on the impact of suicide through periodic literature searches.
PO/ER 1.3 Increase surveillance and data collection on deaths by suicide.
PO/ER 1.4 Evaluate programs and services that deal with the impact of suicide on individuals, families and communities.
PO/ER 1.5 In the case of domestic violence or partner homicide/suicides, refer all incidents of homicide/suicide to the Domestic Violence Death Review Committee. Integrate findings back into research and regional strategy.

Intervention

Discussion

Intervention addresses the need to decrease the risk for suicidal behavior (ideation, attempts), in the short and long-term. It involves identification and assessment of those at risk, working to decrease that risk, and referral to services that can help address long-term factors.

Suicide and suicidal behavior is a complex problem consisting of biological, psychological, social and spiritual factors. While there can be many pathways to suicidal behavior, there are a number of commonalities identified by Shneidman[19].

As Shneidman states, suicide is often the response to overwhelming emotional pain brought on by problems that are perceived as having no solution. As the pain increases, there are increased feelings of helplessness, hopelessness, and thinking becomes constricted.

Suicide consists of "perturbation" and "lethality". *"Perturbation"* refers to how upset, distressed, agitated someone is and can be rated as low, moderate or high. *"Lethality"* is the degree to which someone views suicide as the solution to their pain, and can also be rated as low, moderate or high. It is not perturbation that kills, it is lethality. However, a decrease in perturbation will lead to a decrease in lethality.

The vast majority of those considering suicide are ambivalent about death. While they do not necessarily want to end their lives, they do want some relief from the pain they are experiencing.

Perturbation is generated by a number of situations in which historically a higher risk for suicide has been identified. These situations include:

- Significant unresolved losses and grief (especially if related to loss through suicide).
- Mental Illness (particularly where there is a high degree of stigma and shame)
- Addictions (substance abuse and gambling)
- Abuse (ie. sexual, emotional, physical, bullying)
- Overwhelming and prolonged stressors (e.g. financial, relationships, violence, academic, etc.)
- Trauma

- Marginalization (e.g. sexual and/or gender orientation, ethnicity, culture, or homelessness)
- Acculturation (destruction of culture, e.g. among First Nations, Inuit)

These are not discrete categories. It is common to find the presence of two or more of the above for those at risk for suicide.

There are a number of factors that influence individual's degree of lethality. They include limited or few coping skills, romanticizing "suicide" and easy access to means and methods. For example, the presence of a firearm in the home significantly increases individual risk for a suicide,[20] with estimates as high as 30 times more likely in comparison to other means[21].

Finally, it has become much easier to obtain information about "how" to suicide through internet web sites.[22] A number of internet sites encourage suicidal behavior and the internet has also been used to arrange "suicide pacts"[23].

Over the years, models for responding to those at risk have been described as "emotional first aid," analogous to St. John's physical first aid. The goals are similar: to assess the situation, stabilize and help refer to the appropriate services.

As with physical first aid, one does not necessarily have to have training in the helping professions (psychiatry, psychology, social work, etc.) to learn the skills of emotional first aid. Many gatekeepers are in important positions to identify, help, intervene and refer when necessary.

While intervention focuses on addressing the initial crisis, it is recognized that attention to longer term issues is important to reduce lifetime risk.

While intervention has been described as emotional first aid, it is important to think about "levels of intervention" and the goal for each. Merely providing information on suicide warning signs and suggestions for help doesn't address comfort or confidence issues for many. For the sake of discussion, 3 levels are identified:

> Awareness – *increasing the possibility that someone may recognize warning signs and alert others to the possibility of risk.*
>
> Volunteers and Gatekeepers – *increasing ability to identify warning signs, assess risk and provide some intervention to decrease risk.*

Professional – *increased training and skills level in identification, risk assessment, interventions, and provision of, or referral to other services for short or long-term counseling/therapy.*

Although the safety of a person at potential risk is paramount, the reactions of family and friends should not be ignored. The possibility of a suicide attempt, or the aftermath of a non-lethal attempt is a distressing event for all concerned. Reactions can range from shock to fear, guilt, anger and rejection. Fear and anticipatory grief reactions, not unlike news of a terminal illness, can be experienced. Family members can have lingering questions as to the potential for another attempt. They can express uncertainty as to how they should interact with their family member or friend.

Intervention is not only necessary for the person at risk, the concerns and questions of significant others must also be planned for and addressed.

Intervention (IN)

Goal: To identify and decrease the risk for suicidal behavior.

Public Awareness (PA)

Objectives

IN/PA 1.1 Identify and/or develop a public awareness campaign that addresses warning/risk signs, how to help and support those at potential risk, and services for crisis, stabilization and counseling/therapy.
IN/PA 1.2 Identify and/or develop specific awareness materials and presentations for target groups, (e.g. according to age, gender, ethnic/cultural differences, etc.)
IN/PA 1.3 Ensure that information on stress, mental health and suicide, including how and where to get help, is included in all orientation packages for high schools, colleges and university.
IN/PA 1.4 Identify and/or develop public information opportunities including internet and public presentations (e.g. public information sessions, workshops).

Media Education (MR)

Objectives

IN/MR 1.1 Identify and/or develop materials on warning signs, support and community services (crisis, counseling, therapy, etc) as part of a media awareness kit on suicide.
IN/MR 1.2 Increase the number of media stories that responsibly discuss suicide, warning signs, how to support people at risk and referral to services (crisis, counseling/therapy).
IN/MR 1.3 Identify and/or develop and distribute media guidelines on stories about suicide in order to minimize contagion.
IN/MR 1.4 Develop a system for monitoring/tracking and evaluating media stories regarding suicide, in terms of their consistency with guidelines.
IN/MR 1.5 Develop a system for feeding these evaluations back to the media, including regional awards for public interest reporting about suicide prevention.

Access to Services (AS)

Objectives

IN/AS 1.1 Identify all services that address suicidal behavior throughout the Niagara Region.
IN/AS 1.2 Increase public knowledge regarding crisis, counseling and therapy services available throughout the Niagara Region
IN/AS 1.3 Identify and/or develop policies and procedures for managing suicidal behavior including (i) referral, (ii)risk assessment, (iii) follow up and (iv) discharge/treatment planning.
IN/AS 1.4 All interventions must include steps to assist and support significant others in understanding and responding to those at risk in the short and long term.
IN/AS 1.5 Establish standards that follow-up must occur within forty-eight hours after discharge of all persons hospitalized for suicide risk.
IN/AS 1.6 Identify and/or develop and adopt “Standards of Care” for all services involved in identifying and responding to suicidal behaviour.
IN/AS 1.7 Identify and/or integrate development of “benchmarks” for services based on wait times and availability.
IN/AS 1.8 Identify and integrate practices that respect gender diversity.
IN/AS 1.9 Identify and integrate practices that respect language, ethnicity and cultural diversity.
IN/AS 1.10 In situations where the possibility of violence towards others is suspected or confirmed (e.g. domestic or workplace violence), risk assessment records should include risk of violence to others, and steps to take to alert potential victims, police and to ensure public safety.

Means Restriction (MR)

Objectives

IN/MR 1.1 All risk assessments must include identification of means an individual is considering.
IN/MR 1.2 All interventions must include disposal/control of the means for suicide.
IN/MR 1.3 Medical professionals prescribing for individuals at risk should be informed about the risk of overdose.

Training (TR)

Objectives

IN/TR 1.1 Identify and/or develop training packages for volunteers and professionals regarding identification, risk assessment and intervention to decrease the likelihood of a suicide.
IN/TR 1.2 Increase in the number of gatekeepers, volunteers and professionals trained in identification, risk assessment and intervention skills.
IN/TR 1.3 Collaborate with professional and occupational groups (e.g. College of Psychologists, police associations, etc.) in ensuring adequate suicide intervention training for their members.

Evaluation/Research

Objectives

IN/ER 1.1 Increase data collection and surveillance as to referrals to hospitals, service agencies, etc. due to suicidal ideation and behaviour.
IN/ER 1.2 Increase data sharing among health, education and social services for the purposes of collaboration and planning.
IN/ER 1.3 Increase community research projects regarding stress, mental health and suicide.
IN/ER 1.4 Develop outcome measures for all objectives and activities connected with intervention.
IN/ER 1.5 Regularly review and revise all policies, procedures, and standards of care in light of new information.

Prevention

Discussion

There are two aspects to many prevention efforts. The first involves addressing those factors that increase the risk for suicide (or any other social or health problem). The second involves the identification of resources and activities which increase the community's resilience and capacity to meet challenges.

While many of the activities listed under postvention and intervention focus on individuals or on a limited identifiable group, primary prevention addresses larger systemic and community issues as reflected in the following quotation:

> *No mass disorder afflicting mankind is ever brought under control or eliminated by attempts at treating the individual.*
>
> Dr. G. Albee, Editor – Journal of Primary Prevention[24]

It has been recommended that suicide prevention efforts include promoting awareness of suicide as an important and preventable public health problem[25].

While there can be a tendency to view many of the factors that increase risk as happening within an individual, (e.g. mental illness), it should be recognized that risk for suicide includes both internal *and* external factors. One of the biggest challenges for prevention is in changing underlying attitudes and beliefs.

One prevention program that has received considerable attention is that of the United States Air Force (USAF), and the development of their population-based , community approach program[26]. When the program began the USAF suicide rate was 15 per 100,000 and suicide was the second leading cause of

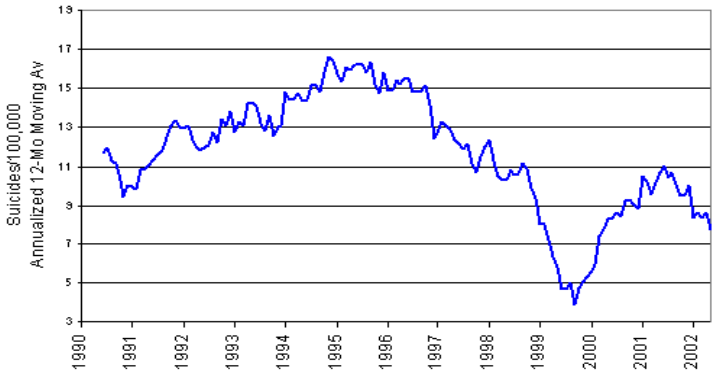

Figure 1

death among air force personnel. (see figure 1) Within the first three years of the program the rate dropped to less than 3.5 per 100,000. The rate increased again in early 2000, but decreased over the next few years to less than the 1995 rate.

A key feature of this program was in changing social norms, particularly with respect to (a) promoting support and (b) help-seeking behavior.

> *Through a series of hard-hitting messages to the force, the Air Force Chief of Staff repeatedly and unequivocally communicated the urgent need for Air Force leaders, supervisors, and frontline workers to support each other during the inevitable times of heightened life stress. Whether encountering the break-up of an intimate relationship, financial difficulties, legal problems, or frequently some combination of these, Air Force personnel were encouraged to personally offer assistance where possible and to promote use of community resources when necessary. He specifically encouraged airmen to seek help from mental health clinics and pointed out that when airmen seek help early it is likely to enhance their careers rather than hinder them. Further, he instructed commanders and supervisors to support and protect those who responsibly seek this kind of help. Finally, he removed policies that had acted as barriers to mental health care for those being charged with violations of military law.*

Other important features included educating the community, improving data surveillance, provision of critical incident stress management, and integrating the delivery system for human services.

Finally, prevention efforts need to emphasize that communities do have people with skills and resources that can be used in addressing a wide range of problems. One problem in media coverage is that when a story about suicide is produced, there is a lack of discussion regarding the resources that exist, or statements are made that the community is deficient in addressing this problem. This tends to reinforce the perception for individuals and families that there is no help and generally increases feelings of helplessness and hopelessness.

While it may be true that a community lacks some specific services, this is not the same as stating that a community lacks strengths and resources needed to address a specific problem. Once people within the community start to explore what is available, they typically find that there are in fact a number of strengths, skills and services that can address the problem.

This type of “discovery” was quite evident in the December 6, 2005, planning day attended by many from different services across the Niagara Region. When evaluations were completed, many participants expressed that it was good to see the number and variety of services that existed, and that so many were interested in doing something about suicide.

There has been a trend to get away from “deficit – based” models of community development and prevention, and towards models that emphasize community capacity. The emphasis on “Community Capacity” has been stressed by authors such as John Kretzman, and John McKnight[27]. They emphasize that all communities possess strengths and resources that can be used to address many of the problems the community is facing. Using a process called ABCD (Asset Based Community Development), communities are able to identity these and develop community driven solutions. This works to increase the community’s sense of pride and accomplishment and reduces the need to “airlift” in outside expertise.

An important cornerstone of prevention efforts within the Niagara Region will be the inclusion of those experiencing the problem in the development of solutions. This includes those bereaved by suicide (Survivors), those experiencing serious ideation and non-fatal attempts, and their families.

Prevention (PR)

Goal: Consistent with the target discussed by the Canadian Association for Suicide Prevention / L'association canadienne pour la prévention du suicide, based on the data from 1994 to 2004 (455 suicides), set a target goal of a reduction of 30% in the number of suicides across the Niagara Region over the next five years (from the adoption of this strategy), and then another 30% in the next five years.

Public Awareness (PA)

Objectives

PR/PA 1.1 Increase public attention to all activities geared towards suicide postvention, intervention and prevention.
PR/PA 1.2 Increase awareness of and participation in existing campaigns such as World Suicide Prevention Day (September 10th).
PR/PA 1.3 Increase public education opportunities through media, presentations, and wider availability of materials (audio-visual, internet).
PR/PA 1.4 Identify and/or increase opportunities to integrate materials on suicide prevention with other public awareness opportunities (ie. mental health, addictions, mental illness, etc.)
PR/PA 1.5 Identify ways in which education about suicide can be integrated into school health curricula, Employee Assistance Programs, Workplace Health/Mental Health Initiatives, etc.
PR/PA 1.6 Increase awareness as to how efforts for increasing community capacity and developing resilience can reduce the number of suicides.
PR/PA 1.7 Increase opportunities to connect with other prevention initiatives for promotion of stress management, mental and physical health.
PR/PA 1.8 Increase opportunities for those experiencing and affected by suicide to become part of the regional plan in developing solutions.

Media Education (MR)

Objectives

PR/ME 1.1 Develop Media Awareness Kits for all media within the Niagara Region.
PR/ME 1.2 Identify media opportunities for awareness and education about suicide.

Access to Services (AS)

Objectives

PR/AS 1.1 Increase community mapping (identification) of all services that address prevention, intervention and postvention.
PR/AS 1.2 Develop community procedures, policies and algorithms for identification, referral and response.
PR/AS 1.3 Increase awareness of, or development of Standards of Care for all services related to postvention/bereavement, intervention and prevention services.

Means Restriction (MR)

Objectives

PR/IN 1.1 Increase surveillance and monitoring of all methods and means used for suicide and suicide attempts.
PR/IN 1.2 Identify and increase opportunities to strategically place information regarding suicide and help (ie. crisis, counseling services) by potential means and methods.
PR/IN 1.3 Identify and integrate training materials from injury prevention into prevention strategies.
PR/IN 1.4 Increase opportunities for endorsement of strategies for firearms safety, poison prevention and medication practices.

Training (TR)

Objectives

PR/TR 1.1 Identify, increase and endorse integration of education on suicide postvention, intervention and prevention in all clinical courses at college, undergraduate and graduate university programs.
PR/TR 1.2 Identify, increase and endorse training opportunities for postvention and intervention skills for all gatekeeper positions.

Evaluation/Research

Objectives

PR/ER 1.1 Develop outcome measures for all activities connected with goals and objectives.
PR/ER 1.2 Identify research opportunities consistent with the six themes as developed by the Canadian Institute of Health Research.
PR/ER 1.3 Increase research within the Niagara region on suicide within university undergraduate and graduate programs.
PR/ER 1.4 Identify funding and funding opportunities to support research into suicide and its impact.

Resources

Information on Community Services - 211

Information

Niagara Region

Canadian Mental Health Association

National

Centre for Suicide Prevention - *http://www.suicideinfo.ca/*
Health Canada - *http://www.hc-sc.gc.ca/index_e.html*
Violence Policy Centre http://www.vpc.org
Mheccu – Mental Health Evaluation and Community Consultation Unit, University of British Columbia. A number of papers on mental health and suicide. *http://www.mheccu.ubc.ca/publications/*

Training Opportunities

Niagara Region

ASIST (Applied Suicide Intervention Skills Training) is provided through Distress Centre Niagara between September and June. Call (905) 688-5124 or email dcniagara@bellnet.ca.

National

Centre for Suicide Prevention – http://www.suicideinfo.ca
Living Works – http://www.livingworks.net
QPR (Question, Persuade, Refer) – http://www.qprinstitute.com

Associations

Niagara Suicide Prevention Coalition (NSPC) 905 688-5284, dniagara@bellnet.ca

Ontario Suicide Prevention Network (OSPN) – http://zope.vex.net/~wbell/OSPN

Canadian Association for Suicide Prevention / L'association canadienne pour la prévention du suicide (CASP/ACPS) – www.suicideprevention.ca

Media Guidelines

The following media guidelines are available on-line.

http://www.afsp.org/education/recommendations/5/1.htm

They were developed through:

- Centers for Disease Control and Prevention
- National Institute of Mental Health
- Office of the Surgeon General
- Substance Abuse and Mental Health Services Administration
- American Foundation for Suicide Prevention
- American Association of Suicidology
- Annenberg Public Policy Center

And developed in collaboration with

- World Health Organization
- National Swedish Centre for Suicide Research
- New Zealand Youth Suicide Prevention Strategy

http://www.samaritans.org/know/media_guide.shtm

Produced through the Samaritans from the United Kingdom

http://www.presswise.org.uk/display_page.php?id=166

Produced through Media Wise

Standards of Care

There is no one set of "Standards of Care" for responding to suicide risk or bereavement. Several share common features including guidelines for risk assessment, contracting, development of safety plans, follow up and referral for additional services. The following focus on physicians, psychiatrists and psychologists. Review and discussions should involve investigation of standards under the respective colleges in Ontario for medicine, psychiatry, psychology and social work.

Bongar, B. (2001) The Suicidal Patient: Legal and Clinical Standards of Care. Washington, DC: American Psychological Association

Ministry of Health – New Zealand (1993) Guidelines for the Management of Suicidal Patients. Available On-line. *http://www.moh.govt.nz/moh.nsf/0/a9d50492544deb27cc256b7f0075e835?OpenDocument*

Bongar, B., Maris, R.W., Berman, A.L., Litman, R.E., & Silverman, M.M (1993) Inpatient standards of care and the suicidal patient. Part 1: General clinical formulations and legal considerations. Suicide & Life-Threatening Behavior, 25 (2): 319-21.

Silverman, M.M., Berman, A.L., Bongar, B., Litman, R.E. & Maris, R.W. (1994) Inpatient standards of care and the suicidal patient. Part II: An integration with clinical risk management. Suicide & Life-Threatening Behavior, Summer (2): 152-69.

Meichenbaum, D. (2005) 35 Years of Working with Suicidal Patients: Lessons Learned. Canadian Psychologist, 46:2, 64-72. Available On-Line: *http://www.erickson-foundation.org/Handout%20Five.pdf*

Standards of Care also apply to education programs and responses with youth. The following resource should be consulted.

School Based Suicide Prevention Programs – SIEC Alert #32 Available On-Line at: http://www.suicideinfo.ca/csp/go.aspx?tabid=23

A thorough presentation of many school based issues can be found in “Maine Youth Suicide Prevention: Youth Suicide Prevention, Intervention and Postvention Guidelines”. *http://www.state.me.us/suicide/sinfores.htm*

Another guide is the Youth Suicide Prevention School Based Guide which includes information and checklists on various aspects of school based programs. *http://theguide.fmhi.usf.edu/*

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[7] For the period of 1986 to 1999.

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