

community caring health listening trust
with education openness
collaboration recovery
family empowerment
communication openness
empathy healing hope
diversity faith community humanity
love resilience compassion support
connecting responsibility respect
sharing cooperation
courage strength transformation
understanding dignity caring health
education openness empathy

NOVA SCOTIA STRATEGIC FRAMEWORK TO ADDRESS SUICIDE

Nova Scotia
Strategic
Framework
to Address
Suicide

Provincial Strategic Framework
Development Committee
NOVEMBER 2006

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to Address
Suicide

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Nova Scotia Strategic Framework to Address Suicide

Developed by the Provincial Strategic Framework Development Committee, in consultation with communities and partners across Nova Scotia.

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The *Nova Scotia Strategic Framework to Address Suicide* was developed through a collaborative process to help create effective, intersectoral approaches to addressing suicide in our province. The development of the *Strategic Framework* was guided by a provincial intersectoral steering committee, whose members were:

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The Strategic Framework builds on work completed in Nova Scotia over the past several years. Thank you to the people who participated in the Nova Scotia Symposium on Suicide in 2003 and contributed to the *Benchmark and Recommendations to Address Suicide in Nova Scotia*. Thank you also to the people who contributed to the *Nova Scotia Injury Prevention Strategy* (2003), and the participants in the first Nova Scotia Suicide Prevention Forum (2005). Special thanks to the members of the Nova Scotia Community Network to Address Suicide for their continuous efforts to ensure that suicide is formally addressed in Nova Scotia.

Several people from Nova Scotia and beyond served as expert reviewers for the *Strategic Framework*. Thank you to Adrian Hill, Steve Kisely, Chris Laforge, and Gayle Vincent for their thoughtful advice and input.

Nova Scotia Health Promotion and Protection worked with several consultants to assist in the development of the framework. The Department and the Steering Committee wishes to acknowledge the contributions of these consultants:

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- Cari Patterson and Jean Robinson-Dexter, Horizons Community Development Associates Inc., Phase 2 Consultations and final framework preparation.

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In the late summer and early autumn of 2006, approximately 250 people participated in 21 consultation sessions held across the province, and nearly 100 people provided input into the *Strategic Framework* through a web survey. Dozens of other people helped organize the sessions and encouraged people to share their experiences and perspectives. Thank you to everyone who contributed.

This work is dedicated to the consultation participants who bravely shared their stories and experiences with suicide, with the conviction that doing so would contribute to making the world a better place. Your courage is truly humbling. Your vision will be carried forward in the implementation of the *Strategic Framework*.

MESSAGE FROM THE MINISTER

Nova Scotia Health Promotion and Protection was created to build a healthier and safer future for all Nova Scotians. This is a daunting task, but our experience to date demonstrates that with solid leadership at the provincial level, and the mobilization of our community partners, we can achieve this goal.

Suicide and attempted suicide is like the many other health and social issues Nova Scotia Health Promotion and Protection is working hard to address:

- There are many concerned and active stakeholders already working to address suicide and attempted suicide, but greater coordination through a comprehensive strategy will further these collective efforts;
- The issue of suicide has not been well recognized in the past, and has, in many cases not received the attention and focus it deserves from government;
- Most suicides can be prevented;
- The causes, and risk and protective factors for suicide are well understood, and many of these are similar to those related to other diseases and injury risks;
- The strategies required to address suicide, while in some instances require further research and understanding, are known and can be acted upon;
- The issue requires an intersectoral approach – an approach where groups, organizations, and individuals who have a role to play in addressing suicide, either directly or indirectly, come together and work on common objectives; and
- Many of the solutions are long term – the results cannot be achieved overnight, and thus will require ongoing resources and efforts.

Given the commonalities between suicide and other issues our department is tasked with addressing, I am confident we are well placed to take on the challenge of leading the implementation of the *Nova Scotia Strategic Framework to Address Suicide*. I look forward to working with my colleagues across government to ensure government does its share of what is required. And, I look forward to seeing the results of this work improve the lives of all Nova Scotians.

In closing, I want to thank the hundreds of people and organizations who have contributed to the development of the *Nova Scotia Strategic Framework to Address Suicide*. Your efforts will not be in vain. Together, we can reduce the impact of suicide and attempted suicide in our province.



BARRY BARNET

Minister, Nova Scotia Health Promotion and Protection

MESSAGE FROM THE CANADIAN ASSOCIATION FOR SUICIDE PREVENTION

It is an honour and a privilege for the Canadian Association for Suicide Prevention to endorse and to support the *Nova Scotia Strategic Framework to Address Suicide*.

The *Nova Scotia Strategic Framework to Address Suicide* represents an outstanding achievement of coordinated effort by clinicians, researchers, educators, consumers, survivors, community, and government and agency directors and staff. In keeping with Nova Scotia's long standing reputation for commitment and caring, this important document brings suicide prevention and bereavement support to public attention at a time when all Canadians are ready to move forward together to address these pressing issues. Your leadership, energy and expertise will benefit peoples everywhere who work to address suicide.

In the past three decades, more than 100,000 Canadians died by suicide. These deaths include our children and our parents, our family members, our friends, our neighbours and people from all socioeconomic, age, gender, culture and ethnic groups. No part of our society is immune. Suicide affects all of us. It remains among Canada's most serious public health issues.

The *CASP Blueprint for a Canadian National Suicide Prevention Strategy* was released in 2004 in the hopes that provinces and territories would lead the way in bringing all levels of government together to address these issues. Nova Scotia now joins Quebec, Alberta, Manitoba and New Brunswick in creating a provincial strategy.

The most important goals of any suicide prevention strategy are to unite all communities, governments, organizations and resources with their key stakeholders to work effectively together to prevent death by

suicide; and to assist, educate and comfort those impacted by suicidal behaviours. Suicide is most often the result of pain, hopelessness and despair. It is the triumph of pain, fear and loss over hope. It is almost always preventable through caring, compassion, commitment and community. *The Nova Scotia Strategic Framework to Address Suicide* is a detailed and caring approach that leads the way in preventing suicide and supporting those bereaved by suicide.

Please accept our congratulations upon an excellent strategy and our thanks and our gratitude for your collective effort, hard work and for your commitment, compassion and caring. Every Nova Scotian can be proud.



ADRIAN HILL

President, Canadian Association for Suicide Prevention
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EXECUTIVE SUMMARY

Between 1990 and 1999, there were over 100 suicide deaths each year in Nova Scotia. In addition, suicide has remained one of the top three causes of death and hospitalizations in Nova Scotia amongst those 16 and older.¹ The public health impact of attempted suicide is substantial: the burden on emergency health services, medical, and psychiatric services is considerable;² and the economic impact alone of suicide in Nova Scotia is estimated to be \$100 million annually.³

As is the case with most injuries, suicide and attempted suicide usually result from a combination of factors interacting together to produce a potential or actual injurious event. Risk factors for suicide and attempted suicide include: mental illness; social isolation; a previous suicide attempt; family violence; physical illness; substance abuse and addiction; and access to means of suicide.⁴

These many factors carry unequal weights and no single risk factor has been proven necessary or sufficient to cause suicide or attempted suicide.⁵ Risk factors can collectively contribute to suicide by increasing general levels of stress or hopelessness within individuals and groups in society, which in turn reduces the ability to cope with adverse life conditions. Risk factors can also disrupt the formation of supportive social networks, over-tax organizations providing services to communities, and potentially reduce help-seeking behaviours.⁶

While the risk factors associated with suicide are important to address, it is also crucial to consider the socioeconomic environment – the determinants of health. Moreover, one must consider how these factors interact to influence other external and personal risk factors. An individual's income, education, social connectedness in the community, and availability of social supports all have an impact on his/her general health and specific risk of suicide.

There are also protective factors that buffer people from suicidal behaviour and the risks associated with suicide. These protective factors are composed of personal protective factors and external protective

factors. Personal protective factors refer to an individual's resiliency and ability to cope with difficult situations and circumstances. External protective factors refer to the support systems available to individuals when they are dealing with difficult circumstances. These support systems can have an additive or a synergistic effect when dealing with crisis situations. Intervention by a person or institution can help an individual access protective factors as a powerful anecdote to suicidal thoughts or behaviours.

Since suicide is a multifaceted issue that involves psychological, social, economic, genetic, cultural, and environmental factors,⁷ one single intervention is not likely to have the potential to reduce suicide rates. A broad array of suicide prevention, treatment, and maintenance strategies that address different suicide risk factors and protective factors will be required to potentially achieve an overall, long-term reduction in rate of suicide/attempted suicide.⁸

In Nova Scotia we have an opportunity to tackle the issue of suicide in a comprehensive and organized fashion. We have the prospect, through collaboration across sectors, of creating and enhancing the necessary societal, policy, and individual supports required to reduce the rate of suicide/attempted suicide, and reduce the impact on our families, friends, neighbors, coworkers, and communities.

The *Nova Scotia Strategic Framework to Address Suicide* is a seven-to-ten year plan for reducing suicide/attempted suicide in Nova Scotia. Euthanasia and self-harming behaviours that are not motivated by an intent to die, while important issues to be addressed, fall outside the scope of the *Strategic Framework to Address Suicide in Nova Scotia*.

The intended audience of the *Strategic Framework* is professionals, policy makers, and communities working across sectors to address suicide. *The Strategic Framework* includes a vision, mission, guiding principles, and six strategic goals and their corresponding objectives. It is intended as a guide for policy makers, professionals, and communities who will be involved in the implementation of the *Strategic Framework*. Specific outcome targets will be set in the implementation plan, which will be developed collaboratively.

The Vision of the *Nova Scotia Strategic Framework to Address Suicide* is:

Working together to reduce the impact of suicide through building hope, strength, and resiliency, so that every person can lead a healthy and safe life.

The Mission of the *Nova Scotia Strategic Framework to Address Suicide* is:

To enhance the necessary societal, policy, and individual supports required to address suicide.

The Guiding Principles of the *Nova Scotia Strategic Framework to Address Suicide* ensure that the *Strategic Framework* will:

- Build on evidence-based suicide prevention, intervention, and postvention strategies and initiatives;
- Be comprehensive – addressing the multidimensional factors that play a role in addressing suicide;
- Be relevant to the needs of all populations based on consultation, surveillance, and research;
- Be a living document that is evidence-based and continuously monitored and evaluated;
- Reflect the different communities, cultures, and diversity of stakeholders;
- Facilitate collaborative strategies across sectors to promote protective factors and strengthen hope and resiliency; and
- Be guided by a population health approach.

The Strategic Goals of the *Nova Scotia Strategic Framework to Address Suicide* are:

1. The *Nova Scotia Strategic Framework to Address Suicide* has the appropriate and adequate leadership, capacity, and infrastructure.

2. Individuals, communities, institutions, policy makers, the media, care providers, survivors, families, and those who may work with at risk populations are aware of and understand the issue of suicide.
3. Integrated prevention programs, services, and strategies, focused on minimizing risk factors, building resiliency, and heightening protective factors for suicide.
4. Integrated and seamless intervention programs, services, and strategies.
5. Comprehensive postvention programs, services, and strategies to support those who are bereaved by suicide or impacted by suicidal behaviours.
6. Community action and decision-making is informed by the timely collection, analysis, and dissemination of data and research on suicide.

The *Nova Scotia Strategic Framework to Address Suicide* is a living document that will be revisited every few years; it will evolve based on evaluation, new best practice and promising practice information, as well as the changing realities in Nova Scotia communities.

INTRODUCTION

The Impact of Suicide

Suicide claimed the lives of approximately 877,000 people worldwide in the year 2000.⁹ In North America and most European countries, suicide has ranked among the top five-ten causes of death in recent years.¹⁰

Suicide in Canada is a significant public health problem that is largely preventable. “Suicide has accounted for about 2% of annual deaths in Canada since the late 1970s.”¹¹ (Unless otherwise stated, mortality rates cited here refer to deaths per 100,000 population). Between 1960 and 1991 the suicide rate in Canada increased from 7.8 to 12.8, peaking at 14.0 in 1986.¹² In 1998, approximately 3,700 Canadians took their own lives; this is an average of about 10 suicides per day. Suicide is currently the fifth leading cause of death among Canadians, and is the second leading cause of death among Canadian children and youth aged 10 to 24 years. Canadians are seven times more likely to die from suicide than to be the victim of a homicide.¹³

Suicide is a complex phenomenon that eventually, in one way or another, touches the lives of most Nova Scotians. Most people in this province have, at some point in their lives, been affected by suicide – perhaps personally, through a friend, in their community, in their school, or in their workplace. This is no surprise, considering that attempted suicide is the third leading cause of injury-related hospitalization in Nova Scotia, and is the leading cause of injury-related death.

Despite the common understanding that suicide affects everyone, there has been limited public attention to suicide in Nova Scotia. Suicide often is under-reported, which indicates a lack of ability to fully comprehend the scope of suicide in our society. However, provincial, national, and global statistics indicate that it significantly filters through most sectors of society.¹⁴

Between 1990 and 1999, there were over 100 suicide deaths per year

in Nova Scotia. In addition, suicide has remained one of the top three causes of death and hospitalizations in Nova Scotia amongst those 16 and older.¹⁵ The public health impact of attempted suicide is substantial: the burden on emergency health services, medical, and psychiatric services is considerable;¹⁶ and the economic impact alone of suicide in Nova Scotia is estimated to be \$100 million annually.¹⁷ These numbers further emphasize that suicide is a significant public health problem in Nova Scotia.

Our government, and past governments, have been criticized for not doing enough to address the issue of suicide. I'm here to tell you that this is going to change.

BARRY BARNET, MINISTER, HEALTH PROMOTION AND PROTECTION
STATEMENT TO STAKEHOLDERS AT THE LAUNCH OF COMMUNITIES
ADDRESSING SUICIDE TOGETHER, SEPTEMBER 11, 2006

Factors Associated with Suicide

As is the case with most injuries, suicide and attempted suicide usually result from a combination of factors interacting together to produce a potential or actual injurious event.

Suicide and attempted suicide risk factors include: mental illness; social isolation; a previous suicide attempt; family violence; physical illness; substance abuse; and access to means of suicide.¹⁸

These many factors carry unequal weights and no single risk factor has been proven necessary or sufficient to cause suicide or attempted suicide.¹⁹ Risk factors can collectively contribute to suicide by increasing general levels of stress within individuals and groups in society, which in turn reduces the ability to cope with adverse life conditions. Risk factors can also disrupt the formation of supportive social networks, over-tax organizations providing services to communities, and potentially reduce help-seeking behaviours.²⁰

The risk factors associated with suicide and attempted suicide can be categorized in a number of ways, including:

Personal Risk Factors

1. **PSYCHIATRIC CONDITIONS** As a group, people who have been diagnosed with clinically severe depression or some other psychiatric disorder face a statistically higher risk of suicide than the general population. However, existing evidence indicates that no single determinant is either necessary or sufficient to bring about suicide, but that each suicide/suicide attempt involves the complex interaction of various factors.²¹
2. **GENETICS** There is some evidence that suicide tends to run in families. Recent reviews state that although it is difficult to differentiate between the genetic factors involved in suicide, the presence of a family member as a role model and psychiatric disturbances in families can contribute to suicide and attempted suicide. It is also possible that although suicide itself is not inherited, some families may have greater probabilities of transmitting psychiatric disorders that increase the risk of suicide.²²
3. **PERSONALITY AND PSYCHOLOGICAL INFLUENCES** The psychological influences that produce suicidal intentions involve emotional and/or personal attributes of the individual. Feeling depressed, hopeless, or frantically anxious are common emotional states for persons who feel suicidal. The suicide risk is heightened if these emotional states are combined with certain characteristics, such as an inability to cope with adverse circumstances, poor self esteem, negative attitudes about the self, or being given to impulsive or aggressive action.²³

*Each suicide is an individual act. Blanket statements are impossible.
We have to deal with individual issues.*

CONSULTATION SESSION PARTICIPANTS SPEAKING
ABOUT THEIR OWN EXPERIENCES

*You have to fit in “this box” when you come for help.
We may not all fit in the box!*

CONSULTATION SESSION PARTICIPANTS SPEAKING
ABOUT THEIR OWN EXPERIENCES

External Risk Factors

1. **SOCIOLOGICAL AND CULTURAL FACTORS** The sociocultural factors that relate to suicide risk might include: a general state of societal demoralization; permissive social attitudes towards suicide; media attention to celebrity suicides; social isolation from a supportive network; suicides of role models or peers; unemployment; and an environment that facilitates suicide, such as one that permits the ready availability of guns.²⁴
2. **LIFE EVENTS** Research has shown that between 27% and 39% of people who attempted suicide had experienced a painful or stressful life event within the six weeks preceding their suicide attempt. The majority of these precipitating events were personal losses or interpersonal conflicts. Those who were diagnosed as suffering from drug or alcohol abuse or addictions were also more likely to have an identifiable precipitating event before their suicide than those with other psychiatric diagnoses.²⁵

While the risk factors associated with suicide are important to address, it is also crucial to consider the socioeconomic environment – the determinants of health. Moreover, one must consider how these factors interact to influence other external and personal risk factors. An individual’s income, education, social connectedness in the community, and availability of social supports all have an impact on his/her general health and their specific risk of suicide.

According to the National Center for Injury Prevention and Control,²⁶ protective factors buffer people from the risks associated with suicide. These protective factors are composed of personal protective factors and external protective factors:

Protective Factors

1. **PERSONAL PROTECTIVE FACTORS** Personal protective factors refer to an individual’s resiliency and ability to cope with difficult situations and circumstances. Examples of personal protective factors include:
 - Ability to readily recover (e.g., resilience from a negative event and tolerance from frustration);
 - Ability to develop strategies to maximize one’s potential in any circumstances;
 - Ability to master, minimize, reduce, or tolerate stress or conflict;
 - Positive expectations for the future;
 - Sense of humour;
 - Strong cultural and/or religious beliefs; and
 - Skills in problem solving, conflict resolution, and non-violent handling of disputes.
2. **EXTERNAL PROTECTIVE FACTORS** External protective factors refer to the support systems available to individuals when they are dealing with difficult circumstances. These supports systems can have an additive or a synergistic effect when people are dealing with crises situations. Examples of external protective factors include:
 - Effective clinical care for mental, physical, and substance abuse disorders;
 - Easy access to a variety of clinical interventions and support for help-seeking; and
 - Positive healthy family and peer relationships.

The majority of suicides can be prevented. By working together in our organizations and communities, we can reduce the risk factors and heighten the protective factors associated with suicide and attempted suicide to make a significant difference in the lives and health status

of Nova Scotians. Together, we can make our community and social environment a safer and healthier place for everyone.

Best Practice Approach to Suicide Prevention Strategies

Since suicide is a multifaceted issue that involves psychological, social, economic, genetic, cultural, and environmental factors,²⁷ one single intervention or strategy is not likely to have the potential to reduce suicide rates. A broad array of suicide prevention, treatment, and maintenance strategies that address different suicide risk factors and protective factors will be required to potentially achieve an overall, long-term reduction in rate of suicide/attempted suicide.²⁸

In 1994, the *Canadian National Task Force Update* identified a number of strategies that might be promising for best practice suicide prevention:

- **PREVENTION** Prevention focuses on a comprehensive approach that involves the use of public education, intervention, and evidence-based research that simultaneously focuses on strengthening resilience, reducing risk factors, and improving protective factors on both the individual and community levels.²⁹
- **INTERVENTION** Intervention activities need to focus on the service options and family supports available to the individual and her/his personal supporters, both during and after the suicidal crisis. A crisis is a time-limited experience. The goal of suicide intervention is to offer immediate support to the individual to mobilize internal and external resources that will enable her/him to survive until the suicidal intent resolves. This intervention needs to be followed by comprehensive treatment and support to reduce the risk of future suicidal crises and enhance the overall resiliency and protective factors within the individual.³⁰
- **POSTVENTION** (Support for those who attempted suicide and their families, and those bereaved by suicide.) Suicide is a complex

phenomenon, and the postvention needs of survivors, families, friends, service providers, and in the case of incompleting suicides, the people who experienced the suicidal crisis, are multifaceted. Support and assistance should be available from a number of sources. Although supportive networks may be crucial to an individual's well being, negative social and cultural attitudes towards suicide often lead to isolation.³¹

*We need open healing, and being able to tell people what really happened.
Don't carry the burden. If we don't talk about it, nothing will change.*

CONSULTATION SESSION PARTICIPANTS SPEAKING
ABOUT THEIR OWN EXPERIENCES

Population Health Approach

The strategic goals and actions identified in the *Strategy for Addressing Suicide in Nova Scotia* encompass a population health/health promotion approach and consider:

- The whole or a large sub-section of the population;
- Strategies for addressing the determinants of health;
- The issue of suicide prevention, and recommended research-based strategies;
- The issue of suicide from an upstream perspective;
- The use of multiple strategies;
- Strategies for working with partners across sectors;
- Processes that incorporate input from stakeholders and those concerned about the issue of suicide; and
- Built-in methods for outcome accountability.

PRIORITY POPULATION GROUPS

Suicide affects all of us – our children, our parents, our family members, our friends, and our neighbours. It affects people from all socioeconomic, age, gender, culture and ethnic groups. Men and women of all ages are at risk of death by suicide, and any death of a young person is particularly painful. No part of our society is immune, and suicide prevention and addressing suicide are everyone’s business.

There are also certain population groups that can be identified as being at even higher risk for suicide than the general population. These groups have been traditionally disadvantaged in our society and there is a special urgency in addressing their needs. It is clear that particular attention must be paid to Aboriginal peoples; lesbian, gay, bisexual, and transgendered youth; and people who have a mental illness. It is important that we prioritize working with these groups as well as with the general population to address suicide.

As suicide surveillance systems are improved, and as the implementation plan for the *Nova Scotia Strategic Framework for Addressing Suicide* is developed, attention will also be focused on other groups identified in the literature as high risk groups including youth, senior men, middle-aged women, and people who are homeless.

Aboriginal Peoples

The suicide rate among Aboriginal peoples is much higher than the rates among the general population. In some Aboriginal communities, the suicide rates are three to five times higher than in the general population.³² The suicide rate for Aboriginal males is 2.6 times higher than for the general Canadian population, and the rate for Aboriginal females is four times higher than the general Canadian population.³³

In Nova Scotia there are significant differences in the suicide rates among Aboriginal communities. In the implementation stage of the

Strategic Framework to Address Suicide in Nova Scotia, attention will be paid to the protective factors correlated with lower suicide rates in some communities, and the risk factors correlated with communities with higher suicide rates.

Many of the factors that affect suicide rates among Aboriginal peoples are beyond their control. Research has shown that suicide rates among Aboriginal peoples are linked to:

- The erosion of conditions that promote a strong sense of identity;
- Colonization and rapid cultural change;
- Trans-generational grief associated with the residential school system and the child welfare system; and
- Being members of a marginalized and economically disadvantaged group.

Suicide may be a way to communicate distress, and/or an escape from oppressive living conditions.³⁴

It's important to address oppression with Mi'kmaq people. We need to go back to lost cultural practices and see through both western and native perspectives. We've learned a holistic approach from our parents, community members, schools, etc. Our siblings and family members are not nuclear – we include friends and other extensions of our families.

FIRST NATIONS CONSULTATION SESSION PARTICIPANTS

Lesbian, Gay, Bisexual, and Transgendered Youth

Lesbian, gay, bisexual (LGB), and transgendered youth must contend with an oppressive social environment that includes homophobia and violence. LGB youth are two to three times more likely to die from suicide than other youth, and 30% of all completed youth suicides are related to issues of sexual identity.³⁵

Risk factors associated with suicide in LGB youth include:

- Low self-esteem;
- Social isolation;
- Depression;
- Negative family interactions;
- Personal or interpersonal turmoil;
- Anger;
- Repeated stress;
- Feelings of inadequacy;
- Sexual-identity difficulties;
- Lack of support;
- Negative social attitudes; and
- Negative reactions by family and community.

Suicidal ideation amongst LGB youth may be viewed as a response to the difficulties of a hostile environment, rather than as a psychopathology or psychiatric disorder.³⁶

It has been difficult to obtain accurate statistics about the impact of suicide on transgendered youth. For the purposes of the *Strategic Framework*, it is assumed that the experiences of transgendered youth are similar to the experiences of LGB youth in terms of having to adapt to an often hostile environment.

Since the LGBT community already knows the risk, it is time for the general public to learn who is at risk, why, and how they can help.

LGBT YOUTH AND LGBT YOUTH SERVICE PROVIDERS'
CONSULTATION SESSION PARTICIPANTS

People Who Have a Mental Illness

There is a clear relationship between mental illness and suicide. The most common diagnoses of people who attempt or complete suicide include: depression; schizophrenia; personality disorders; and alcohol or drug dependence.

One quarter of people who die from suicide have been in contact with mental health services in the year before their death. Half of the people who die from suicide have been in contact with mental health services in the week before their death.³⁷

We don't have the supports to deal with hopelessness, depression, hate, and isolation, and we end up pushing loved ones away and having suicidal thoughts.

CONSULTATION SESSION PARTICIPANTS SPEAKING
ABOUT THEIR OWN EXPERIENCES

STRATEGIC FRAMEWORK

DEVELOPMENT PROCESS

Because suicide is the result of multiple risk factors, the solution to addressing it requires the involvement of many sectors. In Nova Scotia we have an opportunity to tackle the issue of suicide in a comprehensive organized fashion. We have the prospect, through collaboration across sectors, of creating and enhancing the necessary societal, policy, and individual supports required to reduce the rate of suicide/attempted suicide, and minimize the impact on our families, friends, neighbors, coworkers, and communities.

In the spring of 2003, the Nova Scotia government committed to developing a provincial injury prevention strategy. Later that year, under the leadership of Nova Scotia Health Promotion and Protection, the Nova Scotia Injury Prevention Strategy (NSIPS) was developed. The NSIPS was endorsed by government and became the first of its kind in Canada. Among the strategic priorities identified in the NSIPS is the prevention of suicide. At the time the NSIPS was developed, suicide prevention stakeholders identified the need for a provincial strategy for addressing suicide.

In May 2003, the first *Nova Scotia Symposium on Suicide* was held in Halifax. This Symposium was a landmark event in Nova Scotia, and launched the recent efforts to address suicide in the province. Participants identified the greatest priority areas for addressing suicide, and *Benchmark and Recommendations to Address Suicide in Nova Scotia* was published as a result of the Symposium.

The *Nova Scotia Community Network to Address Suicide* was formed as a result of the Symposium, and has been a strong motivating force for this work. Members drew on the *Benchmark Report* to make specific recommendations for addressing suicide to the Department of Health's *Prevention, Promotion, and Advocacy Working Group* (PPAWG). The

PPAWG developed and submitted *Our Peace of Mind*, which included these recommendations, to the provincial Mental Health Services Steering Committee.

The development of the actual *Strategic Framework* document began in the summer of 2005, with the establishment of a steering committee to guide the process. The steering committee was chaired by Nova Scotia Health Promotion and Protection, and included representatives from the mental health services (Department of Health, District Health Authorities, and IWK), Addictions Services (District Health Authorities), the Nova Scotia Community Network to Address Suicide, mental health consumers, First Nations peoples, and the provincial Child & Youth Social Policy Committee.

The Steering Committee worked with a research consultant to conduct research on prevention, intervention, and postvention best practice evidence for addressing suicide (see Appendix B for a summary of the evidence), and to develop a background paper and draft framework, which were presented to stakeholders at the *Nova Scotia Suicide Prevention Forum* in November 2005. Over 70 people from a broad range of perspectives provided input into the draft document.

In the summer of 2006, the literature review was updated with a focus on priority population groups. In September 2006, 350 stakeholders from across the province provided feedback on the revised draft *Strategic Framework* document through a web survey and a series of 21 consultation sessions held throughout Nova Scotia. The consultation sessions included service providers; people speaking directly about their own experiences; First Nations communities; lesbian, gay, bisexual, and transgendered youth and the service providers who support them; and representatives from communities of African descent. Consultation participants also made a number of recommendations about specific aspects of service delivery, which will be addressed in the implementation plan that will evolve from the *Strategic Framework*.

Several expert reviewers, including researchers in Nova Scotia and people working on provincial suicide prevention strategies in other provinces in Canada, also provided feedback on the *Strategic Framework* in the summer and autumn of 2006.

Finally, the draft *Strategic Framework* was revised, and its companion documents (literature review, summary of best practices, glossary, detailed description of the consultation process, considerations for implementation, and documentation about organizations willing to play a role in implementation) were created as appendices.

The *Nova Scotia Strategic Framework to Address Suicide* encompasses the promotion, coordination, and support of culturally competent activities that will be developed, implemented, and enhanced across the province. It will guide our collective efforts through a comprehensive, integrated approach to reducing the human loss, suffering, and economic toll exacted by suicide/attempted suicide.

*Suicide affects the whole community and beyond –
response teams are also affected.*

FIRST NATIONS CONSULTATION SESSION PARTICIPANTS

THE NOVA SCOTIA STRATEGIC FRAMEWORK TO ADDRESS SUICIDE

Purpose

The *Nova Scotia Strategic Framework to Address Suicide* is a seven-to-ten year plan for reducing suicide/attempted suicide in Nova Scotia. (See Appendix A for the logic model for the *Strategic Framework*.) Euthanasia and self-harming behaviours that are not motivated by an intent to die, while important issues to be addressed, fall outside the scope of the *Nova Scotia Strategic Framework to Address Suicide*.

The intended audience of the *Strategic Framework* is professionals and policy makers working across sectors to address suicide. The *Strategic Framework* includes a vision, mission, guiding principles, and six strategic goals and their corresponding objectives. It is intended as a guide for policy makers, professionals, and communities who will be involved in the implementation of the *Strategic Framework*. Specific outcome targets will be set in the implementation plan, which will be developed collaboratively.

The *Nova Scotia Strategic Framework to Address Suicide* is a living document that will be revisited every few years; it will evolve based on evaluation and new best practice and promising practice information, as well as on the changing realities in Nova Scotia communities.

Vision

Working together to reduce the impact of suicide through building hope, strength, and resiliency, so that every person can lead a healthy and safe life.

Mission

To enhance the necessary societal, policy, and individual supports required to address suicide.

Guiding Principles

The *Nova Scotia Strategic Framework to Address Suicide* will:

- Build on evidence-based suicide prevention, intervention, and postvention strategies and initiatives;
- Be comprehensive – addressing the multidimensional factors that play a role in addressing suicide;
- Be relevant to the needs of all populations based on consultation, surveillance, and research;
- Be a living document that is evidence-based and continuously monitored and evaluated;
- Reflect the different communities, cultures, and diversity of stakeholders;
- Facilitate collaborative strategies across sectors to promote protective factors and strengthen hope and resiliency; and
- Be guided by a population health approach.

Goals and Objectives

The strategic goals of the *Nova Scotia Strategic Framework to Address Suicide* focus on six key areas:

1. Leadership, Infrastructure, and Partnerships;
2. Awareness and Understanding;
3. Prevention;
4. Intervention;
5. Postvention (Bereavement Support) and;
6. Knowledge Development and Transfer.

Strategic Goal 1 – Leadership, Infrastructure, & Partnerships

GOAL The *Nova Scotia Strategic Framework to Address Suicide* has the appropriate and adequate leadership, capacity, and infrastructure.

OBJECTIVES

- 1.1 To establish leadership and support structures at the provincial, district, and community levels that facilitate the implementation of a culturally competent provincial framework.
- 1.2 To build capacity of programs, services, and resources to address suicide in Nova Scotia.
- 1.3 To increase awareness and understanding of suicide among policy and decision-makers.
- 1.4 To establish and enhance intersectoral partnerships, which will facilitate the implementation of the framework.

Leadership and vision from that leadership are the most critical part of any successful strategy – without the leadership and the capacity to maintain what we start, there will be no long term outcomes, and people who have participated and who expect results from new programming that is started will probably become disillusioned.

WEB SURVEY RESPONDENT

Strategic Goal 2 – Awareness & Understanding

GOAL Individuals, communities, institutions, policy makers, the media, care providers, survivors, families, and those who may work with at risk populations, are aware of and understand the issue of suicide.

OBJECTIVES

- 2.1 To increase the awareness and understanding of the public and stakeholder communities about suicide prevention, intervention, and postvention.

- 2.2 To increase the media's use of (best practice) guidelines for reporting on suicide and mental health issues.

In the community, suicide is a dirty word – it's hidden.

We need to let people know it's okay to talk about it.

CONSULTATION SESSION PARTICIPANTS SPEAKING
ABOUT THEIR OWN EXPERIENCES

Strategic Goal 3 – Prevention

- GOAL Integrated prevention programs, services, and strategies, focused on minimizing risk factors, building resiliency, and heightening protective factors for suicide.

OBJECTIVES

- 3.1 To develop and foster intersectoral partnerships which will strengthen suicide prevention initiatives.
- 3.2 To develop and implement provincial standards for suicide prevention services and programs.
- 3.3 To reduce access to lethal means of suicide.
- 3.4 To develop and implement *Communities Addressing Suicide Together*.
- 3.5 To develop and implement culturally competent prevention initiatives, services, and programs.
- 3.6 To develop and implement learning opportunities and training for those working in suicide prevention.

We need programs to help build up coping strategies and resiliency, and address abuse issues and self-esteem.

FIRST NATIONS CONSULTATION SESSION PARTICIPANTS

Strategic Goal 4 – Intervention

- GOAL Integrated and seamless intervention programs, services, and strategies.

OBJECTIVES

- 4.1 To establish and maintain seamless and easily accessible intervention services and programs.
- 4.2 To develop, implement, and enhance services and programs for individuals experiencing a suicidal crisis and their families.
- 4.3 To develop and implement culturally competent services and programs for people who experience a suicidal crisis.
- 4.4 To develop and implement learning opportunities and training for suicide intervention providers.

We need timely access to resources for people in a crisis, and we need to know the crisis is taken seriously. Spiritual healing needs to be taken more seriously. Most people know that they need help, but many are too shy to ask.

FIRST NATIONS CONSULTATION SESSION PARTICIPANTS

Strategic Goal 5 – Postvention

- GOAL Comprehensive postvention programs, services, and strategies to support those who are bereaved by suicide or impacted by suicidal behaviours.

OBJECTIVES

- 5.1 To develop and foster partnerships and collaboration to address suicide postvention.
- 5.2 To develop and implement supports, learning opportunities and training for those providing postvention supports and services.
- 5.3 To develop and implement culturally competent postvention services and programs for people who have experienced a suicidal crisis and for loss survivors.

This is long overdue...so important. As a family member of someone who died from suicide, when they are gone you lose them, but then you experience another empty hole...and there are no resources ...

WEB SURVEY RESPONDENT

You need compassion for facing your life again when suicide wasn't completed.

CONSULTATION SESSION PARTICIPANTS SPEAKING ABOUT THEIR OWN EXPERIENCES.

Strategic Goal 6 – Knowledge Development & Transfer

GOAL Community action and decision-making is informed by the timely collection, analysis and sharing of data and research on suicide.

OBJECTIVES

- 6.1 To promote and support suicide prevention, intervention, and postvention research and evaluation.
- 6.2 To develop and enhance systems that support suicide data collection, analysis, and reporting.
- 6.3 To develop a dissemination strategy for surveillance and research information.

We need more information about different groups impacted by the problem of suicide – suicidal thoughts, attempts, completed suicides, methods/means, etc.

SERVICE PROVIDERS' CONSULTATION SESSION PARTICIPANTS.

RESEARCH AND EVALUATION

It is clear that surveillance systems must be improved and expanded in order to increase opportunities for reporting, and to collect accurate data about suicide and attempted suicide in Nova Scotia. Furthermore, it is important to promote and develop suicide-related research.³⁸

In order to monitor the effectiveness of the *Nova Scotia Strategic Framework to Address Suicide* and to continually build on our learnings, a comprehensive evaluation will be needed. Particular components of the *Strategic Framework* will be identified for a summative (or outcome) evaluation as the implementation plan becomes clear; a formative (or process) evaluation will be conducted in relation to the infrastructure created to support the work.

ACTIVITIES UNDERWAY

The *Nova Scotia Strategic Framework to Address Suicide* does not exist in isolation, and cannot be implemented without the involvement of people from across sectors. Several initiatives that will contribute to a reduction in suicide/attempted suicide in Nova Scotia are already underway. A number of these are described below.

Communities Addressing Suicide Together (CAST)

CAST is a four-year initiative led by the Canadian Mental Health Association (NS Division) and sponsored by Nova Scotia Health Promotion and Protection. The goal of CAST is to work with communities (including organizations, agencies, families, survivors, and concerned citizens) to build and strengthen their capacity to address suicide in Nova Scotia. CAST has four broad objectives to achieve this goal:

1. **COMMUNITY COALITION BUILDING AND SUPPORT** Ongoing support of existing suicide prevention coalitions in communities across the province; and support for the development of new coalitions (starting in 2007).
2. **COMMUNITY SUICIDE PREVENTION TOOL KIT** Providing best practice and promising practice information about how to address suicide through the development of a tool kit, which will be provided to community organizations involved in community coalitions. The tool kit will be pilot-tested and evaluated.
3. **COMMUNITY TOOLKIT ORIENTATION TRAINING** Training in the use of toolkit will be provided to all interested coalitions.
4. **NETWORKING AND COMMUNICATIONS** Networking among coalitions and stakeholders will be supported through a suicide

prevention listserv, ongoing opportunities for networking, annual coalition gathers, and/or conferences.

National Aboriginal Youth Suicide Prevention Strategy (NAYSPS)

In September 2004, the Prime Minister committed to addressing suicide prevention among Aboriginal youth. The ultimate goal of the National Aboriginal Youth Suicide Prevention Strategy (NAYSPS) is to reduce risk factors and promote protective (preventive) factors against suicide. Funding was allocated in the 2005 budget in the amount of \$65 million for this five year strategy.

The Assembly of First Nations, Inuit Tapiriit Kanatami, and the First Nations and Inuit Health Branch of Health Canada are working on an evidence-based national strategy to address suicide prevention. A key element of the strategy is to support community-based solutions to youth suicide, which are rooted in the evidence regarding what is most likely to be effective in preventing Aboriginal youth suicide.

The activities supported by NAYSPS include: skills training, tool and resource development, and primary prevention and awareness initiatives that promote mental wellness and youth resiliency. The strategy will also develop protocols to respond to communities in crisis and support various research projects.

In Nova Scotia, some First Nations communities have already developed community work plans for preventing suicide; it is the intention that each community will have a community-wide suicide prevention plan in place at the end of the strategy. In some communities, suicide education/awareness, crisis intervention, bereavement support, and training activities are underway. The first Mi'kmaq Maliseet Atlantic Youth Council Youth conference is planned for 2007.

Health Canada has the lead role in creating a Nova Scotia Tripartite First Nations Task Force, which will include the Mi'kmaq, provincial, and federal governments.

Analysis and Report on Suicide in Nova Scotia

Nova Scotia Health Promotion and Protection is currently working with Dalhousie University's Population Health Research Unit to develop a series of injury profile reports. One of these reports, to be released in the winter of 2007, will be dedicated to the issue of suicide and attempted suicide. It is anticipated that the report will provide an analysis of suicide/attempted suicide trends in Nova Scotia over the past five years and include demographic and regional (District Health Authority-based) comparisons, measure the health system and societal impact of suicide/attempted suicide in Nova Scotia, and provide an analysis of available risk factor data.

Nova Scotia Department of Health

Core Standards of Service Delivery for Crisis Response Services

In 2003, the Mental Health Branch of the Nova Scotia Department of Health approved standards for service delivery for the Core Programs of Mental Health across the province. These programs include prevention and promotion (secondary), inpatient, outpatient, community supports, and specialty services. The goal in relation to Crisis Response Services is for residents of each health district in the province to have twenty-four (24) hour access to crisis response services.

According to Best Practices in Mental Health Reform (1997), the range of functions provided by a CRS includes:

1. Stabilizing individuals in crisis in order to assist them to return to their pre-crisis level of functioning;
2. Assisting individuals and members of their natural support systems to resolve situations that may have precipitated or contributed to the crisis;

3. Linking individuals with services and supports in the community in order to meet their ongoing community support needs; and
4. Linking individuals to appropriate follow-up mental health care.

Media Guidelines for Reporting on Suicide and Mental Illness

In 2005, the Department of Health and the Canadian Mental Health Association (Nova Scotia Division) worked to monitor how the media was reporting on and portraying mental illness and suicide. This project will contribute to the development of media guidelines.

Depression Strategy

In 2005/2006, the Mental Health Branch launched a *Depression Strategy* (Phase I) to raise awareness about depression among adolescents and seniors. *Mental Health in the Workplace*, Phase II of the *Depression Strategy*, which focuses on depression in this setting, will be launched in 2006–07.

Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada

The Senate Standing Committee on Social Affairs, Science and Technology tabled its report, *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada*,³⁹ to the federal government on May 9, 2006. It is the most comprehensive report on the mental health in Canadian history. The report is based on consultations held in each province and territory, and on over 2,000 submissions received from organizations and individuals across the country.

The report makes several recommendations relevant to addressing suicide, including:

- The formation of the Canadian Mental Health Commission, which will be tasked with developing a national action plan for mental health; and
- Support for the efforts of the Canadian Association for Suicide Prevention and other organizations working to develop a national suicide prevention strategy.

Mental Health stakeholders in Nova Scotia are organizing a plan to encourage the adoption of the report at the federal level, beginning with the establishment of the Canadian Mental Health Commission (CMHC). The CMHC will in turn proceed with addressing the recommendations outlined in the report.

RECOMMENDED ACTIONS

The first step in creating the *Nova Scotia Strategic Framework to Address Suicide* was to conduct research and listen to stakeholders about what should be included. The next step is to work with partners and communities to develop plans for implementing the *Strategic Framework*. Working groups will be established to guide the implementation of the *Strategic Framework*, and to develop specific tasks and timelines for achieving goals and objectives, as appropriate for each community and/or population group.

Recommendations for immediate and/or short-term actions for moving forward are based on the past several years of work completed on effective strategies for addressing suicide in Nova Scotia (See *Strategic Framework Development Process*). The recommendations are focused toward Nova Scotia Health Promotion and Protection (NSHPP), because this Department has accepted lead responsibility for the *Strategic Framework*. However, the Strategic Framework is a collective strategy for all who are working to address suicide. The recommendations and the actions required to implement them will follow a collaborative process, requiring the active participation of all stakeholders and partners, including those bereaved by suicide, attempt survivors, and their families.

1. During the September 2006 consultation process, much of the feedback from stakeholders focused on the provision of mental health and other support services to those at risk of suicide. It is recommended that NSHPP share this feedback with the Department of Health and other appropriate government departments. Through this process, NSHPP will work collaboratively with these partner departments to identify their roles in the implementation of the *Strategic Framework*.
2. In recognition of the potential use of the *Strategic Framework*

to support current work to address suicide in Nova Scotia across sectors, and of the existing allocation of resources across sectors for addressing suicide in Nova Scotia, it is recommended that Implementation Steering Committee take a lead role in coordinating and aligning the contributions of various organizations and agencies for implementation of the *Strategic Framework*.

3. It is recommended that NSHPP lead efforts to share the *Nova Scotia Strategic Framework for Addressing Suicide* with stakeholders across the province.
4. It is recommended that NSHPP establish and lead an intersectoral Provincial Steering Committee to guide the work of implementing the *Strategic Framework*.
5. It is recommended that NSHPP work with the Provincial Steering Committee to determine what additional working groups are required to support the implementation of the strategic framework.
6. It is recommended that NSHPP work with its partners to identify success indicators for the *Strategic Framework* and for initiatives involving the specific priority population groups identified.
7. It is recommended that NSHPP work with the Population Health Research Unit at Dalhousie University to complete and publish the profile of suicide in Nova Scotia by the spring of 2007.
8. It is recommended that NSHPP, in collaboration with its partners in the *Strategic Framework*, establish linkages with other agencies (provincial, national, and international) outside of Nova Scotia who are working to address suicide.
9. It is recommended that NSHPP participate in a Nova Scotia

Tripartite First Nations Task Force, which will include the Mi'kmaq, provincial, and federal governments. Health Canada will be taking the lead under the National Aboriginal Youth Suicide Prevention Strategy (NAYSPS).

10. During the consultation process conducted in the autumn of 2006, a meaningful dialogue was initiated between NSHPP and representatives of communities of African descent. It is recommended that NSHPP and its partners in the *Strategic Framework* maintain an ongoing dialogue with representatives from communities of African descent in order to further determine the needs of the communities, and assess the most appropriate ways for addressing suicide in these communities.
11. It is recommended that NSHPP and its partners promote the *Strategic Framework* among the media and the general public.
12. It is recommended that NSHPP lead the development of an evaluation plan for the *Strategic Framework*.
13. It is recommended that NSHPP, in consultation with its partners, identify key research directions and needs that will support the ongoing implementation of the *Strategic Framework*.

APPENDIX 1

LOGIC MODEL

STRATEGIC GOALS

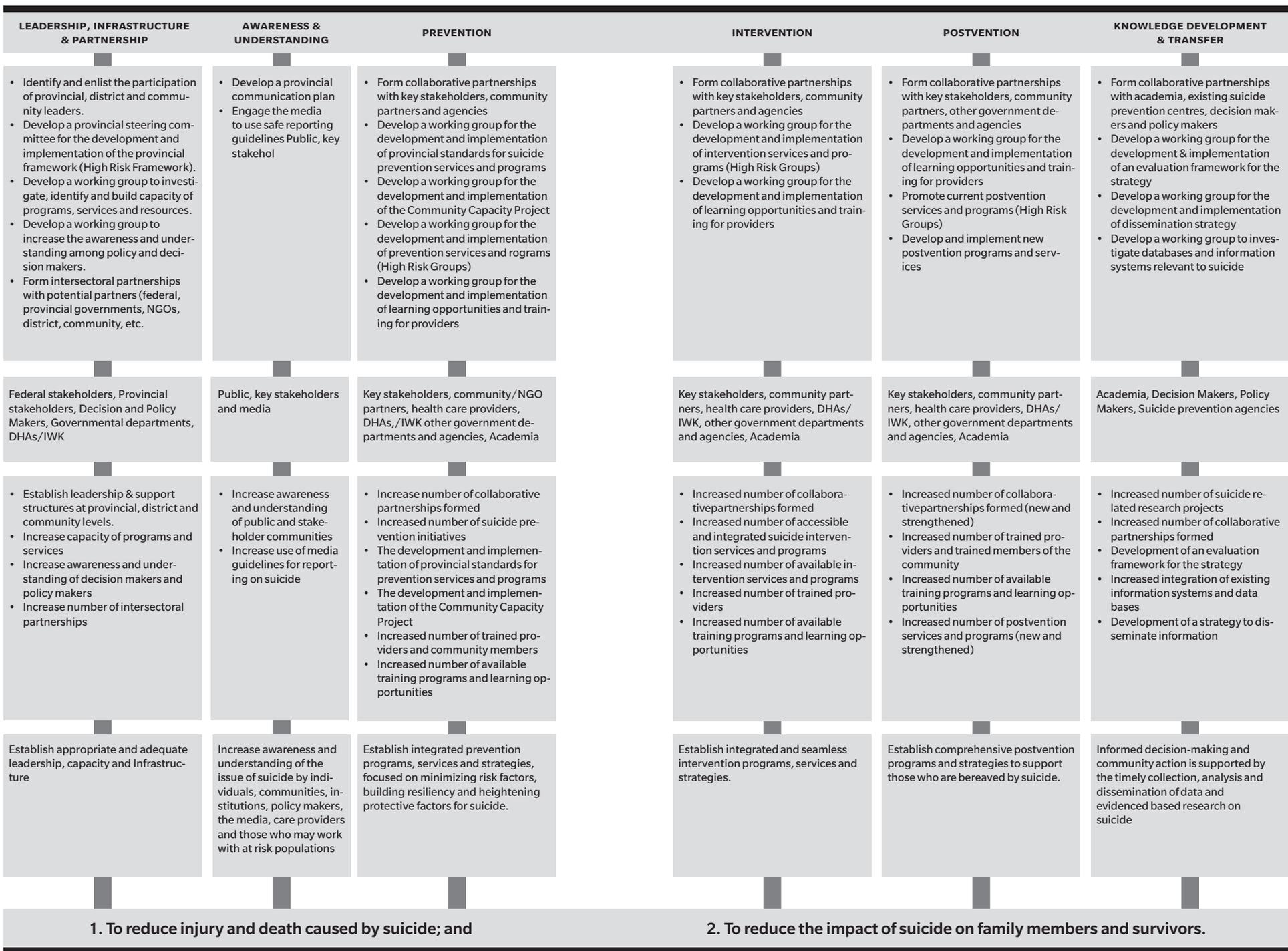
ACTIVITIES

TARGET

SHORT TERM OUTCOMES

INTERMEDIATE OUTCOMES

LONG-TERM OUTCOMES



SUMMARY OF EVIDENCE FOR STRATEGIES TO ADDRESS SUICIDE

1. PREVENTION: includes any self injury prevention or health promotion strategy generally or specifically aimed at reducing the incidence and prevalence of suicide behaviours. Research to date has provided very little clear evidence of the effectiveness of these activities in reducing suicide rates.

GOAL: *Generic skill building. To enhance an individual's personal capabilities so that they may be able to adapt and deal effectively with daily tasks and challenges. To reduce risk factors for suicide and self harm.*

Peer and Community

Support Programs

- Universal strategies target the whole population and include mental health promotion activities that aim to enhance resilience, optimism and life coping skills as well as the quality of social relationships and environments.
- Programs can be conducted in either school or non school settings are designed to foster peer relationships, competency development, and coping skills among high risk youth as a method of preventing suicide among them
- The rationale: to enhance the interpersonal and coping skills of participants, allowing them to increase their use of natural support networks and to improve their school attendance and school and job performance
- Programs might help reduce antisocial behaviour and substance

Research Findings

- Effect of peer support programs in preventing youth suicide has not been evaluated.*
- Found students who participated in peer support program show improvement in academic performance, school attendance and self esteem*
- Peer support programs may be useful in reducing high risk behaviours among youth*
- The success of peer support programs with other high risk behaviours suggests that the programs have potential as an intervention approach to preventing youth suicide*
- Preventative strategies aimed at families, schools or whole communities can reduce a range of behaviours associated with suicide risk, such as harmful drug use, mental health problems, delinquency and early school leaving problems†

abuse, factors associated with suicidal behaviour

- There is strong evidence for the effectiveness of many such programs, although most neither focus on nor evaluate their effect on suicide or suicide risk.

GOAL: *To reduce access to lethal methods: to firearms, drugs, high places and other means to committing suicide*

Means Restriction

- Refers to suicide prevention efforts that reduce access to firearms, drugs, high places and other common means of committing suicide
- The rationale: impulsiveness appears to play an important role in suicide, especially youth suicide
- Many suicide prevention specialists argue that if lethal means are not readily available when a person decides to attempt suicide, he or she might either delay the attempt or use a less lethal means

Research Findings

- Many public health practitioners and researchers believe that the evidence is sufficiently compelling to strongly advocate that parents prevent their children from having unsupervised access to hand guns and other firearms*
- Despite the potential of means restrictions for reducing the incidence of youth suicide, few of the programs examined had a major emphasis on means restrictions*

GOAL: *Appropriate awareness of suicide and suicide attempts by the public*

Media Education

- To educate the media about responsible reporting practices in an effort to lower the negative and potentially contagious effects that sensational publicity about suicides can have on vulnerable people.

Research Findings

- The effects of encouraging the media to adopt more responsible reporting could be effective at reducing suicidal behaviour, although evidence or effectiveness of this intervention, is primarily based on quasi experimental and descriptive studies along with the opinion of experts

2. INTERVENTION: refers to the immediate management and long term care and treatment of an individual or group at risk of suicide. A review of several evaluation studies of suicide prevention centres indicated conflicting evidence about their effectiveness in reducing suicide rates.

GOAL: *Training to increase the capacity for identification, treatment and follow up of problems relating to depression, addiction, mental disorders and suicide.*

Gate Keeper Training

- Gatekeeper training programs are designed to help members of the community identify individuals with a high potential for suicide and refer them to appropriate sources of help

Two types

- School Gatekeeper Training
- Community Gatekeeper Training
- Physician Gatekeeper Training

Research Findings:

- Researchers evaluating school gatekeeper education component found that school personnel who participated in a two hour training program showed an increased awareness of suicide warning signs, knowledge of treatment resources and willingness to make referrals to mental health professionals*
- Referrals for counseling increased awareness of suicide warning signs¹
- Experts estimate that the school gate keeper programs could reduce youth suicide by about 12%*
- Evaluation studies indicate that gatekeeper training programs are effective at educating participants and increasing their willingness to refer at risk students for appropriate help*

Physician Gatekeeper Training

- Some evidence that physician education in treatment of affective disorders can reduce suicide ratesⁱⁱ
- There is poor evidence supporting the effectiveness of intervention by the family physician in preventing suicide, there is fair evidence that family physicians may have a low rate of recognition of psychiatric disorders and suicide risk[†]
- One recent study has shown that physicians' knowledge of the risk and treatment of suicide patients improve after training in a suicide prevention program[†]

GOAL: To provide youth with suicide prevention education

General Suicide Education

- Typically school based programs that review with students the facts and myths about suicide, alert them to warning signs, and provide information about how to seek help for themselves and others
- The rationale: the basic premise is that the more students know about suicide warning signs and sources of help, the more likely they will be asked for help for themselves or refer others for help.

Research Findings

- Participants have at least short term increases in knowledge about suicide¹
- Participants' attitudes show little change. No statistically significant changes among participants in attitudes toward seeking help in suicide, or in willingness to seek help.*
- Concerns that general suicide education programs might de-stigmatize suicide, resulting in increased suicidal behaviour*
- Certain groups of students and highest risk students may react negatively*[§]
- An intuitive approach to youth suicide prevention. Programs can reach substantial numbers of young people¹
- Evidence that the programs influence participants' attitudes about suicide or willingness to seek help is scarce*
- Studies evaluating suicide prevention is school based intervention programs, community based-suicide prevention centers, or hospital based intensive follow up situations have shown that none reduced the incidence significantly^{†§}
- Short term educational interventions were not effective in the prevention of suicide among self identified adolescent suicide attempters[†]
- Programs that target at risk youth appear to be most promising in reducing suicidal behaviour among young people[§]

Screening Programs

- Conducted in schools and involve the administration of a screening instrument to identify high risk youths
- The rationale: since suicide is a rare event, prevention efforts will be most efficient if we can identify persons who are at a high risk of suicide so that they can be referred for specific interventions

Research Findings

- The capability of a screening instrument to detect a potential suicide case is limited, which will limit the potential effectiveness of a screening program*
- Issue to consider: the potentially adverse consequences of referring "false positives" – teens who are not truly at high risk of suicide, but who score in the dangerous zone of the screening instrument*
- In 1989, the US Prevention Task Force recommended against routine screening for suicidal intent[†]
- A number of psychometric tools have been presented in the literature to screen for suicide risk in adolescent/child populations
- Few of the scales have satisfactory reliability and validity and few of the scales have been applied to young adults.

GOAL: Services and support within the community for groups at increased risk.

Crisis Centres and Hotlines:

- The rationale: crisis hotlines relies on the premises that suicide attempts are often precipitated by a critical stressful event, are often impulsive, and are usually contemplated with substantial ambivalence
- Hotlines are designed to respond to the crisis and to deter a caller from self destructive acts until the immediate crisis has passed
- Hotlines offer an immediately available source of support

Research Findings

- Evidence of the effectiveness of crisis centres and hotlines in preventing suicide is scarce and somewhat inconsistent*
- Hotlines reach an important audience. They appear to serve an otherwise underserved population*
- Results of numerous studies have indicated that young women call hotlines more frequently than do young men*

- They do not require a trip to a clinic
- They are anonymous, allowing callers the opportunity to say anything in a context in which they may feel secure and in control
- The results of one study indicated that hotlines may reduce the rate of suicide among young women*
- The consensus from evaluation studies in the US suggest that suicide hotlines are minimally effective in reducing suicidal behaviour and community suicide rates[†]
- Descriptive evaluation survey of two suicide prevention centres in Quebec showed a significant number of callers feel less depressed at the end of the call, and that there was a reduction in suicidal urgency in a large number of callers[†]

Youth Health Clinics:

- These clinics have often been set up in schools and have been staffed by general practitioners and practice nurses
- #### Research Findings
- Suggested that youth health clinics based in schools may have an important role in preventing adolescent suicide by improving access to health care for young adults, especially among young people with serious risk factors for suicide.[‡]
 - Suggested that adolescent youth health clinics have been successful at improving the mental health of young adults, and specifically at reducing suicide among young adults[‡]
 - No formal evaluations have been found that have quantitatively examined the efficacy of these clinics to reduce suicidal behaviour among young people[‡]

GOAL: *services for individuals at risk (Response to attempted suicide & Treatment for mental disorders)*

Medical Treatment

- Medical treatment for the prevention of suicide involves mainly the treatment of depression and management of individuals who have attempted suicide previously

Research Findings

- Hospitalized patients admitted for self inflicted injuries reported fewer subsequent suicide attempts in those who receive psychiatric counseling, compared with controls who were discharged before seeing a psychiatrist[†]
- Studies to date, none has shown a statistically significant benefit of psychosocial intervention on reducing suicide repetition rates[†]
- Evidence from RCTs suggested that pharmacotherapy seems to be effective in terms of treating underlying mental disorders, but less effective at preventing youth suicidal behaviour[§]
- The combination of treatment modalities was likely to be the most effective means of reducing suicidal behaviour among adolescents[§]
- Cognitive behavioural therapy and group support can probably prevent suicidal behaviour among young people*
- Trends toward benefits were also seen with the use of problem solving, emergency cards, dialectic therapy and the medication flupenthixol[†]

3. POSTVENTION: refers to an intervention that is commenced after suicide either with family survivors, school pupils or members of the community

Intervention after a suicide

- In the event of a suicide, one of the aims of crisis intervention involves mobilizing the staff and other resources in order to reduce the risk of a suicide cluster developing

Research Findings

- Interventions after one or more youth suicides is designed in part to prevent or minimize the effect of “copycat” suicides
- Few data available on the effectiveness of these approaches, the advisability of using a crisis intervention plan to manage the risk of multiple youth suicides is widely accepted by suicide prevention experts
- Despite the lack of evaluation most experts agree that there is a strong need for postvention interventions to prevent further deaths by imitation and to assist with providing support and counseling to the peers of the victim
- Professional and volunteer involvement contributes significantly to the success of bereavement programs.*

NOTES FOR APPENDIX 2

- * Youth Suicide Prevention Programs: A Resource Guide. Centre for Disease Control and Prevention. Department of Health and Human Services. Public Health Service.
- † Prevention of Suicide. Jane E McNamee and David R. Offord
- ‡ Youth Suicide Prevention by Primary health care professionals. A critical appraisal of the literature. P. Hider. New Zealand Health Technology Assessment (NZHTA). October 1998.
- § For which strategies of suicide prevention is there evidence of effectiveness? WHO Europe. Health Evidence Network. Evidence for Decision Makers. July 2004.
- ¶ Canadian Association for Suicide Prevention. CASP. Blueprint for a Canadian National Suicide Prevention Strategy. October, 2004.

DEFINITIONS

ABORIGINAL The Aboriginal Peoples of Canada are identified as the First Nations, Métis, Inuit, status Indian, and non-status Indian persons residing in the country.⁴⁰

BEST PRACTICES These are activities based on sound scientific evidence, extensive community experience, and/or cultural knowledge. Healthy living interventions will be more effective if they are based on established best practices.⁴¹

BISEXUAL A person who is sexually and/or emotionally attracted to people of both sexes.⁴²

CONTRIBUTING FACTORS Contributing factors increase the exposure of the individual to either predisposing or precipitating factors. These include physical illness, sexual identity issues, unstable family, physical illness, risk-taking or self-destructive behavior, suicide of a friend, isolation, and substance abuse.⁴³

CRISIS An upset in an individual’s baseline level of functioning that is generally thought to last no more than four to six weeks.⁴⁴

CRISIS INTERVENTION Brief, focused treatment that is begun when an individual is in crisis. The goal is the resolution of the crisis and the attainment of a state of equilibrium.⁴⁵

CULTURAL COMPETENCE Is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables the system or professionals to work effectively in cross-cultural situations.⁴⁶

DETERMINANTS OF HEALTH A number of factors that work together to make people healthy, or not. They include: The social and economic environment; the physical environment, and; the person’s individual characteristics and behaviors.⁴⁷

EVALUATION Evaluation is a systematic way of assessing the effectiveness of an ongoing program in achieving its objectives.⁴⁸

EVIDENCE-BASED Evidence-based decision making or practice means making decisions or basing practice on documented

research information that has gone through a broad, critical review process.⁴⁹

FIRST NATIONS A term that came into common usage in the 1970s to replace the word “Indian,” which some people found offensive. Although the term First Nation is widely used, no legal definition of it exists. Among its uses, the term “First Nations peoples” refers to the Indian peoples in Canada, both Status and Non-Status. Some Indian peoples have also adopted the term “First Nation” to replace the word “band” in the name of their community.

FORMATIVE EVALUATION A formative evaluation is conducted early in the planning stages or early in implementation. It helps to define the scope of a program or project and to identify appropriate goals and objectives. Formative evaluations can also be used to pre-test ideas and strategies.⁵⁰

GAY A person who is sexually and/or emotionally attracted to people of the same sex. The term gay also refers to a *man* who is sexually and/or emotionally attracted to people of the same sex.⁵¹

IMPULSIVITY Activities abruptly engaged in without forethought by an individual or consideration of potential consequences.

INDICATORS A health indicator is a characteristic of an individual, population, or environment that is subject to measurement (directly or indirectly) and can be used to describe one or more aspects of the health of an individual or population (quality, quantity, and time).⁵²

INTENT What the person wants to achieve by suicidal acts, whether it is to die or to influence some significant other.

INTERSECTORAL Working with more than one sector of society to take action on an area of shared interest. Sectors may include government departments such as health, education, environment, and justice; ordinary citizens; non-profit societies or organizations; and business.⁵³

INTERVENTION Strategies that are applicable during the period of suicidal intent. All are related directly to the person at-risk (i.e., individual resources, personal, community supports, crisis

intervention services, 911, counseling, institutional settings, crisis housing).

LESBIAN A woman who is sexually and/or emotionally attracted to people of the same sex.⁵⁴

MEANS The instrument or object whereby a self-destructive act is carried out (e.g., firearm, poison, medication).⁵⁵

MEANS RESTRICTION Techniques, policies, and procedures designed to reduce access or availability to means and methods of deliberate self-harm (i.e., firearms, medications, etc.).⁵⁶

MEDIA EDUCATION Education for the media about responsible suicide reporting practices in an effort to lower the negative and potentially contagious effects that sensational publicity about suicides can have on vulnerable people.⁵⁷

MENTAL HEALTH A state of well being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.⁵⁸

MENTAL ILLNESS Mental illnesses are characterized by alterations in thinking, mood, or behaviour (or some combination thereof) associated with significant distress and impaired functioning over an extended period of time. The symptoms of mental illness vary from mild to severe, depending on the type of mental illness, the individual, the family, and the socio-economic environment.⁵⁹

OUTCOME A measurable change in the health of an individual or group of people that is attributable to an intervention.⁶⁰

POPULATION HEALTH An approach that focuses on the underlying and interrelated conditions that influence the health of populations over the life course. These include factors such as education, income, early childhood experiences, and the social and physical environments that surround individuals and groups. By addressing these factors, a population health approach aims to reach beyond the limited effectiveness of lifestyle-based interventions and reduce disparities in health outcomes.⁶¹

POSTVENTION Support for those bereaved by suicide or impacted by suicidal behaviours.⁶²

PRECIPITATING FACTORS/EVENTS Acute factors that create a crisis, such as interpersonal conflict or loss, pressure to succeed, conflict with the law, loss of stature in society, financial difficulties, or rejection by society for some characteristic such as ethnic origin or sexual orientation.⁶³

PREVENTION A strategy or approach that reduces the likelihood of risk of onset, or delays the onset of, adverse health problems or reduces the harm resulting from conditions or behaviors.⁶⁴

PROMISING PRACTICE Incorporates the philosophy, values, characteristics, and indicators of other positive/effective public health interventions. Based on guidelines, protocols, standards, or preferred practice patterns that have been proven to lead to effective public health outcomes, and is a process of continual quality improvement that:

- Accumulates and applies knowledge about what is working and not working in different situations and contexts;
- Continually incorporates lessons learned, feedback, and analysis to lead toward improvement/positive outcomes;
- Allows for and incorporates expert review, feedback, and consensus from the public health field; and
- Has an evaluation component/plan in place to move towards demonstration of effectiveness, however, it does not yet have evaluation data available to demonstrate positive outcomes.⁶⁵

PROTECTIVE FACTORS Those factors that appear to reduce the risk of suicide; most likely to be stable over time, but with fluctuations and shifts.

RESEARCH Can be described both as the “systematic investigation to establish facts” and more broadly as “a search for knowledge”. The actual methods used to ascertain this information can be varied. Quantitative methods focus on testing of hypotheses, finding generalizable results, measuring outcomes, or proving cause and effect relationships. Qualitative methods concentrate on exploring phenomena, developing theories, formulating hypotheses, and

creating or expanding knowledge. Additionally, indigenous ways of knowing also constitute a class of research.⁶⁶

RESILIENCE Capacities within a person that promote positive outcomes, such as mental health and well being, and provide protection from factors that might otherwise place that person at risk for adverse health outcomes.⁶⁷

RISK FACTORS/INDICATORS Social, economic, or biological status, behaviours, or environments which are associated with or cause increased susceptibility to a specific disease, ill health, or injury.⁶⁸

STAKEHOLDERS Entities, including organizations, groups, and individuals, that are affected by and contribute to decisions, consultations, and policies.⁶⁹

STRATEGY A strategy outlines basic directional decisions and related actions. A strategy answers the question: What are the goals we want to achieve and how should we achieve them.

SUICIDAL BEHAVIOR A spectrum of activities related to thoughts and behaviors that include suicidal thinking, suicide attempts, and completed suicide.⁷⁰

SUICIDAL IDEATION Having thoughts about killing oneself.

SUICIDE ATTEMPT A potentially self-injuring behaviour having a non-fatal outcome, motivated by an intent to die.

SUICIDE ATTEMPT SURVIVORS Individuals who have survived a prior suicide attempt.⁷¹

SUICIDE OR COMPLETED SUICIDE A death caused by self-inflicted injury, motivated by an intent to die.

SUICIDE PREVENTION Term can be used in one of two ways:

1. As an umbrella term for decreasing/eliminating the number of suicides/suicidal behaviours in a population.
2. To describe ‘primary prevention’, or those strategies which are implemented any time during a person’s life prior to thoughts of suicide and/or when thoughts are present but no clear intent exists, i.e., promotion (awareness & stigma reduction), education (encouragement of help-seeking

behaviour, peer recognition & support, information about services, gatekeeper intervention skills training, professional training), and holistic well being (esteem, belonging, safety, support systems, resilience, mental health programs & services).

SUICIDE RATES The number per unit of the population who die by suicide for a given unit of time.⁷²

SUMMATIVE EVALUATION A type of outcome evaluation that assesses the results or outcomes of a program. This type of evaluation is concerned with a program's overall effectiveness. A type of evaluation research that occurs after a program or policy being evaluated ends.⁷³

SUPPORT GROUPS Essentially the same as self-help groups, although some people use the term professionally-led support group to indicate that the group is mainly psycho-educational in nature, or led by a paid professional, who may or may not share the concern (or diagnosis of group members).

SURVEILLANCE The ongoing, systematic collection, analysis, and interpretation of health data with timely dissemination of findings.⁷⁴

SURVIVORS Family members, significant others, or acquaintances who have experienced the loss of a loved one due to suicide; sometimes this term is also used to mean suicide attempt survivors.

TRANSGENDERED A person whose gender identity, outward appearance, expression, and/or anatomy do not fit into conventional expectations of male or female. Often used as an umbrella term to represent a wide range of non-conforming gender identities and behaviors.⁷⁵

TREATMENT SERVICES Includes screening, assessment, and clinical intervention. Linkage to other supports and education is available. Short-term treatment may be sufficient. Longer-term rehabilitation and support is needed for others.⁷⁶

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