

County of Oxford Suicide Prevention Plan

*Why would a small group of dedicated individuals believe that by working together
we can change the world?*

Because, throughout history, it is the only thing that ever has.

Margaret Mead

Draft September 10, 2010

Table of Contents

I. Acknowledgements

II. Dedication

III. Introduction

IV. Guiding Principles

V. Prevention Plan: Goals & Objectives

Appendix #1 – Current Suicide Prevention Initiatives in Canada

Appendix #2 – Canada Wide Crisis/Distress Resources

Appendix #3 – History – How did we get to where we are today?

Appendix #4 – National Strategy Guidelines in Other Countries

Appendix #5 – References used by CASP

Appendix #6 – Health Canada’s Canadian Institutes of Health Research (CIHR)

Appendix #7 – Oxford Suicide Prevention Coalition

I Acknowledgements

The Suicide Prevention Coalition of Oxford County wishes to acknowledge, with thanks, the work of the Canadian Association of Suicide Prevention (CASP) for its hard work and dedication in the area of suicide prevention. More specifically, we wish to acknowledge the work of the Association in developing the Blueprint. For a time line of the work done by CASP and others please see the Appendix.

In addition, the Oxford County Suicide Prevention Coalition has reviewed the plans developed in Waterloo Region, The Region of Niagara and The Region of Hamilton-Wentworth and we owe a debt of gratitude to those groups.

As we move through this process we are reminded of a story. There was a man sitting on a river bank when suddenly he heard cries for help. He looked up to see a man floating in the river. Without hesitation he jumped in the river to save the man from floating downstream. As he stood on the shore with the first man, he heard another cry for help and then a third and a fourth. He jumped back in the river trying to save each man. Soon a crowd gathered and others joined in, each doing what they could to rescue people from the river. Suddenly the first man started to walk up river. Those who had joined him cried out: “Why have you stopped? Many people still need your help.” “Yes”, he said “but there are enough people helping here. I need to go up stream and stop people from getting into the river in the first place”.

We need your continued help. It is time for us to ‘head up river’!

II Dedication

To those people who find themselves struggling with thoughts of suicide and to those who act on those thoughts we dedicate this document.

To all the people who work with those who are touched by the death of someone by suicide we dedicate this document .

To each person who tries to help another with thoughts of suicide we dedicate this document.

To those people for whom the pain and hopelessness and despair was too great and have died by suicide we dedicate this document.

III Introduction

Suicide is the triumph of pain and fear and loss over hope, but it is almost always preventable through caring, compassion, commitment and community.

Rationale for the Oxford County Suicide Prevention Plan

The World Health Organization's (WHO) first report on violence and health, published in October 2002, indicates that suicide is the single greatest cause of violent death around the globe; more deaths occur annually than all war casualties and homicides combined.

The report states that suicide is one of the leading causes of death worldwide and therefore is an important public health problem. Of the 82 countries reporting suicide statistics to the WHO, Canada ranks 26th putting it in the top third. Canada's national government has been aware of suicide as a serious community issue for close to two decades, having published a leading-edge national suicide task force report in 1987 and comprehensive update in 1994.

Suicidal behavior is an action which has a fatal outcome. It is not an illness and does not result from a single cause. Suicidal actions (resulting in fatal and non-fatal outcomes) should be viewed in the context of mental health issues and other conditions of risk - such as social isolation, biological vulnerability, trauma and stress, family violence, illness, and substance abuse - that interact in complex bio-psychosocial ways.

The tragic and complex nature of a suicide action has traumatic and rippling consequences, both for individuals and for those around them. The death of one person affects parents, children, siblings, and grandparents, in addition to relatives, friends, teachers, co-workers and others known to the individual. Although descriptive accounts are available, neither Canadian nor international research has focused sufficiently on the impact of suicide on the well-being of those left behind.

Suicide is generally seen as a preventable action, the causes of which lie in some combination of biological, psychosocial and community factors. There is a need for better understanding of the nature of suicide and for a national strategy designed to mobilize policies and services. We need to affect public attitudes toward suicide and its prevention if the impact on Canadians is to be reduced. A strategy requires a broad array of individuals and organizations, public and private, to join in the common cause of prevention through the coordination and development of appropriate services in communities across the country.

Suicide in Canada

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.

For too long, discussion of suicide has involved secrecy, stigma and taboo. Through our silence, and fueled by our fears, ignorance has resulted in much suffering. Now is the time to confront the silence. We must all be willing to learn. We must all be willing to educate ourselves and become ready to move into action to prevent suicide and to comfort the suffering.

Suicide is a complex problem involving biological, psychological, social and spiritual factors. No one perspective has the corner on truth, but taken together they provide much knowledge. We know that those at risk for suicide experience overwhelming emotional pain. They do not necessarily want to die, but do want help in reducing the pain so that they can go on to lead productive, fulfilling lives. Tragically, when someone dies by suicide the pain is not gone, but merely transferred to family, friends and community. The grief of those bereaved by suicide requires compassion, understanding and support to help minimize its impact.

Canadian statistics

1. The suicide rate in Canada is higher than in many industrialized countries.

The Canadian suicide rate is near the middle of all countries and in the top third of the highest rates of countries reporting to the WHO. The Canadian suicide death rate per 100,000 of population has increased 73% from an average of 7.4 in the 1950's to an average of 12.9 throughout the 1990's. The rate increased significantly from the 1960's to the 1970's but has remained relatively stable throughout the 1980's and 1990's.

2. Over 4,000 Canadians die by suicide every year.

The Canadian population has shown a steady increase from less than 14 million in 1950 to just over 30 million in 1999, an increase of 122%. The numbers of suicide deaths each year have more than tripled in the same period from just over 1,000 to over 4,000, while the population-adjusted rates of suicide have increased from 8.9 per 100,000 in 1950 to 13.13 in 1999, an increase of almost 50%. The most significant 10-year average increase was from the 1960s to the 1970s, which stabilized through the 1980s and showed the beginning of a slight downward trend in the 1990s; this downward trend needs to be continued and sustained.

There are well over 4,000 suicide deaths each year representing 2% of all deaths by Canadians. Canada loses on average 11 people a day to suicide, a figure that has been tragically predictable throughout the 1990s and into the early 2000s. Many actual suicides are not reported as such.

Statistics Canada suicide data go back to 1924 but were incomplete until 1956 when territorial data was included. Female suicide rates from 1924 to 1950 varied from a high of 7 to a low of 4.8 per 100,000, very similar to the current rates. Male suicide rates from 1924 to 1950 ranged from a high of 24 in the late 1920s to a low of under 15 during the Second World War. By the end of the 1990s, they were again approaching 20 per 100,000 .

3. Over 400,000 Canadians deliberately harm themselves every year.

Research shows that the rates of deliberate self-harming behaviours, including serious suicide attempts, may be 100 times higher than rates of suicide deaths. The large number of people engaging in self-harming actions may be one result of the increased levels of stress and resulting mental health problems evident in our current society (Bland, Newman, Dyck, 1994; Kerkhof et al, 1994).

Although it is difficult to arrive at accurate national figures for attempted suicide, a review of hospital discharge records provides another look at the magnitude of the problem. In 1998/99 a total of 22, 887 hospital discharges were related to suicide and intentional self-inflicted injury, close to 6 times the number of suicide deaths. Approximately 9% had been discharged in that year for one previous attempt and among these repeated attempts, approximately 23% had been discharged on at least three occasions following a suicide attempt. Recent (2002) national health survey information indicates that 3.7% of the Canadian population over 15 years has thought of suicide in the past 12 months.

4. Over 2,800,000 Canadians are affected by suicidal behaviour every year.

Using a conservative estimate of seven individuals who have been personally affected by a suicide death or act of intentional self-harm, over 2.8 million Canadians are affected annually.

Suicide and acts of self-harm affect all of us, families, friends, classmates and co-workers. Suicidal behaviours strain our health care system and increase the level of stress in society

5. Suicide is a leading cause of death for Canadians between ages 10 and 49.

In 1995, suicide was the leading cause of death for Canadian males aged 10 to 49. Cancer, motor vehicle collisions and HIV/AIDS were the next most common causes of death. At the end of the 1990s, suicide was the leading cause of death for men between 25 and 29 years and 40 to 44 years, and for women between 30 and 34 years. For young people between 10 and 24 years, suicide was the second leading cause of death for both males and females, surpassed only by motor vehicle collision deaths. For young First Nations people, suicide was the leading cause of death for youth between 10 and 19 years, accounting for 38% of all deaths for that age group, and higher than the 30% killed in motor vehicle collisions.

As we enter a new century, suicide is ranked third after cancer and heart disease across all ages in potential years of life lost for men; for women, it is fourth after cancer, heart diseases, and motor vehicle traffic collisions. Suicide was ranked second (725) behind unintentional injuries (1,036) for the greatest number of potential years of life lost per 100,000 for males. For females, suicide (179) was fourth behind unintentional injuries (375 years), lung cancer (344 years) and breast cancer (339 years).

Among First Nations people in 1999, the potential years of life lost was higher than all cancers combined and 50 percent higher than potential years lost to all circulatory disease. First Nations populations lost three times as many potential years of life to suicide as did Canadians overall. For First Nations people (on-reserve) suicide (1,495 years) ranked second after unintentional injuries (3,218 years) for the greatest number of potential years of life lost per 100,000.

5. Suicide is the second leading cause of death among Canadian youth aged 10-24.

Fatal injuries from suicidal behaviour closely follow motor vehicle collision injuries as the most likely cause of death for young Canadians. While the numbers of MVC deaths have been falling for several years, youth suicide rates in the 10-19 year range have been increasing.

6. Males are more likely to die by suicide but females are more likely to survive a suicide attempt.

Since the 1950s, Canada's suicide rates for males have been at least three times higher than for females, reaching a four times higher peak in the 1990s and dropping back to a 3.5 times higher ratio in 2001 due to a lower number of male deaths (2869) and a slight increase in female deaths (819). Males are most likely to use hanging and firearms in their suicide acts, resulting in fewer opportunities for rescue.

Females are also at high risk for suicide actions but tend to use less immediately lethal methods in their suicide attempts and are thus more likely to survive. They are more likely to use drugs, poisons and gases in their suicide acts resulting in better chances to prevent death with effective medical intervention. Although females have some tendency to utilize more lethal and less reversible methods in recent years, they are more likely to take advantage of community suicide prevention services and to ask for help even after initiating a suicide attempt. Males are less likely to ask for help from any source at any time.

7. Suicide is the third leading cause of death among adults in their primary parental years from ages 25-49.

Suicide follows cancer and diseases of the circulatory system as one of the major causes of death in this age group. One of the primary factors which enable people to manage the stress evident in daily life is a stable home relationship. The suicide of a family member is one of the most significant stressors a family can face.

8. Suicide deaths and attempts cost the Canadian economy over \$14.7 billion annually.

Several Canadian and US studies have estimated the cost of death due to AIDS, gunshot wounds and suicide. The estimated cost of a suicide death ranges from \$433,000 to \$4,131,000 per individual depending on potential years of life lost, income level and effects on survivors.

The estimated cost of attempted suicide ranges from \$33,000 to \$308,000 per individual depending on the hospital services and rehabilitation required, as well as family disruption and support required following the attempt. Psychological distress and ongoing mental health problems may result in long term treatment and care for the suicidal individual and family members. Suicidal behaviour in one family member may result in other family members choosing similar responses to distress in the future.

9. Suicide can be prevented.

Prevention requires a comprehensive strategy guided by federal policy and implemented with full federal participation. The conditions evident in the Canadian population which lead to suicidal actions are also manifested in other social problems such as violence against others, substance abuse, delinquency, employment disruption, poverty and family breakdown. A national strategy that contributes to the reduction of suicide may also contribute to the reduction of many other social problems.

10. Deaths by suicide in Oxford County.

The following chart provided by the Office of the Chief Coroner for the Province of Ontario shows the number of deaths by suicide in Oxford County. However, it does not include Woodstock, Tillsonburg or Ingersoll, which are the population centres of the County. It would be reasonable then to assume that for the entire County of Oxford the number of deaths by suicide would be higher than those listed below. This speaks to the need to ensure that accurate data is gathered and easily accessed.

YEAR	TOTAL
2000	8
2001	9
2002	12
2003	10
2004	16
2005	15

IV Guiding Principles

1. Suicide prevention is everyone's responsibility.
2. As Canadians we will respect our multicultural and diverse society and accept responsibility to support the dignity of human life.
3. Suicide is an interaction of biological, psychological, social and spiritual factors and can be influenced by societal attitudes and conditions.
4. Strategies must be humane, kindly, effective, caring and should be:
 - a) Evidence-based.
 - b) Active and informed.
 - c) Respectful of community and culture-based knowledge.
 - d) Inclusive of research, surveillance, evaluation and reporting.
 - e) Reflective of evolving knowledge and practices.
5. Many suicides are preventable by knowledgeable, caring, compassionate and committed communities.

V The Plan: Goals and Objectives

(A) Awareness and Understanding: Goal #1

To promote awareness in Oxford County that suicide is our problem and is preventable.

Objectives:

- 1.1** We will have a coordinated public awareness campaign that will reach the majority of the population and target special populations.
- 1.2** Convene an annual forum on special target populations and specific issues as needed (example: physician education on risk assessment).
- 1.3** Increase the number of public and private institutions and volunteer organizations active in suicide prevention.
- 1.4** Develop an awareness program to coincide with World Suicide Prevention Day.
- 1.5** Increase awareness and support for persons suffering from mental illnesses, substance use disorders, trauma and grief.

(A) Awareness and Understanding: Goal #2

To develop broad-based support for suicide prevention and intervention.

Objectives:

2.1 Ensure a broad representation of government, private and public stakeholders in further development, adoption and implementation of the Oxford County Suicide Prevention Plan.

2.2 Increase the number of Oxford County professional, voluntary and other groups that integrate suicide prevention activities into their ongoing programs and efforts.

2.3 Identify and increase the number of advocacy activities for suicide prevention in Oxford County.

(A) Awareness and Understanding: Goal #3

To develop and implement a strategy to reduce stigma associated with all suicide prevention, intervention and bereavement activities.

Objectives:

3.1 Increase the proportion of the public who value mental, physical, social, spiritual and holistic health.

3.2 Improve public understanding of mental health, treatment for depression, other mood disorders and mental illness, substance abuse, and suicide prevention services that are fundamental and essential components of health care.

3.3 Improve public understanding that to break the silence surrounding suicide increases realistic opportunities to save lives and reduce suffering.

(A) Awareness and Understanding: Goal # 4

To increase media knowledge regarding suicide.

Objectives:

4.1 Promote media news packages and training to increase knowledge and sensitivity regarding suicide.

4.2 Create a community media award for excellence in reporting as it relates to suicide and mental health.

(B) Prevention and Intervention: Goal #1

To develop, implement and sustain community-based suicide prevention programs while respecting diversity and culture at the local level.

Objectives:

1.1 The development of special emphasis on :

- persons suffering depression, other mood disorders and mental illness.
- those with a history of suicidal behaviour or multiple suicidal acts.
- gay, lesbian, bisexual, transgender, transsexual, intersexed and two-spirited persons.
- youth, young adults, family, community service providers, employers,
- schools
- in-home and community based services for seniors, persons with disabilities.
- police and emergency response.
- mental health, medical personnel, and other health care providers.

1.2 The development of a working agenda, timeline and target dates for implementation of these objectives.

(B) Prevention and Intervention: Goal # 2

To reduce the availability and lethality of suicidal methods.

Objectives:

2.1 Educate the public to reduce access to lethal means.

2.2 Support CASP as it advocates for the development and use of technology to reduce the lethality of means: for example firearm locks, carbon monoxide shut-off controls, bridge barriers, and medication containers.

2.3 Educate the public about the specific risk of harm and death by suicide any time there is a firearm in the home or otherwise available.

(B) Prevention and Intervention: Goal #3

To increase training for recognition of risk factors, warning signs and at-risk behaviours and for provision of effective intervention, targeting key gatekeepers, volunteers and professionals.

Objectives:

3.1 Increase the number of professional groups in the training and management of suicide risk and identification and promotion of protective factors.

3.2 Increase the number of employers in the training and management of suicide risk and identification and promotion of protective factors.

3.3 Increase the training and management of suicide risk and of identification and the promotion of protective factors within schools and education systems, and for:

- youth, family, community service providers, employers.
- school districts and private school associations, colleges and universities.
- in-home and community based services for seniors.
- persons with disabilities.
- police and emergency response.
- mental health, medical personnel, and other health care providers.

(B) Prevention and Intervention: Goal #4

To improve access and integration with strong linkages between the continuum-of-care components/services/families.

Objectives:

4.1 Advocate for follow-up within twenty-four hours of discharge or other transition of care for everyone deemed to be high risk, or with severe mental illness or history of self-harm within the previous three months, or with face-to-face contact within a maximum of seven days.

4.2 Support and advocate for the development guidelines and protocols to actively seek out and respectfully utilize collaborative input from families and friends.

(B) Prevention and Intervention: Goal# 5

To promote intervention and service delivery for high-risk groups.

Objectives:

5.1 Support interventions and coordinated service delivery for persons with mental illness, mood disorders, substance abuse and addiction, and dual diagnosis disorders (those with Intellectual Disability and Mental Health concerns).

5.2 Support interventions and coordinated service delivery for persons experiencing severe distress as gay, lesbian, bisexual, transgender, transsexual, intersexed and two-spirited persons.

(B) Prevention and Intervention: Goal #6

To increase crisis intervention and support.

Objectives:

6.1 Increase the number and training of programs and service providers for those affected by suicidal behaviour.

6.2 Support crisis and support networks and certification standards that are appropriate to the needs of this community.

6.3 Support the development of a crisis resource data base accessible to all crisis lines and crisis intervention facilities.

6.4 Support the development of structures for families living with suicidal people. Acknowledge their roles both as caregivers and as contributing members of the care team.

(B)Prevention and Intervention: Goal #7

To increase services and support to those bereaved by suicide.

Objectives:

7.1 Ascertain the number of support services, both immediate and longer-term, to those impacted by a suicide.

7.2 Review the needs of first responders regarding death notifications, funeral arrangements, community systems of support and aftercare.

7.3 Review the need for information packages for funeral directors, churches, schools and other community resources to improve services, education and support to those bereaved by suicide.

(B) Prevention and Intervention: Goal #8

To increase the number of primary prevention activities.

Objectives:

8.1 Support training events which promote resiliency and protective factors.

8.2 Increase connections and networking and improve cooperation and communication between suicide prevention and intervention programs, and services and associations to those programs that promote community wellness, public health and injury prevention.

(C) Knowledge Development and Transfer: Goal #1

To improve and expand surveillance systems.

Objectives:

1.1 Support the development of consistent standards and protocols for collecting information on suicide deaths, non-fatal attempts and ideation.

1.2 Support the development of standards for coroners to assist in accurately determining and reporting on cause of death.

(C) Knowledge Development and Transfer: Goal #2

To promote & support the development of effective evaluation tools.

Objective:

2.1 Support communication between survivors, community resources and researchers to facilitate knowledge transfer and knowledge uptake.

(C) Knowledge Development and Transfer: Goal #3:

To promote and develop suicide-related research.

Objectives:

3.1 Support the study and reporting of risk factors, warning signs and protective factors for individuals, families, communities and society.

3.2 Support efforts to increase opportunities including scientific journals, conferences, workshops and training for dissemination of data and knowledge from surveillance, evaluation and research activities.

Appendix #1

Current Suicide Prevention Initiatives in Canada

Atlantic Canada

New Brunswick

The Mental Health Commission offers suicide intervention training for caregivers in English and French. A Provincial Suicidologist has recently been appointed.

Newfoundland

Suicide intervention training by independent trainers.

Nova Scotia

There is now a province-wide network linked through a local newsletter, Suicide Alert, an annual symposium, NS Symposium on Suicide, and a leadership/coordinating committee, the N.S. Community Network to Address Suicide. This inter-agency type of coordination, while a relatively new and loose arrangement, is province-wide.

Prince Edward Island

Community crisis services and independent suicide intervention training.

Others

Suicide intervention training by independent trainers along with crisis and distress centres in many communities in Atlantic Canada. There is no standardized training program or established minimum standards for staff or volunteers.

Central Canada

Quebec

The only funded provincial suicide prevention association in Canada. Established provincial policy with designated funding. Established network of community crisis/distress centres. Annual conferences and awareness week activities. Independent suicide intervention training. Government funded suicide prevention research centre. Repertoire of available resources produced by the Conseil permanent de la jeunesse.

Ontario

Independent suicide intervention and bereavement training. Established network of crisis/distress centres. Some regional suicide prevention organizations and initiatives such as the Hamilton Suicide Prevention Council, the Toronto Council on Suicide Prevention, the Ottawa-Carleton Regional Inter-Agency Suicide Prevention Committee, and The Arthur Sommer Rotenberg Research Chair at the University of Toronto (established through private funding). The recently established, unfunded, Ontario Suicide Prevention Network is working to improve education, networking and sharing of suicide prevention resources.

Western Canada

Manitoba

Suicide prevention training and resources responsibility with mental health staff in government and regional responsibility for direct services through Regional Health Authorities without designated funding for suicide prevention services. Independent trainers and crisis/distress centres provide services.

Saskatchewan

Government coordinated Adolescent Suicide Awareness Program (ASAP) with a designated youth suicide prevention facilitator in each health district and a part time provincial coordinator. Corporate funded youth suicide prevention program (Friends For Life) currently winding down with the end of funding. Independent trainers and crisis/distress centres work throughout the province.

Alberta

Provincial programs since 1981 with internationally recognized components but no formal provincial policy. Active components include: Coordinated Community Outreach, Information and Training (The Alberta Model), but little funded research. The Suicide Information & Education Centre (SIEC) is the only provincially funded suicide specific resource centre in Canada and the Suicide Prevention Training Programs (SPTP) was the first provincially funded program to develop, deliver and coordinate gatekeeper and caregiver training in suicide intervention, postvention and awareness. Independent crisis/ distress centres provide service. Some staff training at Solicitor General and Child Welfare agencies. Intervention training in some school systems.

British Columbia

The Ministry of Health funds the BC Suicide Prevention Program which is administered through the University of British Columbia to provide leadership for the province in the area of youth suicide prevention. Encourages community consultation and support, education and skill development, information and research, and provincial coordination and monitoring. Assists

and supports the development of community suicide prevention services and coordinates government funded Community Wide Suicide Prevention Pilot Projects. Developed a manual of Best Practices in Youth Suicide Prevention.

The North

Yukon Territory

Independent suicide intervention training with some government departments supporting staff training

Northwest Territories

A cooperative government/foundation suicide intervention training initiative in final stages of training for trainers. Volunteer crisis/distress services in some communities and some independent training offered.

Appendix 2

Canada Wide Crisis/Distress Resources

The Canadian Association for Suicide Prevention (CASP)

A non-profit association dedicated to reducing suicidal behaviour.

Choosing Life: Special Report on Suicide Among Aboriginal People -

The Royal Commission on Aboriginal Peoples Report on Suicide which contains many recommendations.

Corrections Services Canada

Suicide intervention training for staff and inmates, utilizing the LivingWorks suicide intervention program, is offered in the Atlantic, Ontario and Prairie regions.

Crisis/Distress Centres

Communities across Canada have established Distress/Crisis centres to address suicidal behaviour and other crisis situations. These are primarily operated by a large component of volunteers with few paid professional staff. Training is not standardized. There is no standardized training program or established minimum standards for staff or volunteers and standards are set individually by each agency. There are no universal Canadian standards or external accreditation and evaluation criteria on a national level. A small number of distress centres have been certified by the American Association of Suicidology, but there is no other Canadian certification standard.

In Oxford County, Crisis Services are provided by the Crisis Team of the Canadian Mental Health Association – Oxford County Branch. This is a team of Mental Health professionals and is available 24 hours a day by telephone and is a mobile service as well. CMHA Oxford is accredited by Accreditation Canada a National Healthcare Accrediting body.

(Tele-care Oxford disbanded several years ago; it had served as a distress line with volunteers.)

Government of Canada

Established the Task Force on Suicide in Canada which resulted in the publication of the report Suicide In Canada, 1987 and the Update in 1994. Some suicide research has been funded. National meetings have been hosted to discuss suicide prevention. Co-hosted a special workshop on suicide-related research in 2003.

Kids Help Line

A toll-free professionally staffed crisis line to assist youth.

LivingWorks Education, Inc.

A public service corporation providing research and development services, as well as training and support for national and international independent suicide intervention trainers.

CMHA Oxford provides 2 LivingWorks education programs: SafeTalk and ASIST. Both programs deal with suicide awareness and intervention training and are offered by CMHA staff. All CMHA Oxford staff are trained in ASIST along with many others in Oxford County who have been trained to provide suicide intervention.

LPAC ~ Legal Profession Assistance Conference of the Canadian Bar Association

LPAC's 1997 Lawyer Suicide Study, by Dr. Adrian Hill, LSM, Ph.D, Juris.D., ICADC, identified a rate of death by suicide among older male lawyers at a rate nearly six times Canada's national suicide rate. LPAC established a comprehensive suicide prevention and bereavement support program including education, training and web-based learning as well as professional counseling and peer support. The LPAC program has been the catalyst for this CASP Blueprint project.

RCMP

The Aboriginal Police Service of the RCMP provides five-day suicide prevention conferences in aboriginal communities, managed and delivered by SPTP in Calgary. Aboriginal trainers are used and community members are trained to establish and operate their own suicide prevention services.

SIEC

The Suicide Information and Education Centre of the Centre for Suicide Prevention provides a collection, database search, document delivery service and provides suicide prevention information via the Internet, on CD-ROM, and through a variety of publications and serials.

SPTP

The Suicide Prevention Training Programs of the Centre for Suicide Prevention develops and delivers caregiver training through a variety of workshops ranging from two hours to five days. SPTP also manages a network of trainers offering caregiver training across Canada and worldwide. Workshops include Suicide Intervention, Suicide Bereavement, Awareness, Adolescent Suicide, Elderly Suicide, Surviving Suicide, Crisis Management and others.

Suicide in Canada, Leenaars et al., 1998

A compilation of articles by Canada's leading experts. This book makes a strong call for action from all segments of our population.

Appendix 3

History — How did we get to where we are today?

1987

United Nations Guiding Principles for Developmental Social Welfare Policies and Programmes in the Near Future (UN, 1987)

1989

UN General Assembly reaffirms the Guiding Principles

1991

The UN General Assembly approved the Guiding Principles as a major framework for action in developmental social welfare at the local, national, regional and inter-regional levels to address:

- Widespread stress and anxiety causing increased incidence of individual dysfunction, including rising rates of suicide among young people.
- Decline in the capability of many families and communities to provide adequate care for their younger members.
- The absence of comprehensive national strategies to prevent and resolve severe dysfunctional conditions, including suicide.
- UN Centre for Social Development and Humanitarian Affairs requested help to prepare a global review of social welfare services and make recommendations on areas of concern set forth in the 1987 Guiding Principles.
- The Secretary General of the UN called on countries to formulate social policy strategies that would deal with prevention as well as care and rehabilitation.
- The UN invites LivingWorks and SIEC to organize and host inter-regional expert meeting on suicide prevention.

1993

A Calgary based group organized and conducted a five day Inter-Regional Expert Meeting to develop a policy guideline for national strategies on suicide prevention that could be adopted by countries from all regions of the world.

1996

Publication of the guidelines in the United Nations document Prevention of Suicide – Guidelines for the formulation and implementation of national strategies.

1996

Publication of the book Global Trends in Suicide Prevention - Toward the Development of National Strategies for Suicide Prevention, edited by R.F. Ramsay, and B.L. Tanney.

1998

Health Canada commissioned and received a report outlining a four-stage process for the development of a national strategy for suicide prevention, which would include:

1. A study of the economic burden of distress and suicide in Canada.
2. Informal consultation among federal, provincial/territorial departments and major stakeholders on the feasibility of a national strategy.
3. The establishment of a coordinating body to guide the development.
4. The development and implementation of the strategy.

2003

CASP embarks on a blueprint strategy to be released at CASP meeting in 2004.

2005

Dr. William McLeish, one of Oxford County's coroners, had concerns over suicides in Oxford County and with the support of his faith community an invitation was sent to various community stakeholders to attend a meeting on November 15, 2005.

Representation was present from a good cross-section of the county including mental health professionals, psychiatry, faith communities, police services, education, suicide survivor family members and community volunteers.

Following this initial meeting several individuals continued to meet with the establishment of the Oxford Suicide Prevention Coalition in 2006.

2010

The Oxford Mental Health and Addictions Network supported the concept of a coordinated effort with the Oxford Suicide Prevention Coalition to develop a suicide prevention plan for Oxford County.

Appendix #4

National Strategy Guidelines in Other Countries

2003/04

Finland

Finland was the first nation to develop a comprehensive national suicide prevention strategy. The National Board of Health formulated a 10-year strategy in 1986 to reduce their high suicide rates by 20 percent. Their rates increased during the first years of the project to a peak in 1990, followed by a reduction of 20% between 1991 and 1996, and an overall reduction of 9% from the 1986 base rate. It is the only national strategy to have a completed international peer evaluation.

Norway

Norway established the National Plan for Suicide Prevention (1994-1999) under the direction of their National Board of Health. Annual funding of 6 million NOK (approx. \$1.2 Million CAD) was approved. The objectives of the plan were externally evaluated and largely achieved. The plan was extended as Measures Against Suicide (2000-2002) that includes a national training strategy under the direction of National Board of Health.

Sweden

In 1997 The Swedish National and Stockholm County Centre for Suicide Research and Prevention was designated a WHO Collaborating Centre in order to assist the WHO in initiating and evaluating suicide preventive research and programmes. The centre has a national responsibility for devising measures to prevent suicide and is active in four main areas - research and development of suicide preventive methods, epidemiological surveillance, information and teaching.

England

In 1994, the Department of Health established a target of reducing national suicide rates by at least 15% and the suicide rate for severely mentally ill people by at least 33% by the year 2000. In 2002 England released its national strategy for suicide prevention, which will be administered by the new National Institute of Mental Health.

Australia

Australia initiated a four-year \$13 million budget for a Here For Life Youth Suicide Prevention Initiative in 1995/96. In 1999 the Federal Budget allocated \$39.2 million over four years to the National Suicide Prevention Strategy (NSPS) to extend suicide prevention strategies across the age spectrum, addressing the needs of all groups at risk of suicide or suicidal behaviour, including youth. The National Advisory Council on Suicide Prevention was established to advise on implementation of the funds. Of the total budget, 40% was allocated to projects of national relevance with the remaining funds for all States and Territories to allocate through an appropriate selection process.

New Zealand (Youth)

The National Youth Suicide Prevention strategy was published in 1998. It has two parts: In Our Hands, which is the general population strategy and Kia Piki Te Ora o te Tātariki (Strengthening Youth Wellbeing), which specifically targets Maori needs and issues.

United States

The US Senate and House passed resolutions (1998) that recognized suicide as a major public health problem. The process of developing a national strategy was grounded to the UN national strategy guidelines and spearheaded by the volunteer led Suicide Prevention Advocacy Network (SPAN) with the help of public and private supporters. The issue was championed by the Surgeon General with the release of a Call for Action report in 1999. The first-ever national suicide prevention strategy was published in 2001 and implementation steps are now underway.

Scotland

"Choose life: A National Strategy and Action Plan to Prevent Suicide in Scotland" was published in December 2002 by the Scottish Executive. This document outlines the national and local strategy for suicide prevention in Scotland and raises issues such as public awareness, taking action to prevent problems arising in the first place, providing early support and intervention where problems do occur, developing a wider range of supports and services, improving training for front-line workers, and research and monitoring.

Canada

In 2004, the Canadian Association for Suicide Prevention publishes the CASP Blueprint, Canada's first National Suicide Prevention Strategy.

Appendix #5

References used by CASP

Beland, Y. (2002). Canadian Community Health Survey – methodological overview. *Health Reports*, 13(3), 9-14.

Bland, R. C., Newman, S. C., & Dyck, R. J. (1994). The epidemiology of parasuicide in Edmonton. *Canadian Journal of Psychiatry*, 39(8), 391-396.

Clayton, D., & Barceló, A. (1999). The cost of suicide mortality in New Brunswick, 1996. *Chronic Diseases in Canada*, 20(2), 89-95.

Commonwealth Department of Health and Family Services, Mental Health Branch. (1997).

Youth Suicide in Australia: The National Youth Suicide Prevention Strategy. Canberra, Australian Capital Territory: Australian Government Publishing Service.

Department of Health. (2002). National suicide prevention strategy for England. London, UK

Fiske, D. Heather (1998) Suicide Prevention for Lawyers, Judges, Law Students.

The Health, Wellness and Recovery Education Series of the Legal Profession Assistance Conference.

Gouvernement du Québec, Ministère de la Santé et des Services sociaux. (1998). *S'entraider pour la Vie: Stratégie Québécoise D'Action Face au Suicide*. Québec City, PQ: Bibliothèque nationale du Québec.

Health and Welfare Canada. (1987). *Suicide in Canada: Report of the National Task Force on Suicide in Canada*.

Ottawa, ON: Minister of National Health and Welfare.

Health Canada. (1994). *Suicide in Canada: Update of the Report of the Task Force on Suicide in Canada*. Ottawa, ON: Minister of National Health and Welfare.

Health Canada. (2001). Unintentional and intentional injury profile for Aboriginal people in Canada 1990-1999. Ottawa, ON: Minister of Public Works and Government Services Canada.

Health Canada. (2002). A report on mental illnesses in Canada. Ottawa, ON: Health Canada Editorial Board.

Health Canada. (2002). Healthy Canadians: A federal report on comparable health indicators 2002. Ottawa, ON: Minister of Public Works and Government Services Canada.

Hill, Adrian (1997) LPAC Study on Lawyer Suicide. (1998) LPAC National Suicide Prévention Program. (2003) LPAC Report on Its Suicide Prévention Program.

Inuit Tapiriit Kanatami. (2002). Suicide prevention in Inuit communities: An Inuit Tapiriit Kanatami discussion paper (Draft). Ottawa, ON

Kerkhof, A. J. F. M., Schmidtke, A., Bille-Brahe, U., De Leo, D., & Lönnqvist, J. (Eds.). (1994).

Attempted suicide in Europe: Findings from the Multicentre Study on Parasuicide by the WHO Regional Office for Europe. Leiden, The Netherlands: Leiden University, DSWO Press.

Kingdon, D., & Jenkins, R. (1995). "The health of the nation": Suicide prevention in England. *Italian Journal of Suicidology*, 5(1), 9-17.

Langlois, S., & Morrison, P. (2002). Suicide deaths and suicide attempts. *Health Reports*, 13(2), 9-22.

Leenaars, A. A., Wenckstern, S., Sakinofsky, I., Dyck, R. J., Kral, M. J., & Bland, R. C. (Eds.). (1998).

Suicide in Canada. Toronto, ON: University of Toronto Press.

Mehlum, L., & Reinholdt, N. P. (2001). The Norwegian Plan for Suicide Prevention: Follow-up Project 2000-2002:

Building on positive experiences. Retrieved April 15, 2004, from <http://www.med.uio.no/ipsy/ssff/engelsk/menuprevention/Mehlum.htm>

Ministry of Youth Affairs, Ministry of Health, & Ministry of Maori Development. (1997). An approach for action: Phase two in the development of a national strategy to help prevent youth suicide in New Zealand. Wellington, New Zealand

National Council for Suicide Prevention, National Board of Health and Welfare, National Institute of Public Health, & Centre for Suicide Research and Prevention. (1996). Support in suicidal crises:

The Swedish National Programme to develop suicide prevention. Stockholm, Sweden: National Board of Health and Welfare.

Norwegian Board of Health. (1995). The national plan for suicide prevention 1994-1998. Oslo, Norway (Report IK-2539)

Nunavut Department of Health and Social Services. (2002). Report on comparable health indicators for Nunavut and Canada. Iqaluit, NU: Health and Social Services, Information and Research Section.

Ramsay, R. F., & Tanney, B. L. (Eds.). (1996). Global trends in suicide prevention: Toward the development of national strategies for suicide prevention. Mumbai, India: Tata Institute of Social Sciences.

Retterstøl, N. (1995). The national plan for suicide prevention in Norway. *Italian Journal of Suicidology*, 5(1), 19-24.

Sørås, I. (2000). The Norwegian plan for suicide prevention 1994-1999: Evaluation findings. Retrieved April 15, 2004, from <http://www.med.uio.no/ipsy/ssff/engelsk/Soeraas.htm>

Statistics Canada. (2001). Leading causes of death at different ages, Canada, 1998. Ottawa, ON: Author. (Catalogue No. 84F0503XPB)

Scottish Executive. (2003). Choose life: A national strategy and action plan to prevent suicide in Scotland. Edinburgh, Scotland

Taylor, S. J., Kingdom, D., & Jenkins, R. (1997). How are nations trying to prevent suicide? An analysis of national suicide prevention strategies. *Acta Psychiatrica Scandinavica*, 95(6), 457-463.

United Nations, Department for Policy Coordination and Sustainable Development. (1996). *Prevention of suicide: Guidelines for the formulation and implementation of national strategies*. New York, NY: Author. Upanne, M., & Arinperä, H. (1993). *Finlandi's suicide prevention project (1986-1996)*. Helsinki, Finland:

Finnish National Research and Development Centre for Welfare and Health.

U.S. Department of Health and Human Services, Public Health Service. (2001). *National strategy for suicide prevention: Goals and objectives for action*. Rockville, MD

World Health Organization. (2002). *World report on violence and health*. Geneva, Switzerland

Appendix #6

Health Canada's Canadian Institutes of Health Research ("CIHR"),

Report on the Workshop on Suicide-Related Research in Canada, Montreal, February 7-8, 2003, identified 6 Broad Themes for Ongoing Investigation, as follows:

In alphabetical, not priority order

1. Data Systems: Improvement and Expansion

The improvement and expansion of data systems depends on a strong classification system, reliability and the elimination of biases. Data should be comprehensive, e.g., include information on both completed suicides and suicidal behaviours.

2. Evidence-based Practices

Research on evidence-based practices includes the evaluation of interventions (ranging from clinical treatments, public education and professional/volunteer training to systems-level interventions, policy changes, and strategies for improving knowledge translation and uptake). The focus of evaluative studies can be broad, including the impact on practice and community responses. Research under this theme may also address the determination of what constitutes acceptable influence, and as such will likely use (and examine the use of) methodologies that extend well beyond Random Clinical Trials to include various qualitative and quantitative approaches as well as indigenous knowledge. Also eligible would be studies of how suicide research and the development of evidence-based practices are influenced by current peer review and ethics review processes, and research into the nature of evaluation in this subject area, including its intent and utilization.

3. Mental Health Promotion

The Mental Health Promotion theme includes components such as actualization, advancement, the development and dissemination of culturally and community-appropriate information. It also covers community capacity, community-based initiatives and cultural continuity at multiple levels, e.g., individual/family/community/ nations. Research topics include protective factors, risk factors and resiliency over the life span and address issues related to discrimination, care for the caregiver (the wounded healer), social competence, shame, stigma and the perception of mental illness. The focus is on a problem-solving approach that is based on efficacy and excellence and that

acknowledges the need for growth and fulfillment of human potential. Positive psychology and the effects of social supports and isolation should also be considered under this theme.

4. Multidimensional Models for Understanding Suicide-Related Behaviours

Multidimensional models can be community- and theory-driven, but must be based on theoretical models and multi-dimensional approaches. Models must (a) address more than one factor and (b) explore interactions among factors. There is a need to encourage (but not require) interdisciplinary themes. The focus must be broader than suicide, i.e., it should cover the spectrum of suicide-related behaviour. Priority should be given to projects where design, methodology and measurement cross different domains.

5. Spectrum of Suicide Behaviours, including Suicide Attempters

The spectrum of suicidal behaviours includes aborted, attempted and assisted suicide, attempts disguised as accidents, deliberate self-harm, euthanasia, the hastening of death through life-threatening or self-injurious behaviour, suicidal gestures, suicidal ideation and suicide threat. It includes non-fatal/sub-intentional attempts, premature death, risk behaviour, screening identification. There is a need for mutually-accepted operational definitions for terms such as parasuicide.

6. Suicide in Social and Cultural Contexts

The incidence of suicide in Canada varies dramatically as a function of institutional, regional, social, spiritual, cultural and political contexts. It is critical to develop new knowledge about how these contextual factors have an impact, not only on the incidence of suicide, but on determining what constitutes best practices in the prevention of suicide and in responding to suicide-related social and human problems.

The CIHR Report on the Workshop on Suicide-Related Research in Canada can be found in its entirety at: <http://www.cihr-irsc.gc.ca/e/institutes/inmha/18918.shtml>

Appendix #7

Oxford Suicide Prevention Coalition

Purpose:

To work toward the development of a coordinated Oxford County Suicide Prevention Strategy with the ultimate goal of suicide reduction in Oxford County.

Functions:

- Collect and document current community resources
- Development and dissemination of resources
- Organization and facilitation of public community forums for stakeholder feedback
- The development of proposals, as required, to provide resources for activities of the coalition
- Conduct public consultation on issues related to suicide

Vision

We envision a community that is, by its attitudes and practice, compassionate, caring, informed, and educated and supports the well being and safety of all people.

Mission

Believing that every person has the right to be supported in living a healthy, positive life, our mission is to reduce suicidal behaviour and its impact on individuals, families, and communities within Oxford County.

Goals

1. To reduce suicidal behaviour in Oxford County through:
 - Public awareness
 - Education and skill development
 - Public health advocacy

2. To reduce the impact of suicidal behaviour on individuals, families, groups and communities within Oxford County through:
 - Advocacy for improved or enhanced services
 - Community consultation, coordination and collaboration

Membership:

Efforts will be made to ensure that membership reflects a wide range of stakeholders. This includes geographical representation as well as skill, organizational and personal experiences.

- Various ministries/government representation(local municipal representation)
- Faith Communities
- Mental Health Workers
- Injury Prevention Workers
- Health Promotion Workers
- Family Violence Workers
- Child and Youth Workers
- Labour Union Reps

- Survivors of Suicide (family members impacted) (those who have attempted)
- Seniors representation
- Community Professionals
- Education System Representation
- Hospital Representation
- Physicians and psychiatrist
- Emergency Providers – EMS and Police
- Industry
- Media
- Any Concerned Individual or Organization
- **YOU!**

Membership in the Coalition will be implied through individual participation and/or monetary donations.

Current Oxford Suicide Prevention Coalition Executive

Co-Chair	Dr. Bill McLeish	wmcl@execulink.com
Co-Chair	Terri McCartney	terrimccartney@cmhaoxford.on.ca
Treasurer	Tony Sheldon	inthemist@sympatico.ca
Member at Large	Vicki Travnicek	mar8vic@porchlight.ca

Letters and enquiries to the Oxford Suicide Prevention Coalition may be directed in care of the Canadian Mental Health Association-Oxford County Branch
522 Peel Street
Woodstock ON N4S 1K3

519 539-8055 or 1 800-859-7248

