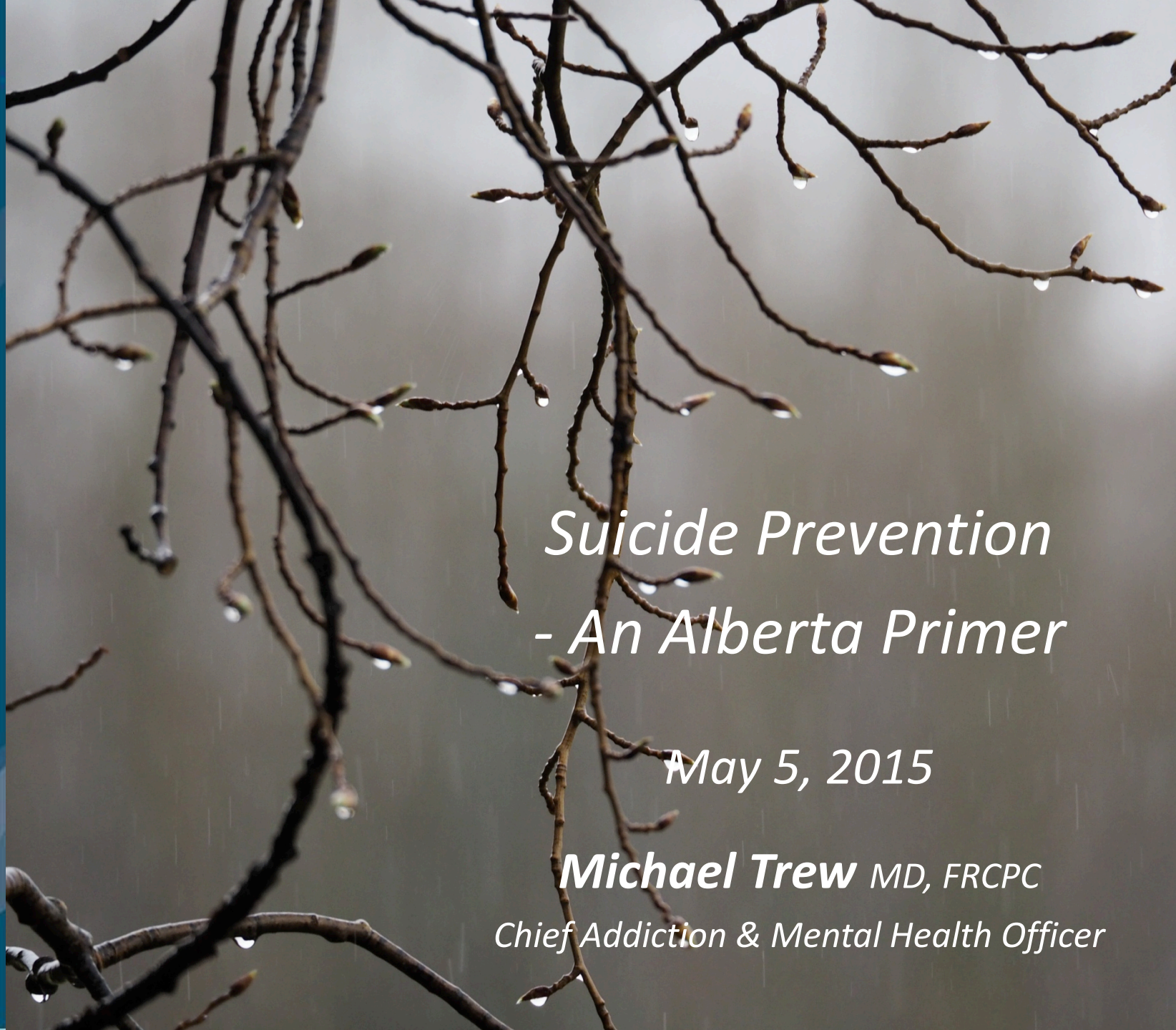

Suicide Prevention - An Alberta Primer

May 5, 2015

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Chief Addiction & Mental Health Officer

Declaration:

- No Conflicts of Interest

- Thanks to:
  - Catherine Davis – AHS
  - Michael Sanderson - AH

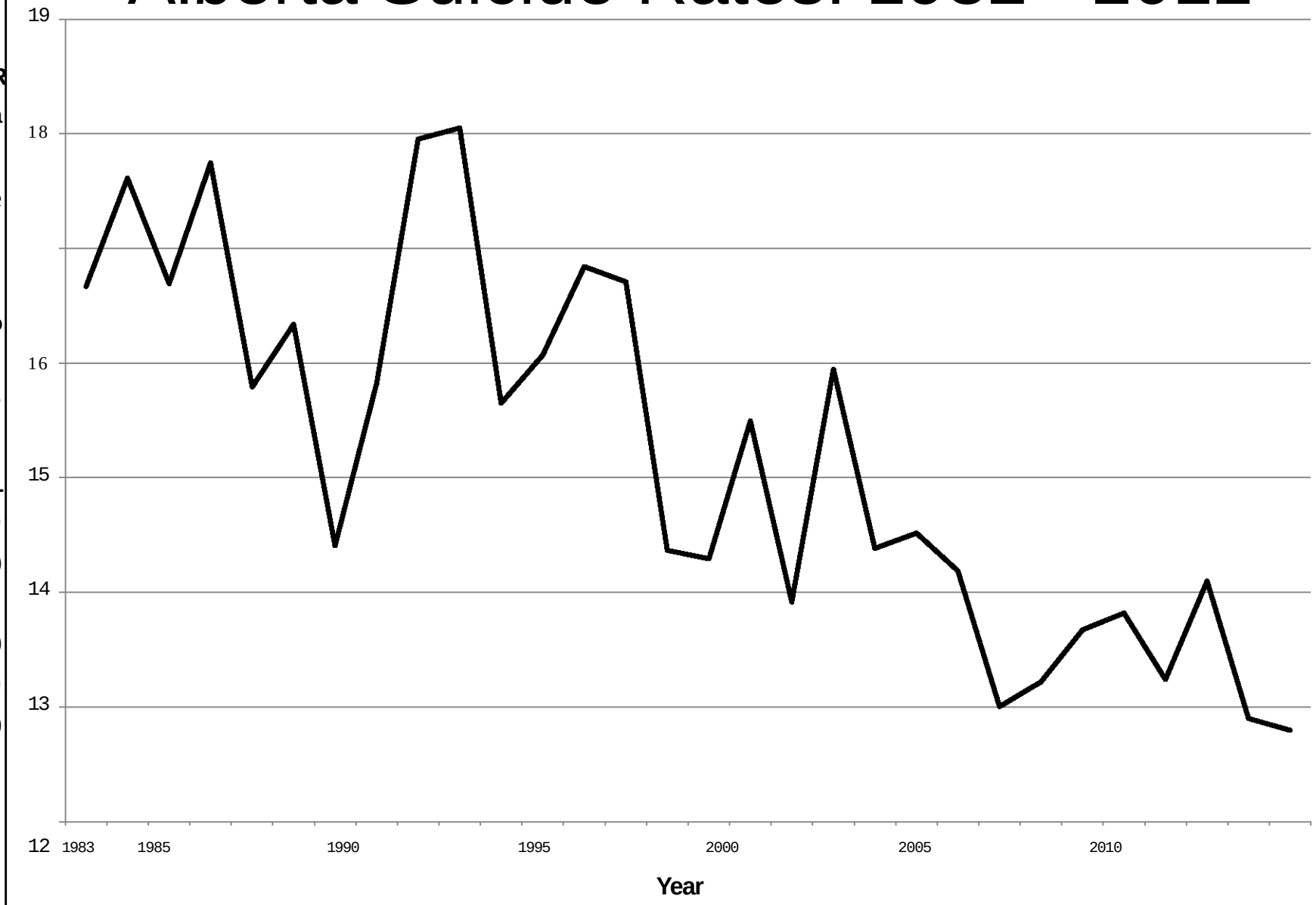
Are you a Suicide Survivor?

Quick facts on suicide in Alberta

- More than 500 per year
- One of the highest suicide rates in the Canada at almost 14 per 100,000
- Almost 75 % of suicides are male
- Females attempt more
- Males 25-55 years account for more than 50% of deaths
- Aboriginal youth are up to 5 times more likely to die by suicide as compared to the general population

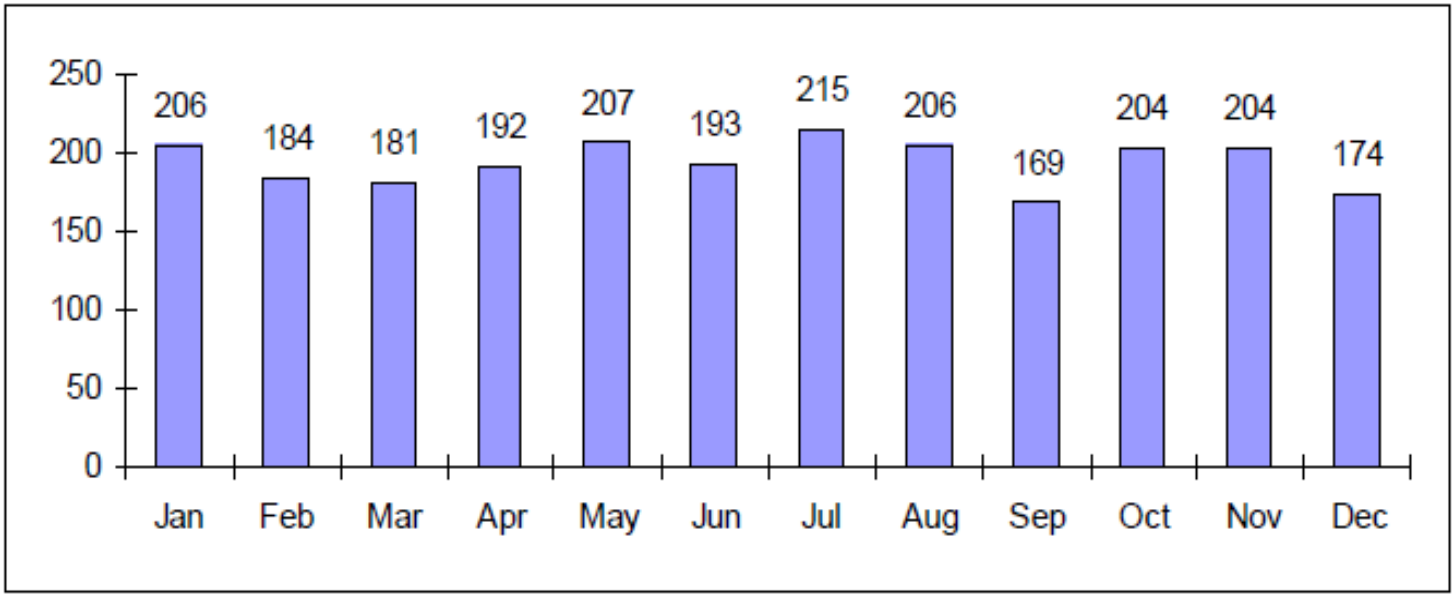
- Public Health concerns about suicide rates since 1950's
  - Below 10/100,000 per year in 1950's
  - High rates in 1990's getting close to 20/100,000
  - Generally above the Canadian average by 3-4/100,000
  - Why is rate in southern Ontario half of AB?

Alberta Suicide Rates: 1982 - 2012

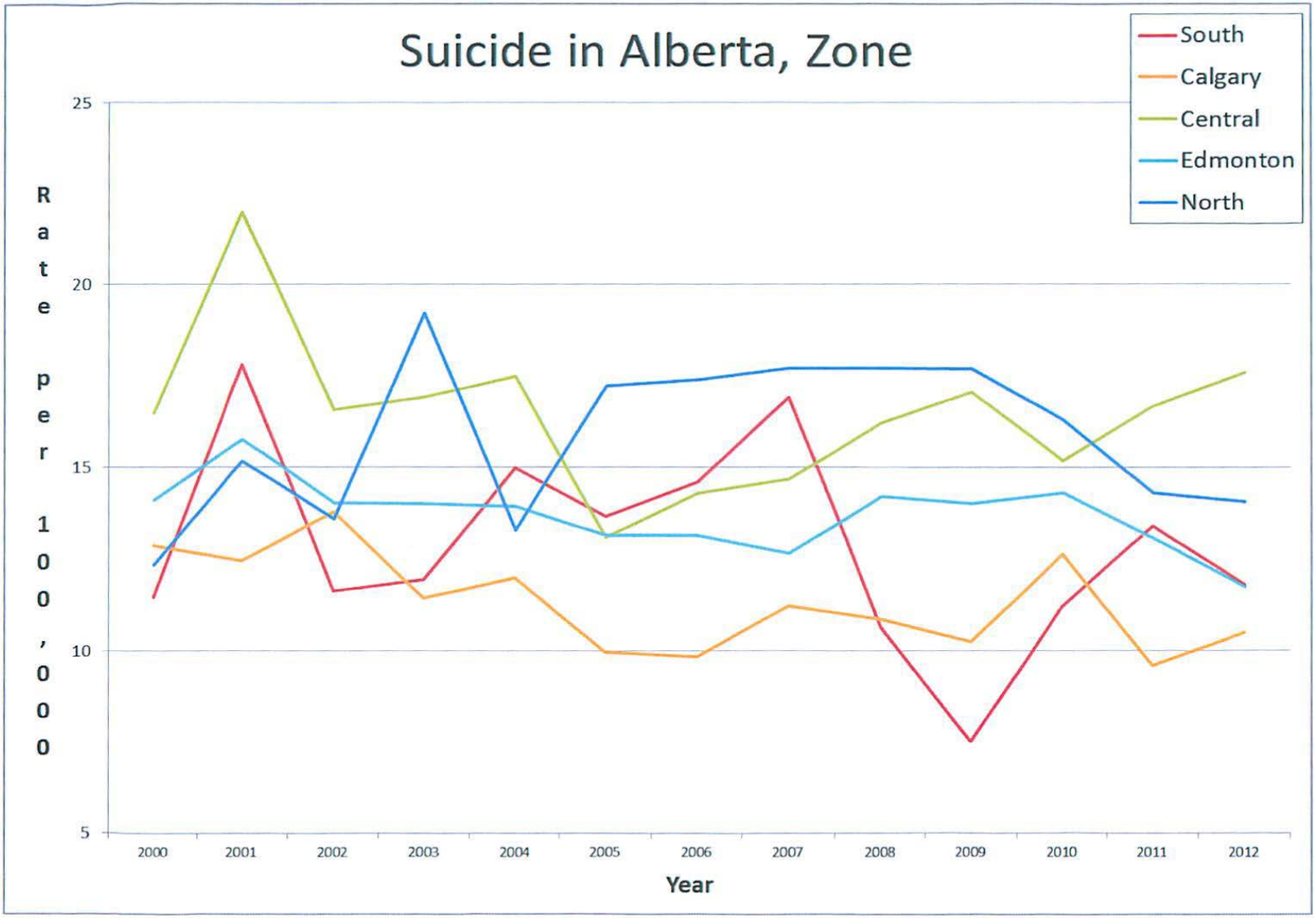


Suicides by Month

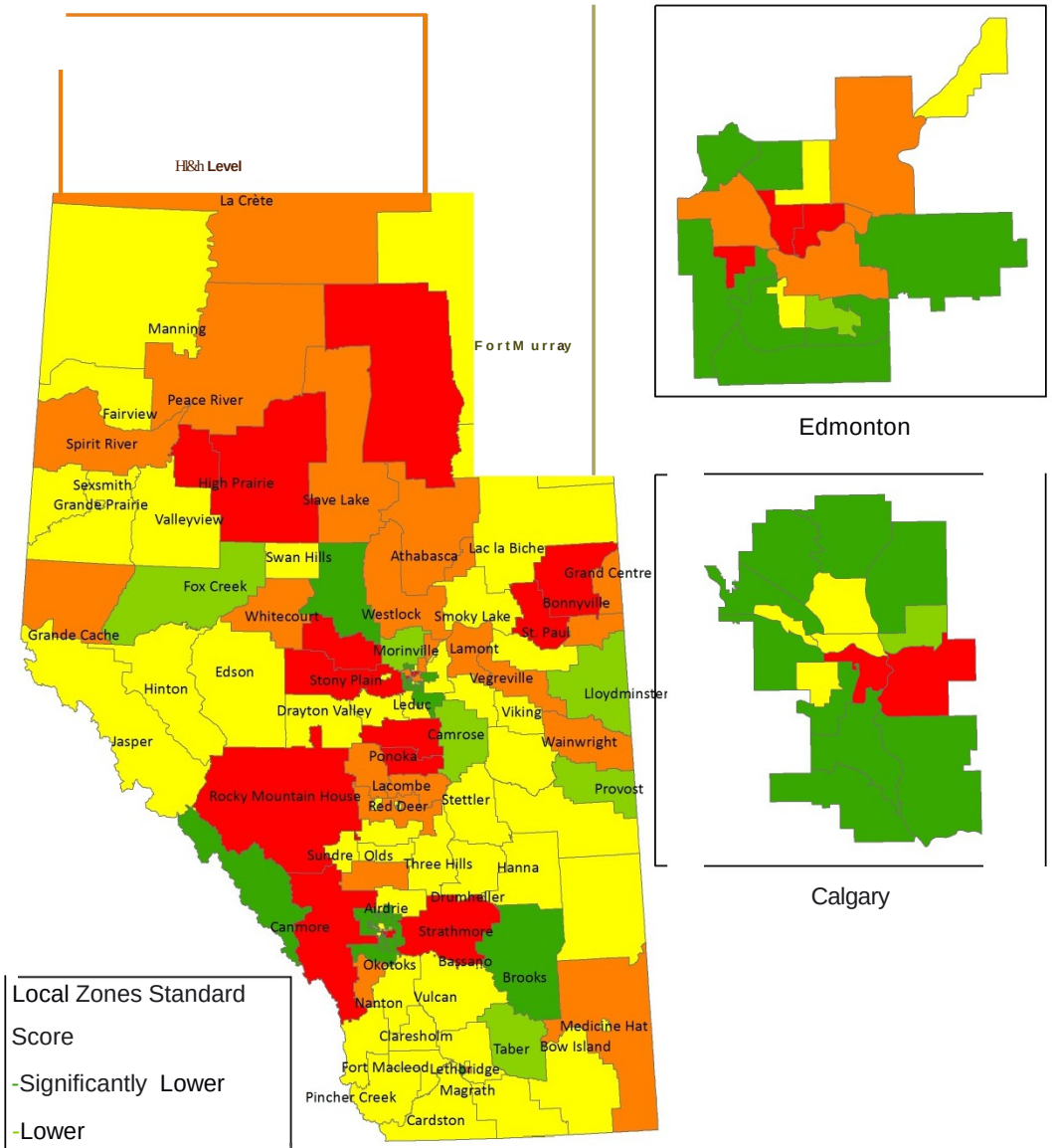
Suicides by Month, 5 Years Combined 2005 through 2009



Source: 2009 OCME Annual Review


Suicide in Alberta, Zone
South
Calgary
Central
Edmonton
North
Rate per 100,000
25
20
15
10
5
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
Year

Suicide in Alberta, 2000 to 2012



The Epidemiology of Suicide in Alberta

Geographic Differences

Why do some geographies have high suicide rates?

Age, gender, mental illness, alcohol abuse, substance abuse, lower socio-economic status, and being alive are all risk factors for death by suicide.

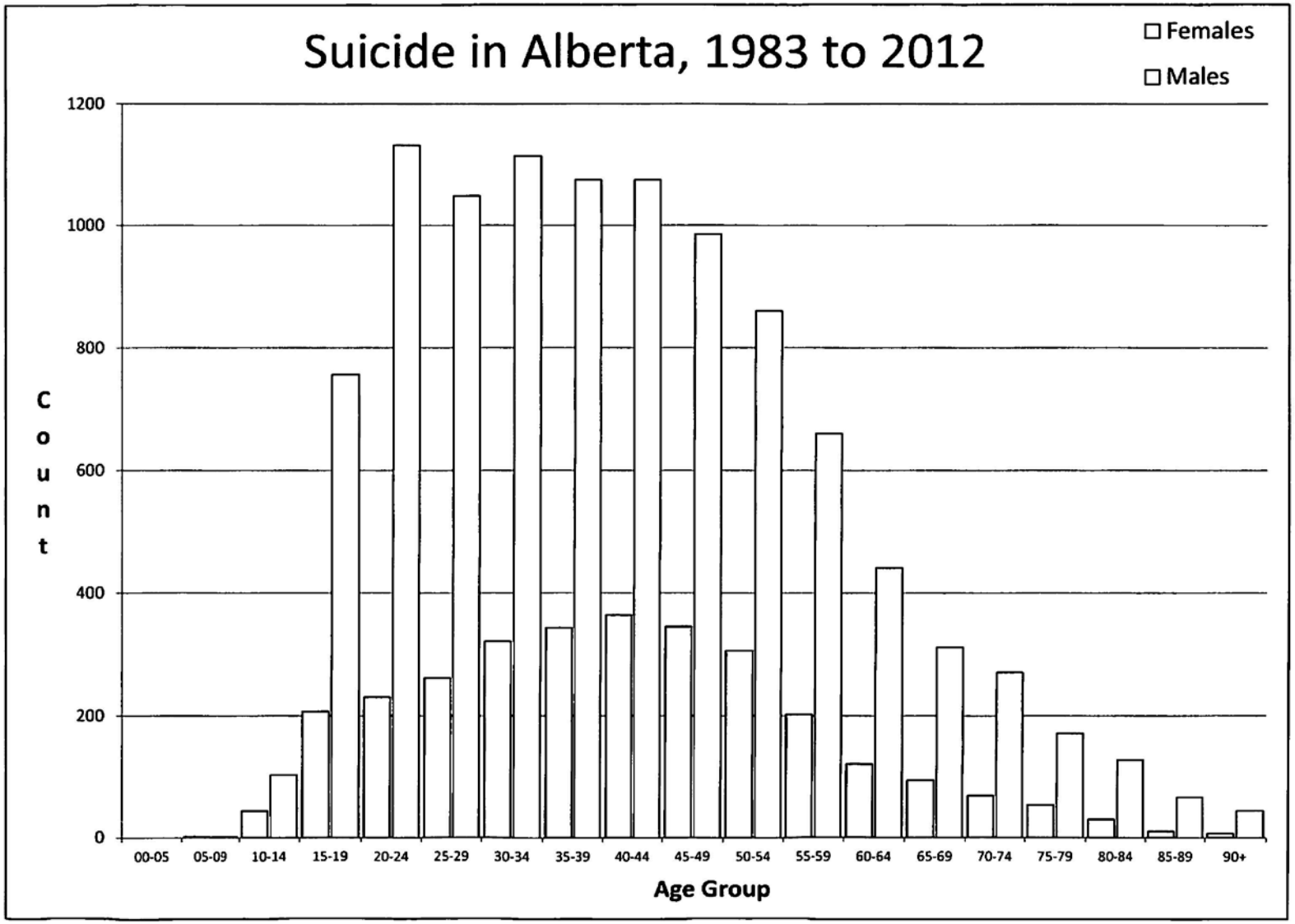
The risk factors are highly correlated.

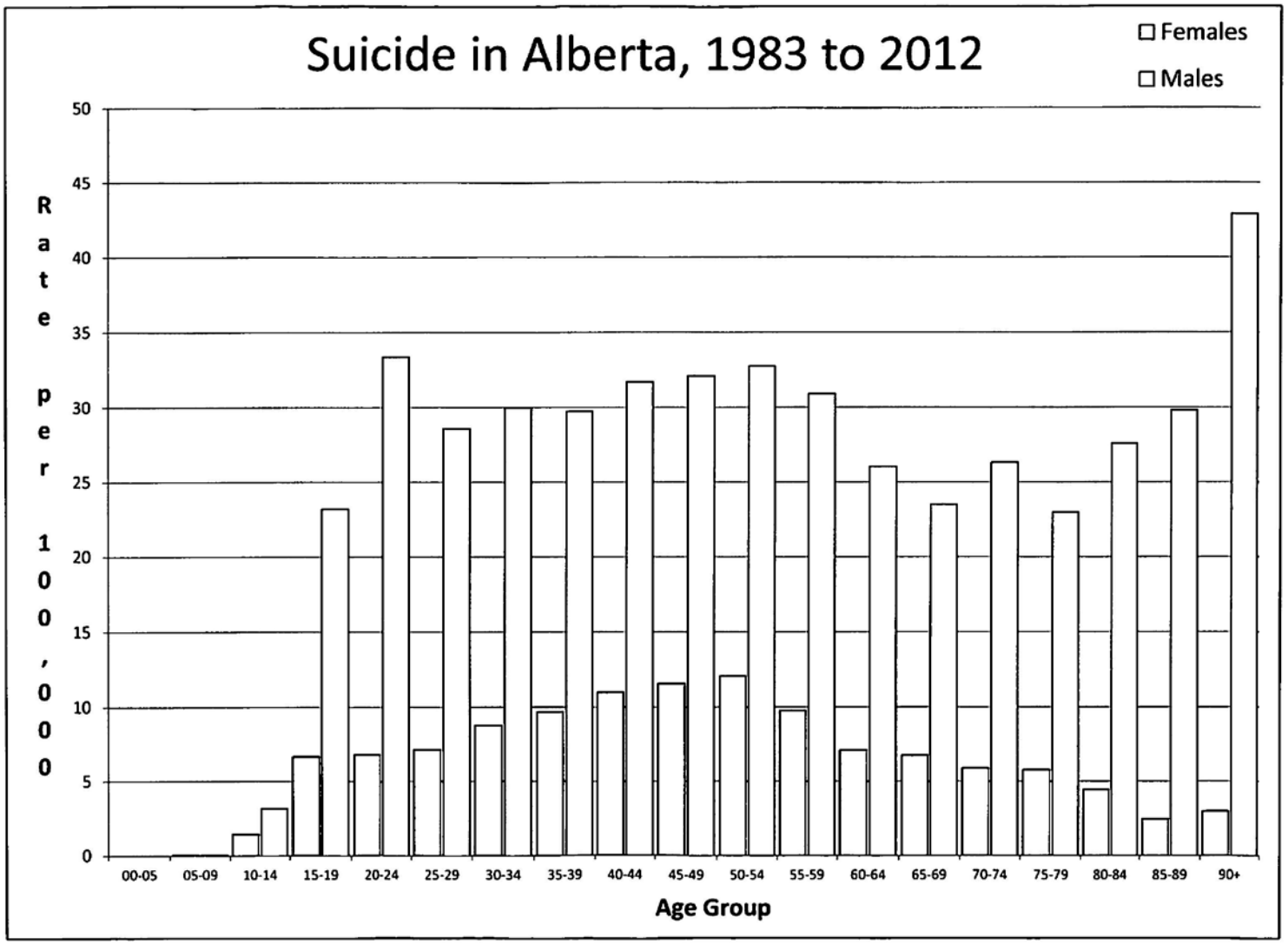
The Epidemiology of Suicide in Alberta

Geographic Differences

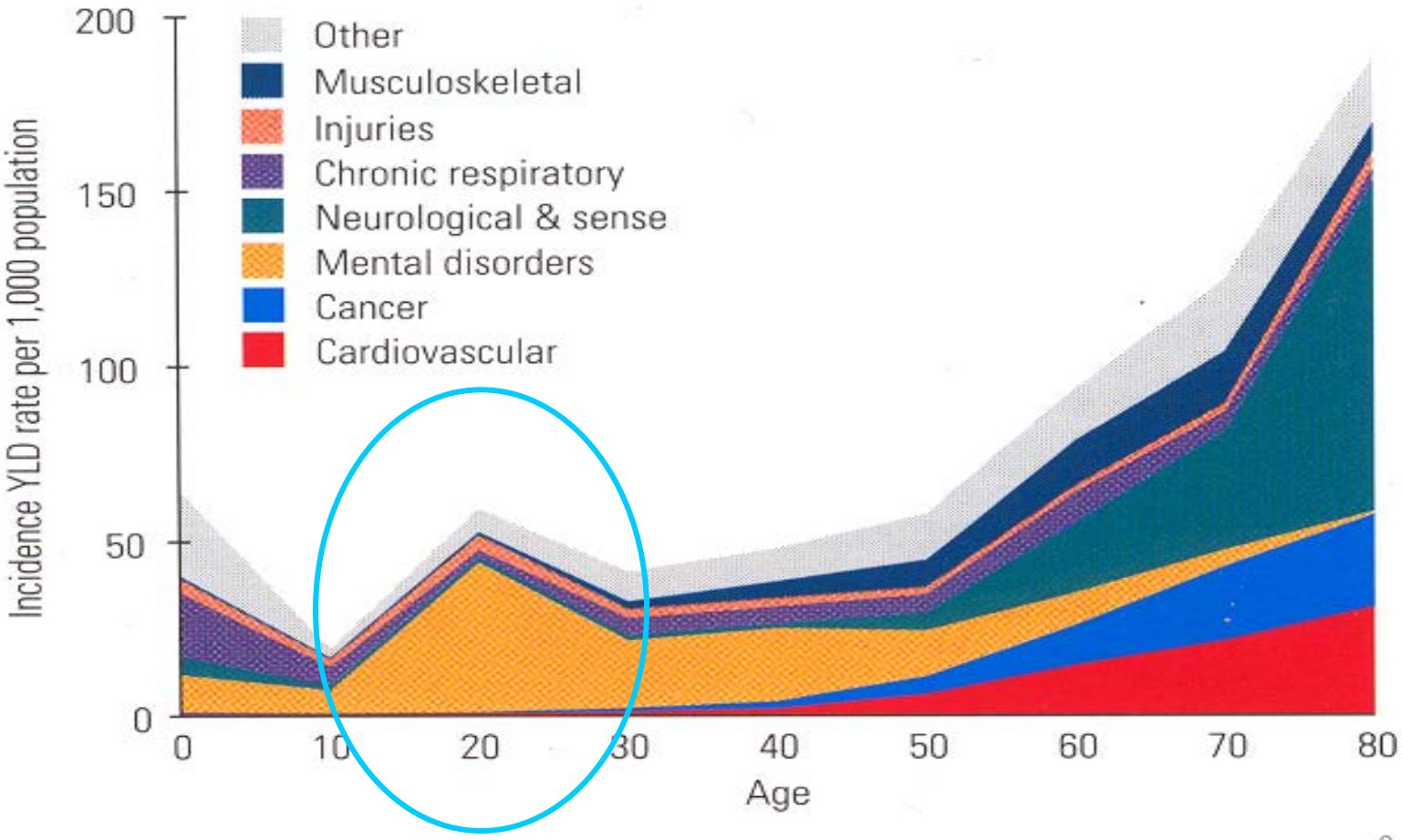
An *adversity metric* was created that summed the z-scores of the **alcohol** abuse, **substance** abuse, and **socio- economic measures** (median income, unemployment, proportion with full AHCIP premiums) for each geography.

Geographies with high suicide rates tend to have a higher adversity metric.

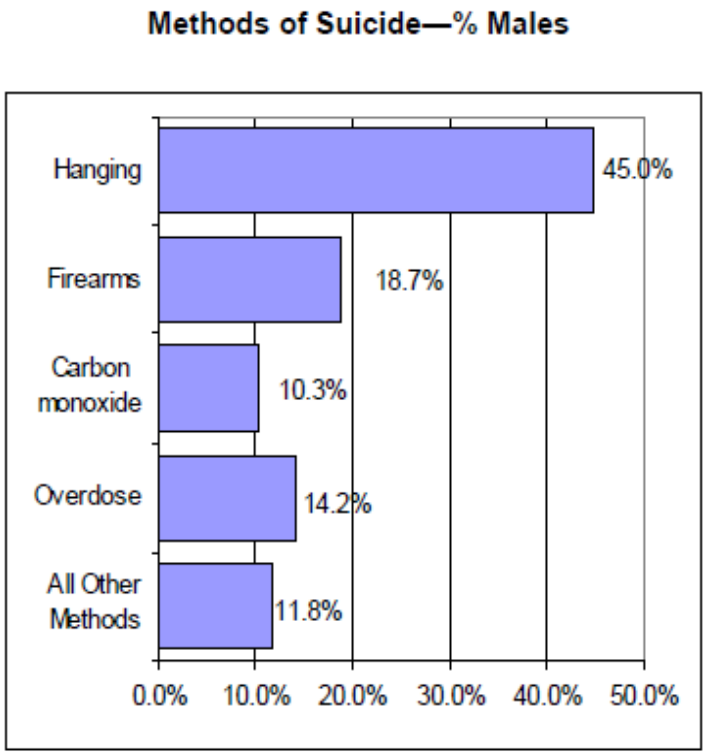

Suicide in Alberta, 1983 to 2012
Females
Males
1200
1000
800
600
400
200
0
Count
00-05
05-09
10-14
15-19
20-24
25-29
30-34
35-39
40-44
45-49
50-54
55-59
60-64
65-69
70-74
75-79
80-84
85-89
90+
Age Group

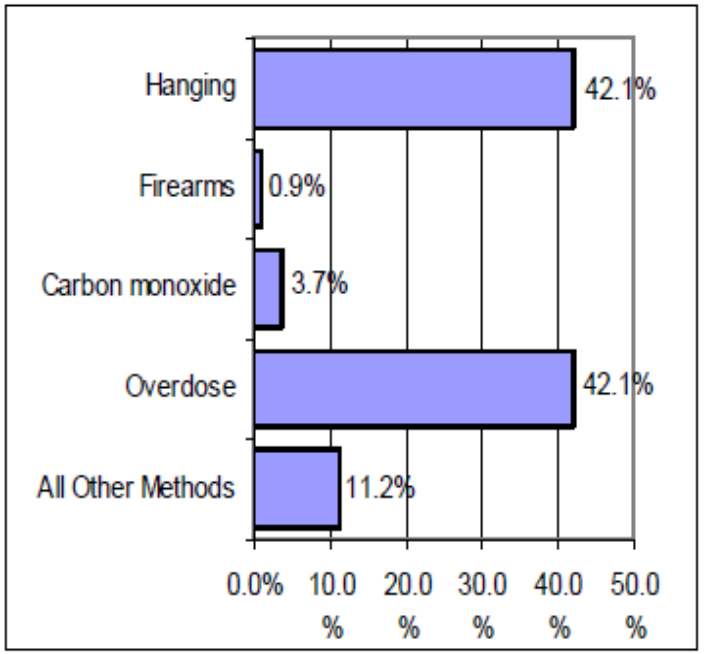

Suicide in Alberta, 1983 to 2012
Females
Males
Rate per 1000,000
50
45
40
35
30
25
20
15
10
5
0
00-05
05-09
10-14
15-19
20-24
25-29
30-34
35-39
40-44
45-49
50-54
55-59
60-64
65-69
70-74
75-79
80-84
85-89
90+
Age Group

Incidence of Disease across the Lifespan



Methods of Suicide





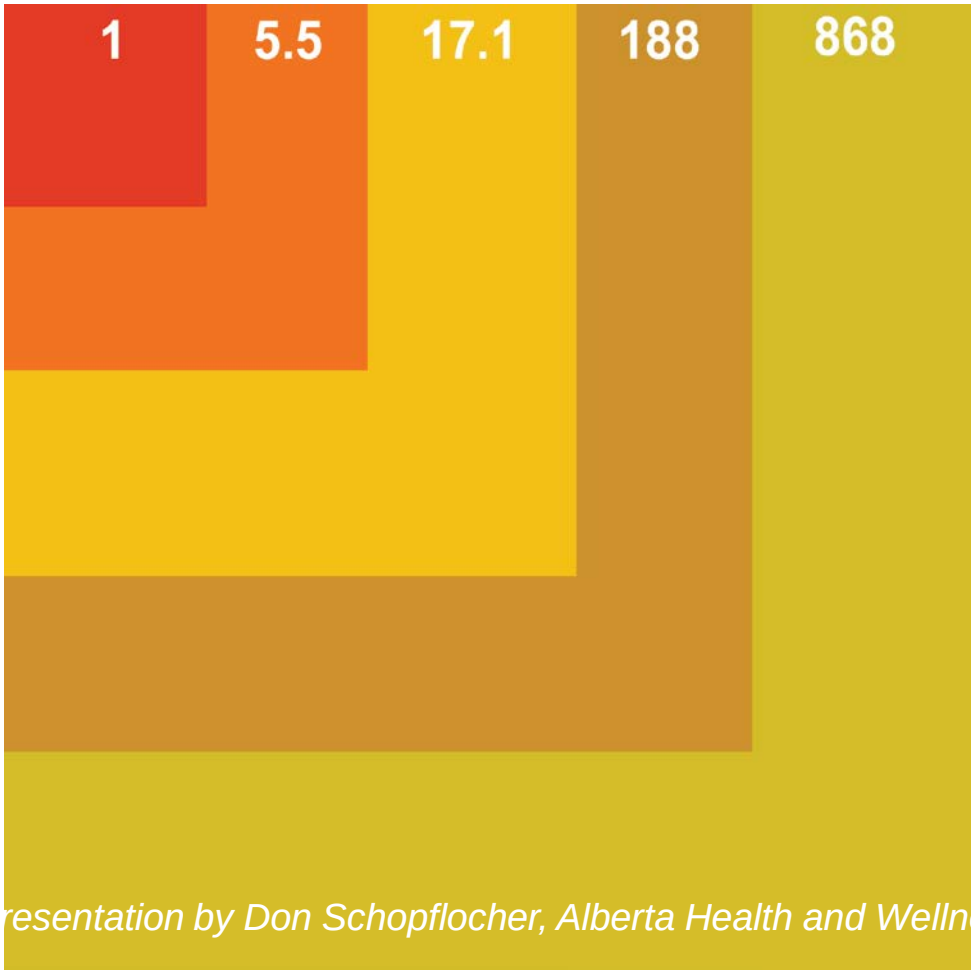
Source: 2009 OCME Annual Report

Suicide Picture

- For every **death** by suicide, there are approximately:
  - 5.5 **hospitalizations**
  - 17.1 **ER visits** for suicidal concerns
  - 188 people **thinking** of suicide in a year
  - 868 who will **consider** suicide *over a lifetime*

Source: *2003 Presentation by Don Schopflocher, Alberta Health and Wellness*

Suicide Picture



- Estimates of *mental disorders* in those who die by suicide indicate:
  - > 95% have either mental disorder or substance abuse
  - 50% depressed
  - 65% substance abuse
- But
  - Only 15-20% within mental health/substance abuse treatment system

Relative Risk for Suicide:

Prior attempt	38.4
Eating disorders	23.1
Bipolar disorder	21.7
Major depression	20.4
Mixed drug abuse	19.2
Dysthymia	12.1
Obsessive compulsive disorder	11.5
Panic disorder	10.0
Schizophrenia	8.5
Personality disorder	7.1
Alcohol abuse	5.9
General population	1.0

Assessment

Risk Factors - Static

- Age – peaks in youth and 30-55
- Male : Female ratio 3:1 for death by suicide
  - Female > Male for suicide attempts
- Previous history of suicidal act
- Family history of suicide / attempts

Risk Factors - Modifiable

- Current depression / psychosis
- Current substance abuse
- Recent stressful life event / loss
- Recent change in treatment *(discharge)*
- Ineffective coping
- Lack of social support
- Access to lethal means – n.b. guns & pills
- Lack of hope
- Suicide viewed as only solution

Columbia Suicide Severity Rating Scale – C-SSRS

- Severity of thoughts: *active vs passive*
- Intensity of ideation: *frequency, duration, controllability, deterrents, reasons*
- Suicidal behaviours – *degree of directed action*
- Lethality: actual / potential
- http://www.cssrs.columbia.edu/

C-SSRS cont'd

- Encouraging research on consistency, sensitivity and predictive value
- Positive results both anecdotally and some outcome data with regards reduced suicidal behavior when used systematically

SAFE-T

Suicide Assessment Five-step Evaluation and Triage

- 1 – Identify risk factors
- 2 – Identify protective factors
- 3 – Conduct suicide inquiry
- 4 – Determine risk level / intervention
- 5 – Document

- **www.sprc.org**

Warning Signs:

I – Ideation

S – Substance Abuse

P – Purposelessness

A – Anxiety

T – Trapped

H – Hopelessness

W – Withdrawal

A – Anger

R – Recklessness

M – Mood Changes

ANY warning sign in combination with any chronic risk factors (especially history of previous suicidal behaviour) should prompt ongoing mental health care.

Protective Factors
(Reasons for Living)

- **Internal:**
  - ability to cope with stress
  - religious beliefs
  - frustration tolerance
- **External:**
  - responsibility to children or beloved pets
  - positive therapeutic relationships
  - social supports

Goals of Intervention

- *Infect with hope*
- Build on strengths
- Connect with supportive contacts – personal and professional
- Safety plan
- Treat underlying conditions

Safety Plan

- Prioritized written list of coping strategies and resources
- Provides sense of control / framework
- Written using their own words
- Commitment to treatment & staying alive
- *Warning signs / Internal strategies / Distractions / Own network / Professionals / Environmental safety*

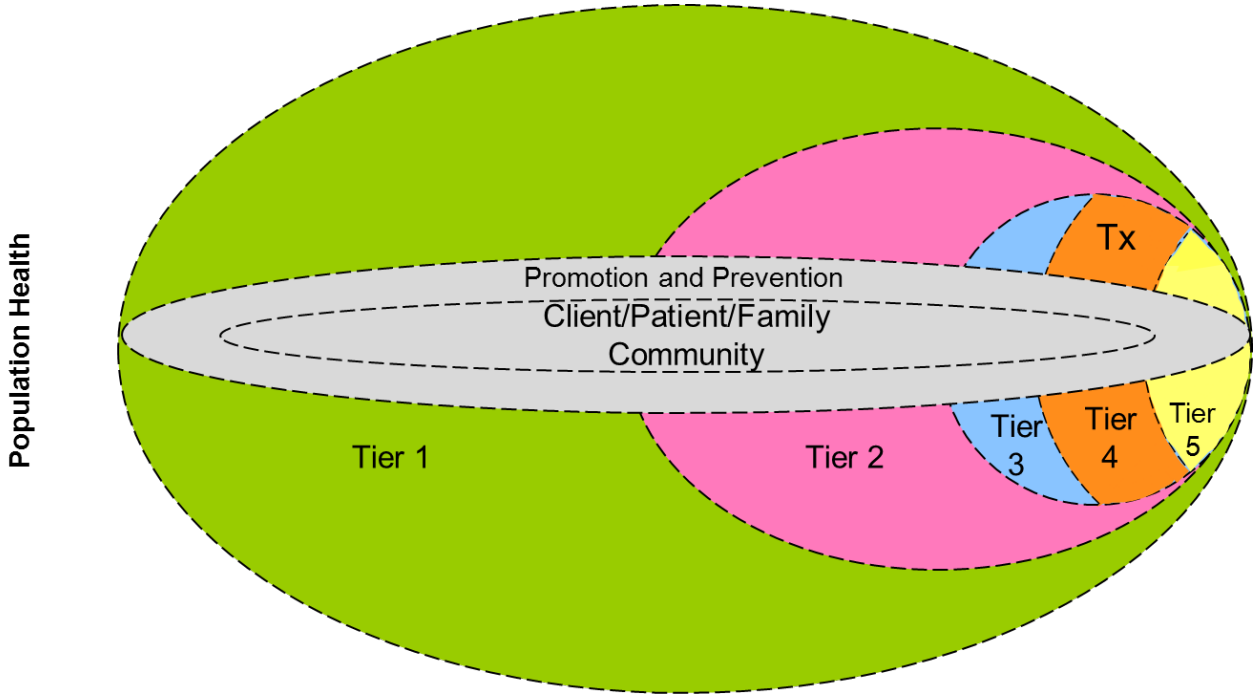
Prevention: Looking Upstream

Continuum of Suicide Prevention

- Health Promotion
  - Suicide *Prevention*
  - Suicide *Intervention*
  - Suicide *Postvention*

- Focus on levels of action
  - Universal
  - Selective
  - Indicated

Integrated Addiction and Mental Health Model



Tier 1	Tier 2	Tier 3	Tier 4	Tier 4	Tier 5
Health Promotion and Prevention (universal, targeted and indicated)	Screening and brief intervention, support and relapse management	Short-term clinical intervention, support and relapse management	Intense, longer-term treatment, rehabilitation, support and relapse management	Complex, long-term treatment, rehabilitation and associated supports, and relapse management	Specialized treatment, rehabilitation and associated supports, and relapse management

PROVINCIAL LEGISLATION, REGULATION AND POLICY

Challenges:

- 80% of those at risk not connected to AMH system
- High numbers are in contact with primary care – but not screened
- Help seeking barriers / Stigma
- High correlation with elevated ACE scores
- *Social Determinants of Health*

Action…

Level of action

- **Universal** strategies/initiatives: Those that address an entire population, designed to influence everyone and reduce the number of individuals in the higher risk populations while making the whole population less susceptible to suicide

- **Selective** strategies/programs: Those that address subsets of the population, focusing on groups that are identified as being at risk, for example middle aged males; Aboriginal youth; school age adolescents and young adults; people with a mental illness and/or addiction

Action…

- **Indicated** Programs: Those that target specific *individuals* who are at high risk

Toward action

- Focus areas of action – Areas where evidence suggests that we can make a difference
  - **Communication and coordination**
  - **Building Capacity**
  - **Encouraging and facilitating help seeking**

- *These areas are not separate and distinct but interconnected in a symbiotic relationship*

Communication and Coordination

- *School Based* - suicide prevention awareness programs
- *Public Education* Campaigns
- *Health literacy* – mental, emotional and trauma
- *Media Guidelines* for reporting on suicide
- *Increased interconnectivity* – engaging all stakeholders, levels of government and departments in government

Communication and Coordination

- *Research and evaluation* – need access to reliable data and empirical evaluation
- *Increased access* to information and resources
- *Knowledge translation* – putting what we know into action

Building Capacity

- Programs that target *enhancing coping skills*
- Improved *screening, detection and treatment* of depression
- *Education and training* for professionals and lay people
- Increased *awareness and knowledge* of the general public

Building Capacity

- Education and resource distribution at *natural community connection points* such as:
  - Schools
  - Primary Care clinics, well child clinics
  - Workplace
  - Liquor establishments
  - Sports and recreation facilities
  - Agencies serving new immigrants
  - Faith based organizations

Adolescents

- Protective factors moderate depression and stress
- Higher risk:
  - Females: hopelessness
  - Males: keep to yourself
  - Non-productive coping includes: worry, wishful thinking, ignoring the problem, blame
- Protective:
  - Females: focus on the positive
  - Males: self-discovery (Spirituality scale)

Enhance and facilitate help seeking

- Peer support
- Enhanced social networks
- Increased access to resources and treatment
- Improved health literacy
- Stigma reduction

What have we learned from others?

- Countries that have been focused in suicide prevention and have demonstrated success and leadership include:
  - Australia
  - Scotland
  - New Zealand
  - England
  - Other

Communication and coordination

- England: Intergovernmental department planning for suicide prevention
- Scotland: National strategy - *Choose Life*
  - *Breathing Space* targets young men 18-40
- Australia: National Strategy- *LIFE* (Living is for everyone), *Headspace* for youth
  - Public awareness campaigns, website, plain language resources, newsletters, PSA's
  - Aboriginal projects
- New Zealand
  - Increased communication and support for primary physicians
  - Projects focussing on Maori youth

Building Capacity

- Scotland established targets for *training in suicide prevention* for all health care professions
- *H*ealth Improvement, *E*fficiency, *A*ccess *T*reatment (*HEAT*) targets
  - Introduced maximum waiting times for *access* to alcohol misuse and psychological therapies
  - *50 % frontline staff will be trained* in suicide prevention (combination of ASIST, and SafeTalk)

Building Capacity – cont'd

- Australia
  - *MATES* in Construction - Training in the Construction Industry: gatekeeper training provided to over 9000 construction workers in Queensland
- New Zealand
  - Gatekeeper training, community engagement
- Ontario Trillium Health Centre
  - A multi-pronged initiative that used committees, research and evaluation, engagement with front line staff, patients and families to develop *standards and policies for practice*

Enhancing and facilitating help seeking

- Scotland – *Breathing Space*
- Australia – *Men's Shed*
- Alberta
  - *Community Helpers* (youth and young adult)
  - *Mental Health Capacity Building Projects* (children)
  - *Men at Risk* (males 20+)
  - *Twisted Mister (Some other Solutions)*

Postvention:
The Morning After…

Support to Family

- Family will now become higher risk themselves for suicide, so postvention is prevention
- Often complex feelings of anger, guilt and sometimes relief
- Shame & isolation may be issues
- Physical, emotional, social and spiritual impacts of grief, possibly complicated grief

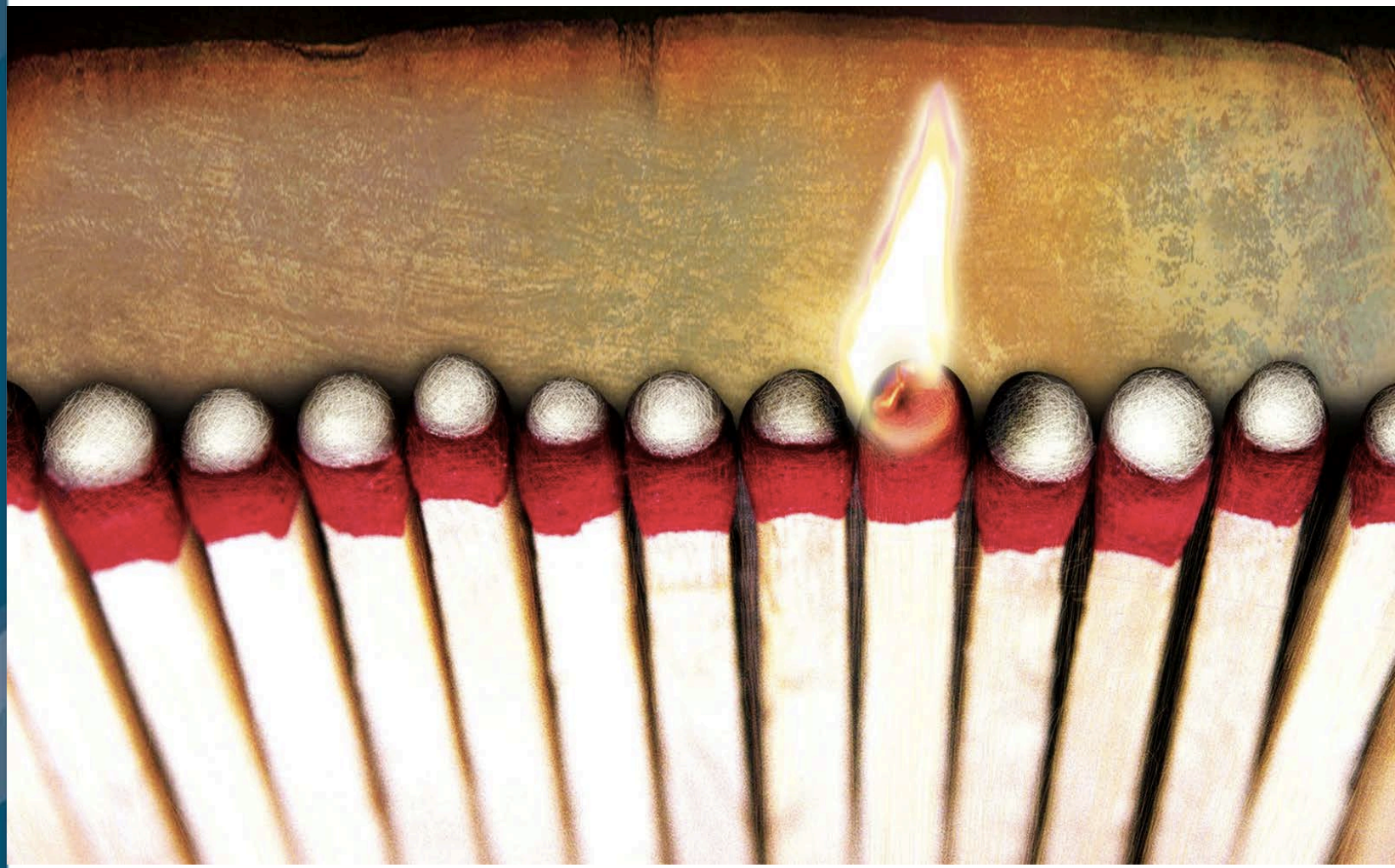
Support to Patients

- Particularly a concern if death occurs while an inpatient or in day treatment
- May be combined with shock, fear for their own safety, guilt, anger, blame and possibly delusional guilt
- Temporarily increase general safety limits
- Review environmental safety
- Request backup as needed
- Consider unit meeting to inform – then support individually

Support to Staff

- Staff often reticent to discuss their own response – include the medical staff
- Need some form of safe discussion / review of case
- Self-recrimination may be followed by anger at patient, family or institution
- Often helpful with inpatient suicide to have outside facilitation
- Contact with family may be difficult but helpful to all involved

Suicide Contagion



Schools and Youth

- See clusters in linked communities – most commonly schools and youth 15 - 19
- Interplay of preexisting risks, social context and trigger
- Increased risk for schoolmates of person who died by suicide
  - especially younger
  - can last 2 years or more
- Risk not confined to ones who knew person

Cluster Response

- There will be some with pre-existing risks and known – close monitoring
- Need general response as well – risk is elevated in general group
- Memorials require careful thought
- Media engagement may be helpful
- Schools with MH programs have more opportunities to work with
- Interventions may be social / sports activities, not just usual MH

Media

- Concerns about coverage of suicide for years
- Kurt Cobain – April 5, 1994
- Robin Williams – August 11, 2015
- Recommend they not focus on method, nor romanticize death
- Link with info re: risk signs and sources of help
- http://suicideprevention.ca/news-resources/media-guidelines-and-social-marketing/

Community Resources:

- Community development is a key to suicide prevention
- This means not just usual addiction or mental health treatments, but also social, cultural, arts and sports activities help
- Clubs, churches, parents and police have a place
- We tend to think too much about *treatment* – forget that *prevention* is earlier

First Nations:

- Communities have lower rates of suicide with:
  - Controlling and managing self government
  - Land claims
  - Education
  - Local policing
  - Developed and supported cultural activities
- Higher suicide rates with:
  - Poverty
  - Low levels of education
  - High unemployment
  - Poor housing
- Effects of colonialism / intergenerational trauma

As a Professional:

- Assess well
- Treat well
- Connect with the person
- Build Safety Plan
- Recognize that we are one thread in the web of each person's life
  - *An important thread, but only one thread*

As Individuals and Family:

- We talk –
  - Normalize suicidal ideas as part of many people's lives at some point
  - Non-judgmental support
  - Encourage positive / active coping
  - Call for help when we need it

As Community Members:

- We talk to reduce stigma –
  - With individuals
  - With groups
  - With governments
- We respect & value individuals, each with their own view of life
- We encourage the community networks of caring connection
- We become *vectors of infectious hope*

Summary

- *Prevention* of suicide is difficult to measure
- Suicide is complex – no one intervention or program can be shown to prevent suicide
  - Suicide is a multi dimensional issue with many contributing factors
- The gold standard would be an real reduction in suicide and suicidal behaviour

Summary

- Focus areas
  - *communication and coordination*
  - *building capacity*
  - *help seeking* - are interconnected
- Focus on these 3 broad areas to build suicide prevention in Alberta
- The Challenge: no one group owns this...

Summary

- So…

  It Really is **Everybody's Business**

Websites of interest

Twisted Mister Archives a program of Some Other Solutions

http://www.someothersolutions.ca/index.php?option=com_content&task=view&id=21&Itemid=36

Suicide Prevention Resource Centre – Grande Prairie

Information on Men at Risk and Men's Support Groups

- http://www.sp-rc.ca/msg.html

Headspace – Australia

http://headspace.org.au

More websites

http://www.theshedonline.org.au/

Beyond Blue - Australia
http://www.beyondblue.org.au/

Breathing Space - Scotland
http://www.breathingspacescotland.co.uk/

Questions?

Call to Action - 2005

- Eight Goals:
  - 1. Secure targeted & sustainable funding
  - 2. Enhance mental health and well-being among Albertans
  - 3. Improve intervention and treatment for those at risk
  - 4. Improve intervention and support for those affected by suicide

A Call to Action

- 5. Increase efforts to reduce access to lethal means
- 6. Increase research activities in Alberta on suicide, suicidal behaviour, and suicide prevention
- 7. Improve suicide and suicidal behaviour-related surveillance systems in Alberta
- 8. Increase evaluation and continuous quality improvement for suicide prevention programs in AB

Call to Action: Target groups

- Targeted groups:
  - Aboriginal Peoples
  - Suicide Survivors
  - Those diagnosed with Mental Illness
  - Middle-Aged Males
  - Previous Attempters
  - School-aged Teens and Young Adults

Funding from Strategy:

- Community Helpers Program
- AYCES – Aboriginal Youth and Communities Empowerment Strategy
- Means Restriction – bogged down...
  - Funding passed on to Child & Youth Depression Treatment Pathway