EDMONTON SUICIDE PREVENTION STRATEGY

2016 – 2021

Edmonton Suicide Prevention Advisory Committee

Table of Contents

Foreword

Suicide is the leading cause of death by injury in the City of Edmonton and area. Twice as many deaths result from suicide versus vehicular accidents. Those who die by suicide have engaged in an ultimate expression of pain, hopelessness and despair, and their families, friends and communities are left devastated by loss, bewilderment and guilt.

Suicides are preventable. Although each story is unique, it is possible to piece together the commonalities which provide a better understanding of why suicide occurs and what needs to be done. In recognition of this, the Edmonton Suicide Prevention Advisory Committee came together in January 2015 to explore how to prevent suicide in the city.

As part of City Council's Urban Isolation/Mental Health Initiative, diverse stakeholders were invited to consider the prevalence of suicide, to examine the causes and to develop recommendations that would ultimately reduce suicide in Edmonton.

The development of this strategy has taken place at an opportune moment, where there is a growing recognition across the country that suicide prevention needs to be a priority. Community members, non-profits and different orders of government are coming together to better understand the complexities of suicide and to use this knowledge to further its prevention.

The Edmonton Suicide Prevention Strategy shines a spotlight on suicide in Edmonton and recognizes that while access to treatment within the health system is essential, a more comprehensive community wide response is also required. Each Edmontonian, every business and every community take part in the collective responsibility to prevent suicide.

The public discussion about suicide has begun and Edmontonians are invited to be part of growing the conversation. It is now time to make suicide prevention a priority and to participate in actions that build resilience and offer supports for the community members who need them.

The Edmonton Suicide Prevention Advisory Committee Leadership Team

Jenny Kain, Director, Community Inclusion and Investment, Citizen Services, City of Edmonton

Mark Snaterse, Executive Director, Addiction and Mental Health, Alberta Health Services Edmonton Zone

Ione Challborn, Executive Director, Canadian Mental Health Association, Edmonton Region

Mickey Wilson, Executive Director, Pride Centre of Edmonton

Acknowledgements

EDMONTON SUICIDE PREVENTION ADVISORY COMMITTEE (ESPAC) MEMBERS

Each committee member brought their expertise to the table, and dedicated hours to listening and learning in a spirit of respectful collaboration in order to develop the strategy. Informed by research and engaged stakeholders, collective decision making drove the contents of the strategy complete with goals, outcomes and recommended actions.

Carol Carifelle–Brzezicki
MANAGER, NORTHERN ALBERTA ABORIGINAL HEALTH PROGRAM, ALBERTA HEALTH

Chelsey Anseeuw
ADVISOR, ADDICTION AND MENTAL HEALTH, ALBERTA HEALTH

David Rust
COORDINATOR COMMUNITY MENTAL HEALTH ACTION PLAN, MENTAL HEALTH CONTINUUM

Diane McNeil
DIRECTOR, PROMOTION, PREVENTION AND COMMUNITY INITIATIVES, PROVINCIAL ADDICTION AND MENTAL HEALTH, ALBERTA HEALTH SERVICES

Georgette Reed
HEALTH AND WELLNESS COORDINATOR, FIRE RESCUE SERVICES

Ione Challborn
EXECUTIVE DIRECTOR, CANADIAN MENTAL HEALTH ASSOCIATION – EDMONTON REGION

Jenny Kain
DIRECTOR, FAMILY AND COMMUNITY SUPPORTS, COMMUNITY INCLUSION AND INVESTMENT, CITIZEN SERVICES, CITY OF EDMONTON

Kesa Shikaze
SENIOR MANAGER, PREVENTION AND EARLY INTERVENTION SUPPORTS BRANCH, HUMAN SERVICES

Lianna Chondo
SOCIAL WORKER, FAMILY AND COMMUNITY SUPPORTS, COMMUNITY INCLUSION AND INVESTMENT, CITIZEN SERVICES, CITY OF EDMONTON

Mark Neufeld
SUPERINTENDENT, CRIMINAL INVESTIGATIONS DIVISION, EDMONTON POLICE SERVICE

Mark Snaterse
EXECUTIVE DIRECTOR, ADDICTION AND MENTAL HEALTH, EDMONTON ZONE, ALBERTA HEALTH SERVICES

Marty Landrie
ACTING EXECUTIVE DIRECTOR, INDIGENOUS HEALTH PROGRAM, ALBERTA HEALTH SERVICES

Mickey Wilson
EXECUTIVE DIRECTOR, PRIDE CENTRE OF EDMONTON

Pam Brown
SAFETY & SECURITY MANAGER, OXFORD PROPERTIES GROUP

Patti Stark
COMMUNITY MOBILIZATION COORDINATOR, INJURY PREVENTION CENTRE, UNIVERSITY OF ALBERTA

Rispah Tremblay
COORDINATOR, EDMONTON MENNONITE CENTRE FOR NEWCOMERS

Shane Darby
MANAGER, EMERGENCY MEDICAL SERVICES, ALBERTA HEALTH SERVICES

Sheena Abar
COORDINATOR, COMMUNITY SOCIAL WORK TEAM, HEALTH AND WELLNESS SERVICES, UNIVERSITY OF ALBERTA

Toni Boyko
MENTAL HEALTH COORDINATOR, FIRE RESCUE SERVICES

Violet Shepard
ABORIGINAL HEALTH COORDINATOR, ALBERTA HEALTH SERVICES

THANKS ALSO TO GUEST SPEAKERS:

- Joanne Graham, Director of Business, Edmonton Police Service
- Michael Sanderson, Surveillance and Assessment Branch, Alberta Health
- Robert Olson, Librarian and Writer for the Centre for Suicide Prevention
- Mitchell Weinberg, Assistant Chief Medical Examiner, Office of the Chief Medical Examiner

A particular word of thanks is owed to the many Edmontonians who took the time to share their experiences with suicide and provide suggestions about what would make a difference. It's not an easy subject to discuss, but the strategy is richer for their courage.

Executive Summary

The Edmonton Suicide Prevention Strategy represents the collaborative effort of the Edmonton Suicide Prevention Advisory Committee (ESPAC). It is a strategy developed with confidence in the community's ability to come together and engage in actions that offer the best support, care and treatment for those at risk of suicide.

Motivation to develop a prevention strategy arises from the finding that suicide is the leading cause of death by injury in Edmonton. The statistics reveal the published suicide rate; however this is likely an underestimate as some suicides are not confirmed as such.

What is known:

- In 2013, there were 165 people who died by suicide and self-inflicted injury in Edmonton and surrounding areas[1] and 117 in Edmonton specifically (1).
- The largest numbers of people dying by suicide are middle aged men (2).
- Mental health issues are present in 90% of suicides (15).
- Communities in Edmonton with higher rates of poverty, alcohol abuse and substance abuse tend to have higher suicide rates (28).

In conveying personal stories of suicide, relevant research and statistics, the Edmonton Suicide Prevention Strategy endeavors to raise awareness of suicide and facilitate a better understanding of what can be done to prevent it.

The strategy was also intended to offer a solid foundation needed to inform an implementation plan. It is anticipated that a multifaceted public health approach would form the foundation of a future implementation plan as it promotes a shared responsibility between service providers and the larger community.

The strategy includes three goals and 14 outcomes that call for greater awareness, improved accessibility to services and a commitment to address the needs of higher risk populations. The strategy also outlines 35 recommended actions intended to enhance the community's ability to offer the protective factors that decrease the risk of suicide.

The Edmonton Suicide Prevention Strategy places an emphasis on awareness, education and training for both healthcare professionals and the community at large. Programs, services and treatment for those contemplating suicide can then be provided according to best practices, which for many at risk of suicide, involves the inclusion of trauma informed care.

Though recognized as a gap, a coordinated approach to suicide prevention is not yet a reality in Edmonton. The strategy, therefore calls for a level of coordination that fosters greater information sharing, an integration of services and collaboration. A coordinated system of care better ensures that no one falls through the cracks and that opportunities to intervene are maximized. As strategic alignment further enables this co-ordination, the strategy takes into account other suicide prevention activities currently underway in all orders of government.

[1] Alberta Health Services - Edmonton Zone — Edmonton and surrounding municipalities. Population of 1,295,164 in 2014.

Strategy at a Glance

THE STRATEGY

The Edmonton Suicide Prevention Strategy promotes a universally preventative approach that seeks to enhance access to the protective factors that decrease the risk of suicide.

VISION

A suicide free Edmonton.

MISSION

All citizens of the city of Edmonton share a role in educating, increasing hope and promoting healing in order to prevent suicide in the city.

INTENDED AUDIENCE

All Edmontonians should be able to see a role for themselves in this strategy. The responsibility for ending suicide does not lie with one government department or one set of health professionals. Rather, it is a community responsibility.

SCOPE

This is a strategy that serves as a collation of baseline data, experiences and initiatives concerning suicide in Edmonton. It also offers a set of goals, outcomes and recommended actions to move forward with suicide prevention. The strategy is to be broad-based, and while recognizing the importance of tackling the prevalence of suicide among middle aged men, the Edmonton Suicide Prevention Advisory Committee also strongly advocates for action in supporting other high risk populations.

This strategy is to be followed by the development of an implementation plan. The identified outcomes and the recommended actions are intended to serve as the foundation and framework for the implementation process.

GOALS

Guided by its strategic priorities and multifaceted public health approach, the Edmonton Suicide Prevention Advisory Committee has developed three goals that when realized will bring the city of Edmonton one step closer to being suicide free. These three goals promote a multi-level, broad-based community response that aims to build on protective factors that create resilience and decrease the risk factors associated with suicide.

STRATEGY AT A GLANCE

GOAL 1

To provide awareness and education that promotes positive mental health and reduces the stigma of suicide.

OUTCOMES

1. Edmontonians are fully literate in mental health and its connection to suicide.
2. Edmontonians experience reduced isolation through active engagement in community life.
3. Edmonton schools, communities and workplaces promote a safe environment and healthy relationships.
4. Initiatives and policies are driven and measured by data that is shared between relevant stakeholders.

GOAL 2

To ensure the whole continuum of services — prevention, intervention, postvention — is fully accessible.

OUTCOMES

1. Every door into the addiction and mental health system is the right door.
2. Edmontonians involved in the social service and/or health systems are continuously supported by the most appropriate practitioner.
3. Families of Edmontonians who have died by suicide, or who have attempted suicide, receive the help they need.
4. Professionals supporting Edmontonians struggling with suicide and suicidal ideation are equipped to care for each person with empathy and the most effective treatments.
5. An implementation team that champions, stewards and monitors implementation of the strategy.

GOAL 3

To address the needs of higher risk populations.

OUTCOMES

1. Everyone working with higher risk populations is properly trained on suicide awareness and prevention.
2. Everyone involved with higher risk populations understands the connection between suicide and the Social Determinants of Health and can incorporate this understanding into assessment, care and planning.
3. Higher risk Edmontonians are involved as full stakeholders in developing skills to promote resiliency and increase protective factors.
4. Communities of practice share tools and resources.
5. Best practices are developed and promoted through rigorous data collection and outcome measurement.

Recommendations for Implementation

The Edmonton Suicide Prevention Strategy provides a foundation for action. It offers recommendations to create meaningful change in the city of Edmonton. The Edmonton Suicide Prevention Advisory Committee is confident that given the broad-based level of support achieved thus far, that there is the community will to move to action.

The essential next step is the development of a suicide prevention implementation plan that outlines the collaborative and coordinated processes for mobilizing action and funds. While many of the recommendations found in this strategy do not require new funding, others do. It is therefore recommended that one key action of the implementation plan be the creation of a community based implementation team, whose members are empowered to coordinate community partners and recruit champions adept at identifying diverse sources of funding.

DEVELOPMENT AND IMPLEMENTATION OF THE SUICIDE PREVENTION STRATEGY

SPECIFIC OBJECTIVES OF THE IMPLEMENTATION PLAN:

1. Formation of a Community-based Implementation Team composed of partners who represent various orders of government, non-profit organizations, the private sector and those with lived experience.
    a. Team members should include (but are not limited to) those who have expertise in:
        - mental health services delivery;
        - promoting social connections between Edmontonians;
        - addressing the Social Determinants of Health; and
        - providing support and care for diverse needs of Edmontonians identified as being at higher risk of suicide.
2. Development of a Community-based Implementation Team governance structure as outlined in a Terms of Reference. The structure should address mandate, roles and responsibilities and resources.
3. Prioritization of the actions outlined in the Edmonton Suicide Prevention Strategy and identification of the accompanying tasks. Particular focus should be on prioritization of the catalysts for change given the impact they can have.
4. Identification of financial resources needed to successfully carry out the implementation of the Edmonton Suicide Prevention Strategy.
5. Establishment of a timeline that determines the order and anticipated time required to complete the specific tasks.
6. Alignment with the initiatives and related strategic planning currently underway.
7. Determination of processes for public consultation and/or stakeholder consultation.
8. Creation of an evaluation framework for which outcomes and targets can be measured and evaluated.

The Reality: Alex Thomas-Haug

As a child Alex was a fun-loving boy with a wide smile, blue eyes and red hair – and a love of Lego.

He grew into a handsome and popular young man, passionate about snowboarding, and after high school he moved to Banff to dedicate himself to the sport. Alex eventually chose welding as a trade. Welders are known to work long, hard hours, and they can be isolated behind their protective mask. Alex's mom, Lorna, remembers how concerned the family was about him, as he appeared depressed. For young men like Alex, depression often presents with irritability, mood swings and negativity.

When Lorna expressed her worry, Alex always explained it away with a ready excuse: a breakup with a girlfriend or exhaustion from long work hours. When she brought up the possibility of mental illness, bipolar disorder specifically after seeing a brochure in the doctor's office, he just nodded but changed the subject. Like many young adults, perhaps Alex didn't want to think about mental health. Weren't his struggles just part of growing up?

Then in May 2012 Alex disappeared. Alex had arrived at his home late one night, dropped off by a friend at 4 a.m., and had forgotten his keys to the house. He phoned people still at the party, asking them to bring his keys but they didn't. His roommates were worried when he didn't make it home but they thought he may have gone to a friend's place. The next day his employer phoned Lorna to let her know Alex hadn't returned his calls and hadn't shown up for work. Because he was missing, Alex's father Phil and sister Cayley organized a search. Hundreds of friends, neighbours, as well as police officers and search and rescue volunteers set out to find Alex; thousands more spread the word on social media. A few days later, though, Alex was found in the ravine: he had died by suicide at age 24, using a rope from the backyard to hang himself.

Since then, Lorna has pieced together bits of information to find an explanation for why Alex made the decisions that led to his death. She's found out that there is, in fact, a history of bipolar disorder in her family, though no one had told her. She's thought about how impulsive his death was, and researched the relationship between young men and impulsive decisions. She's learnt that Alex was using drugs. Lorna thought too of an acquaintance who had died by suicide, by hanging, six months before Alex. Contagion, she understood, is a reality. And she's thought back to the knee injury that stopped Alex from snowboarding, taking away his strategy to cope.

Fundamentally, Lorna has come to believe that although Alex was much loved by family and friends, he internalized the stigma of poor mental health and self-medicated with drug use.

She has become a vocal advocate for treating drug misuse as a health issue rather than a justice problem, and for promoting education about mental health and suicide prevention in the trades. Lorna knows that Alex wanted life, but the life he couldn't access. She's determined to do what she can to prevent the loss of other lives to suicide.

Introduction

UNDERSTANDING SUICIDE

The Edmonton Suicide Prevention Advisory Committee (ESPAC) has developed a strategy that is grounded in research and in the insights shared during the engagement process.

The reasons behind each death, and behind each attempted suicide, ESPAC learned, are complex but almost invariably lie in poor mental health. People who die by suicide are not choosing to die: they are choosing to end the pain of living. The following findings about who dies by suicide are of particular significance to ESPAC:

- Those who die by suicide are exposed to significant risk factors that may be individual, social or structural in nature.
- People who belong to a high risk population are not at greater risk for suicide because of their identity; rather because certain risk factors tend to be more prevalent among certain populations.
- Communities with higher suicide rates tend to have a higher proportion of people treated for mental illness. While mental health is important, suicide is complex and there are usually multiple factors at play (32).
- Communities with higher suicide rates tend to have a higher proportion of people treated for alcohol and substance abuse (32).
- Communities with higher suicide rates tend to have lower measures of socio-economic status (32). These communities may also be the source of many protective factors, such as social support, as well.

TRAUMA AND SUICIDE

The Edmonton Suicide Prevention Advisory Committee learned of the link between childhood trauma and suicide. Adverse Childhood Experiences (ACEs) include emotional, physical and sexual abuse, household substance abuse, the mental illness of a caregiver, the incarceration of a family member, parental domestic violence and familial separation or divorce. Research has demonstrated that individuals who experience four or more ACEs before the age of 18 years old are four to 12 times more likely to attempt suicide than individuals who experience no ACEs (17).

Trauma that occurs in adulthood is also linked with suicide, most notably when Post Traumatic Stress Disorder (PTSD) exists. Certain elements of PTSD including intrusive memories, anger, impulsivity as well as suppressive coping mechanisms have been identified as particularly predictive of suicide risk (7, 29).

It is in recognition of the link between trauma and suicide, that it is necessary for the strategy to adopt a trauma informed approach. Trauma informed care takes into consideration ACEs and enables practitioners to identify the underlying issues a person at risk of suicide is dealing with. Furthermore, it promotes a manner of working with individuals that is holistic and respectful.

SUICIDE FACT

Adults who are victims of abuse are four times more likely to report self-harm or suicidal thoughts.

Sheldon Kennedy Child Advocacy Centre.

Risk and Protective Factors

Understanding risk and protective factors is an important element of the preventative approach that is at the heart of this strategy. Behind each suicide or attempted suicide is a complex web of factors at play. There is never one, simple explanation.

The Social Determinants of Health and adverse childhood experiences, including trauma, are important risk factors to consider. Risks can be multiple and overlapping, as biological, psychological, social, cultural and environmental factors come together and interact. At the same time, protective factors can mitigate risk and build a person's resilience.

It is important to understand that many risk factors are related to suicidal ideation, or thought, but do not always translate into suicide attempts or deaths. There is a considerable gap in the understanding of the transition between thought and attempt. How factors interact and affect a person vary from individual to individual (33).

People who die by suicide come from all walks of life, but those who are living in poverty, for example, and those who are isolated within their community, face a greater risk of suicide (3). Tackling the broader Social Determinants of Health, therefore, is an important aspect of suicide prevention at both the individual and community levels.

The comprehensive, multilevel approach that ESPAC has adopted aims to boost protective factors, while mitigating risk factors, with a broad range of interventions.

> Suicide is a symptom, what we need is to address the underlying issues.
>
> *– Stakeholder Engagement Participant*

KEY RISK AND PROTECTIVE FACTORS[1]

Risk

- Mental illness
- Addictions
- Social isolation and lack of social support
- Trauma and/or abuse history
- Barriers to accessing care for mental health and addictions
- Major life transitions, changes and losses
- Stigma associated with help-seeking behaviour, mental illness and suicide
- Previous suicide attempts
- Family history of suicide
- Physical illness (especially when causing chronic pain and/or disability)

Protective

- Effective clinical care for mental, physical and substance use disorders
- Positive coping skills
- Social support and cohesiveness
- Healthy relationships
- Comfort with help seeking behaviour
- Reduced stigma related to mental illness and suicide
- Reasons for living and a sense of purpose
- Cultural and religious beliefs that discourage suicide and support self-preservation
- Restricted access to highly lethal means of suicide
- Good health

[1] A more comprehensive set of risk and protective factors can be found in Appendix II.

Higher Risk Populations

An Edmontonian who belongs to a higher risk population is not at greater risk for suicide because of their identity; rather the risk factors outlined above tend to be more prevalent among certain populations.

PEOPLE WITH MENTAL ILLNESS AND/OR ADDICTIONS

Edmontonians who live with a mental illness, poor mental health and/or addiction are at increased risk for suicide. There is an abundance of research that connects mental illness and suicide, with major depression and other mood disorders presenting the most significant risk (5).

People who abuse substances are at greater risk of suicide from the toxic effects of the drugs and/or alcohol, and the mental illness that often accompanies the addiction. Individuals with mental illness are twice as likely to experience addictions and of the various substances, addiction to alcohol is most closely associated with suicide risk (9).

In addition to the physiological effects of substance abuse, the multiple stressors that often accompany addictions can increase the risk of suicide. Social isolation, loss of employment, financial difficulties, physical illness and damaged relationships can result in the individual feeling hopeless and alone, which are risk factors for suicide.

Important to know:

- Over 90% of people who die by suicide have a diagnosable mental illness and/or addictive disorder, and of those, about 60% suffer from depression (3).
- People who are living with a Major Depressive Disorder usually experience the intense emotional pain and sense of hopelessness associated with suicide.
- Stigma and poor mental health literacy still prevent people from seeking the help they need (14).

SUICIDE FACTS

People with a diagnosis of depression are at 25 times greater risk for suicide than the general population.

Only one third of those with depression seek help (12).

MIDDLE AGED MEN

Men are known to die by suicide at a rate that is significantly higher than for women. In fact, three of four deaths by suicide in Alberta are male. One explanation for this disparity is that men at risk of suicide tend not to engage in help seeking behaviours and will often mask their stress or depression (20). They are also known to select more lethal means of suicide. Though no single determinant is known to cause suicide, of particular risk are men who are socially isolated and experience substance abuse.

Important to know:

- Middle aged men are the largest number of those dying by suicide. Men account for over 75% of suicide deaths in Alberta (2).
- The highest risk time for males is between ages 30 and 69 years. Of the males who die by suicide, 68% do so in these years (2).
- Hanging was the leading method of suicide death for males at 40% followed by death by firearms at 23% (2).

Suicide prevention in action

Men at Risk, developed by the Suicide Prevention Resource Centre in Grande Prairie, is specifically designed for men working in the trades, industry and agriculture. It provides a video presentation delivered by a skilled facilitator that discusses how to identify signs of distress or mental illness – and how to respond to people at risk. Through personal stories, men talk about their experiences, how to reduce stigma and promote reaching out for help.

In Edmonton, the Men at Risk program is part of the curriculum for some NAIT trades students. They learn about Alberta's suicide statistics, that men make up the majority of those statistics, that mental health issues are common and how to get help. The program attempts to break through the 'tough guy' culture of the trades.

INDIGENOUS PEOPLE

Rates of suicide for Indigenous people are higher than for the general population in Canada and in Alberta (2) (31). These rates, however, differ significantly across communities for a variety of reasons that reflect the diversity of their political (order of government), social, cultural and economic conditions (31). As is the case with the non-Indigenous population, Indigenous people with robust protective factors are not at higher risk of suicide.

Of the risk factors Indigenous people do experience, many are understood to be the result of the intergenerational trauma inflicted by the residential school experience, racism and of policies arising from colonialism (13).

Important to know:

- Suicide is a leading cause of injury death for Indigenous people in Alberta (2).
- Self-reported, physician-diagnosed mood and/or anxiety disorders, substance abuse and lack of high self-worth were associated with suicidal thoughts for those First Nations, Métis and Inuit adults living off reserve across the country (22).

The increased rates of suicide for Indigenous youth makes it an urgent issue for communities across Canada. The Office of the Child and Youth Advocate in Alberta released a report in 2016 *Toward a Better Tomorrow: Addressing the Challenge of Aboriginal Youth Suicide* that contains 12 recommendations to help prevent Indigenous youth suicide.

The development of community-led solutions that enhance protective factors and that are rooted in Indigenous culture and values are understood to be crucial components of effective suicide prevention strategies for Indigenous people (31).

SUICIDE FACTS

Indigenous youth are five to six times more likely to be affected by suicide than the general population.

Over a third of all deaths among Indigenous youth are attributed to suicide. (25)

LESBIAN, GAY, BISEXUAL, TRANSGENDER, TWO-SPIRIT, QUEER (LGBTTQ) COMMUNITIES

Members of the LGBTTQ communities are two and a half times more likely to have attempted suicide than heterosexual individuals (21). Possible explanations include the stigma and discrimination many experience throughout their lives. Many LGBTTQ individuals also experience trauma from sexual and physical violence, harassment and from being targets of violent hate crimes. Additionally, many in the LGBTTQ communities experience the rejection of loved ones and the often accompanying social isolation, the stress from hiding their sexual orientation and gender identity, or from changing their behaviour in order to feel safe and accepted (2, 24).

Many young people struggle with questions around identity, sexuality and how to find a fit in the world, but it is particularly difficult for LGBTTQ youth. While there has been some progress with Gay Straight Alliances in schools, for example, there is still a long way to go in ensuring that LGBTTQ youth are supported in developing the tools they need to become healthy adults – and in keeping LGBTTQ youth safe.

SUICIDE FACTS

A study of transgender people in Ontario found that:

- 77% had seriously considered suicide
- 45% had attempted suicide (8)

Important to know:

- Lesbian, gay and bisexual youth are at a higher risk of attempting suicide: 33% vs. 7% of heterosexual youth (16).
- One in four LGBTTQ students is physically harassed about their sexual orientation. While suicide is never the result of one cause, bullying can have a long-lasting effect on suicide risk and mental health (16).
- LGBTTQ youth are one and a half to seven times more likely than non-LGBTTQ youth to have reported attempting suicide (12).
- There exists significant limitations in the statistical information about members of the LGBTTQ community who die by suicide. The data provided here is broad because research specific to LGBTTQ community members and suicide is limited. Sexual orientation and gender identity are not usually included in a case of death report. There is an urgent need to remedy that, and to develop baseline data which will ensure that prevention and intervention are focused, intentional and evidence-based.

FIRST RESPONDERS

Witnessing traumatic events is often part of the daily work for first responders, who include paramedics, firefighter and police. The stress that first responders face affects each individual differently, but those who experience Post Traumatic Stress Disorder (PTSD) are believed to be at an elevated risk for suicide. This is of particular concern for paramedics as up to 22% of them will develop PTSD.

A work culture that does not always deal effectively with post-traumatic stress is now slowly changing, but for many first responders it is still difficult to acknowledge that they need help — and to ask for it.

SUICIDE FACTS

In 2015

- **40 first responders**
- **12 military members**

died by suicide in Canada (30)

SURVIVORS OF SUICIDE

Survivors of suicide include family members or friends of someone who has died by suicide (6). Grieving a loved one who has died by suicide can be a traumatic experience made more complex by the confusion, shame and self-blame that often follows. It is believed that when the bereavement is accompanied by social isolation and stigma, that survivors are at increased risk of attempting suicide (26).

Suicide, particularly, among youth is sometimes described as contagious: youth who know someone who has died by suicide are more likely to contemplate suicide themselves. The younger a youth is, the more likely they are to be affected by the suicide death of a peer.

Those who attempt suicide, but do not die are also referred to as survivors. Research indicates that those who have attempted suicide are at a higher risk to try again: once a person has overcome the pain and dread of suicide once, it is easier to contemplate a subsequent attempt (33).

Suicide prevention in action

The Community Helpers Program (CHP) is designed to help youth support their peers — as well as adults who work with youth, such as teachers or coaches.

Training the community's 'natural helpers' makes sense, since most kids and young people are more likely to turn to friends when they're in trouble. It's important that those friends know how to recognize when their friends are struggling and know what to do. The training develops helping skills, supportive listening, mental health awareness, self-care and knowledge about local helping resources. This ensures the 'natural helpers' have the skills and knowledge necessary to support their peers' mental health and well-being.

The Community Helpers Program is being implemented by Alberta Health Services in partnership with 20 communities across the province. In Edmonton, the University of Alberta and Edmonton Public School Board run Community Helpers Programs. Edmonton Public School Board has found the program enormously successful. The Community Helpers Coordinator has more requests for the program than she can handle. Since starting to offer the CHP, the program has grown from being offered in two Edmonton Public schools to eight schools now offering the program to their students.

The Reality: Jane's Story

In the middle of the afternoon, a member of the Pride Centre of Edmonton staff was headed to lunch. As he was leaving he noticed "Jane" sitting on the front step. Turning to say hello, he then saw a pool of blood in front of her.

Asking if she was okay, she told him she had called the police and they pulled up moments later. She had cut her wrists deeply. He got paper towel and tore strips off a new t-shirt to wrap the deep wounds. Emergency Medical Services came and they dressed her wrists, and she left in the ambulance. The police asked a few questions about what had happened, then left.

Jane had been in the day before asking to see a counsellor but the Pride Centre didn't have one in that day as they lack funding for full-time mental health supports. She was connected with another agency for support, but was reluctant to go somewhere else. She trusted the staff at the centre.

Jane clearly wanted to die. She told the Pride Centre staff: "No one accepts me. My Mom won't accept me as a trans woman, and I can't get a job. I will always be alone. I'm tired of being called names. It would be better if I were dead."

After the ambulance left I got a call from the staff person who found Jane asking what he should do now.

I recommended meeting with a counsellor and asked him to write an incident report. What has stuck with him? The sense of helplessness and going out with a bucket of soapy water to wash the blood off sidewalk.

Many times we send people to the hospital by ambulance from the centre. We call the mental health team to support people who are engaging us in other ways. Members of the community alert us about messages they see posted online by people they know and are worried about. We spend hours on the phone, in our offices, on Facebook and text supporting people who experience the rejection of family and friends, can't find employment, experience hate and sexual violence because of their sexual orientation and/or gender identity.

Sometimes, we are able to support or intervene and things stabilize. Sometimes they don't and the loss and sense of failure we feel is profound. Something you never really recover from.

Told by Mickey Wilson, Executive Director of the Pride Centre of Edmonton.

Suicide in Edmonton

Economic and social pressures in the city of Edmonton create a unique environment that can leave some vulnerable to suicidal feelings. The boom and bust economy is stressful to navigate as job security can be temporary. Some who come for short term employment, or who are newcomers, may have difficulty accessing the social and community supports that are protective.

That being said, the suicide rate in Alberta showed a slight but steady decline between 1983 and 2013, the last year for which publicly available data is available. This decrease has been attributed to a decrease in the suicide rate for men. Typically, the suicide rate for men is three and a half times higher than the rate for women, but the difference has been growing slightly smaller. Although there is no conclusive data as to why the decrease, anecdotal evidence points to a combination of two factors: more men are seeking help and the new generation of antidepressant medication is more effective with fewer side effects.

This would seem to corroborate the assumption that if the stigma attached to talking about suicide ends and Edmontonians are aware of how to find the help they need – and that help is easily accessible when they are ready – the numbers of people dying by suicide can be reduced or eliminated.

THE FACTS

- 75% of suicide deaths in 2010 were men. (19)
- The majority were between 30 and 69 years old. (19)
- Women are more likely to attempt suicide than men, though men are more likely to die by suicide. (19)

THE NUMBERS

This is what is known about suicide and attempted suicide in Edmonton using data from 2004 to 2013:

- In 2013, 117 people died by suicide in Edmonton and 165 died by suicide in the Edmonton zone (1).
- Over the ten year period there was a slight decrease in suicide, attempted suicide and self-inflicted injury rates of less than 1% (1).
- On average, 529 people were admitted to hospital each year because of a suicide attempt or a self-inflicted injury (1).
- On average, 1,832 people visited emergency departments every year because of a suicide attempt or a self-inflicted injury (1).

THE FACTS

In 2010, suicide and self-harm cost Albertans

$447 million

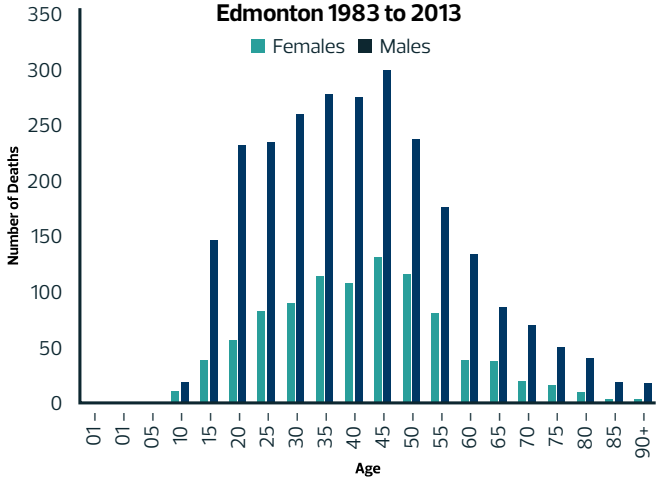
through direct (healthcare) costs and indirect (loss of productivity) costs. (19)

Who dies by suicide

The largest numbers of Edmontonians who die by suicide are middle aged men. Figure 1 shows the spike in the numbers of men in their mid to late 40's who are dying by suicide. It also shows an increase for women in that age range.

The picture changes slightly looking at the numbers as a proportion of the population for each age range. Then a significant proportion of men over the age of 80 are dying by suicide, even though the absolute numbers are fewer.

Figure 1: Numbers of deaths by suicide in Edmonton 1983 to 2013



Where and why people die by suicide

According to the Edmonton Police Service (EPS), most calls about a suicide or an attempted suicide come from the downtown area, just to the north of downtown, up towards the north east and south around the university area.

Indeed, in looking at suicide rates in individual communities across Edmonton, there is a difference — a difference that cannot be explained by random variation or differences in ages alone. (28)

In an epidemiology study when each person that died by suicide (cohort) was matched to ten persons (matches) with the same age, sex and geography to compare health problems, it was discovered that those who had died by suicide were more likely to have mental health and/or addiction issues and depression than other health conditions. (28)

Furthermore, the epidemiology tells us, across Alberta, that a higher proportion of people who died by suicide had Alberta Health Care Insurance Plan (AHCIP) premium subsidies than their matches, which meant that they were more likely to have been living in poverty.

An adversity metric was created that calculated the level of alcohol abuse, substance abuse and socio-economic measures (median income, unemployment, proportion with full AHCIP insurance) for each community examined in Edmonton. Communities with higher suicide rates tend to have a higher adversity metric.

Figure 2: Cormorbidities in Edmonton

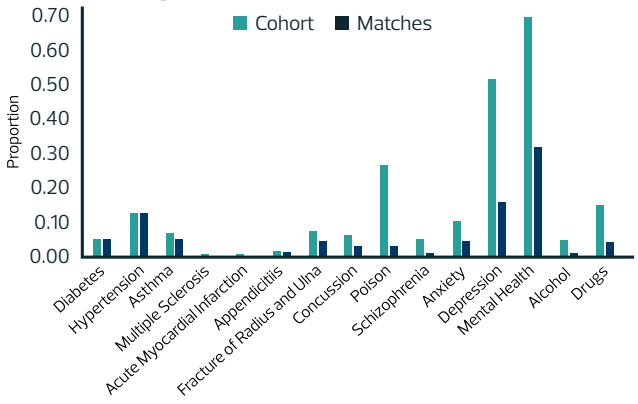
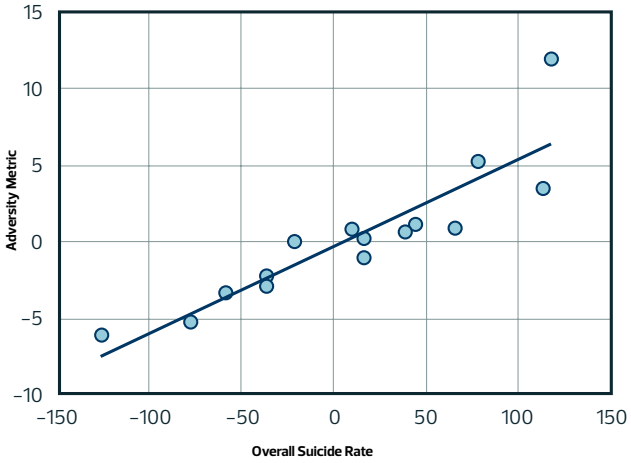


Figure 3: Suicide in Edmonton 2000 to 2012



What it all means

When the adversity metric was plotted against the overall suicide rate, it was discovered that communities with a high suicide rate also have a higher proportion of people treated for mental illness and a higher adversity metric (alcohol abuse, substance abuse and lower socio-economic status). This is further confirmed by the Edmonton Police Service data: the highest concentrations of suicides and suicide attempts occur in areas of the city where there are higher proportions of people with multiple risk factors.

The Social Determinants of Health are therefore integral to suicide prevention.

MEANS RESTRICTION

Suicide prevention strategies often include means restriction, reducing access or availability to the means to self-harm, as a best practice. Design guidelines around viaducts, bridges, train tracks or LRT stations, would be examples of means restrictions.

In Edmonton, safety barriers were installed along the High Level Bridge in 2016 in order to make it more difficult for people to jump off. In other cities, the stainless-steel mesh and high-tension wire barriers had contributed to a drop in suicide rates. The City of Edmonton also installed emergency telephone boxes on either end of the bridge.

However, since the number of men dying by hanging is high, the potential of means restriction strategies to reduce suicide rates is limited. While means restriction is one tool for preventing suicide, it does not tackle the underlying reasons behind each suicide.

CURRENT LIMITATIONS OF DATA

In Edmonton, as in many areas, comprehensive data collection and analysis for suicide does not exist. There are many underlying factors which lead to the depth of pain each person experiences who engages in suicidal behaviour. While experts may have a glimpse of some and can deduce others, they are rarely able to understand all of them.

The investigation processes currently used to determine a cause of death do not collect complete demographic information. It is anticipated that more detailed demographic data collection would better enable the development of effective interventions.

The challenges of knowing what happened immediately preceding some suicides limit the ability of developing interventions that might have been preventative.

There are also challenges associated with classifying the manner of death as some try to make their death not appear suicidal when in fact it is.

The picture the statistics paint is incomplete and there are still many unknowns. Recommended actions in this strategy are intended to resolve the current information limitations as more comprehensive data is needed to address gaps in the knowledge of suicide in Edmonton.

In addition, up until recently, there has been little research on 'what works' in suicide prevention: few empirical studies have tested interventions for their effectiveness (3). More recent public health studies, however, are providing more research that offers promising evidence-based practices (34).

Suicide prevention in action

Men without Hats is a weekly support group for men who are experiencing a variety of life challenges. Men may be reluctant to seek help, and when they do there aren't many supports that are specifically designed to support men through personal challenges. At Men without Hats, they are welcomed by their peers and a City of Edmonton social worker and encouraged to talk openly about the problems they're experiencing. Whether it's challenges in relationships such as dealing with separation or divorce, challenges with parenting, job loss or having to adjust to a new stage in life — the men who attend receive the support they need to make changes in their lives. In the group, men are able to find connections with other men in similar situations which can provide hope and perspective for discovering new directions to move forward.

The Reality: Pam Brown

Pam Brown has seen suicide up close in both her personal and professional life. Not only have eight of her family members or friends died by suicide, but also as Safety and Security Manager at Oxford Properties Group she deals with people wanting to take their own lives regularly at City Centre Mall.

In fact she has dealt with over 20 suicides either directly or indirectly in the workplace. Pam says "Until last year I would offer up a small prayer, do the paperwork and get on with my life. And then I met a sister of one of the young men who had died on our property and he became a 'person' rather than a statistic. I felt her pain and found it very difficult to reconcile it within my own mind."

Pam's response was to bring in training for her frontline staff to look after their own mental health. During the training session, Pam realized how vulnerable she herself was, and broke down as she understood the full implications of her own and her daughter's depression: that she had in fact nearly lost her at the age of 13. Pam connected her daughter Cora with a therapist, little knowing how valuable that move would prove to be. Later that year Pam lost her husband to cancer, and she herself was hospitalized for a major operation.

As Cora worked through this dark time with her therapist, she became afraid for her mom: she began to understand that her mother was depressed and at risk of suicide. Pam herself was beginning to understand more clearly what was going on: "I am a high functioning, depressed individual and am stable as long as my meds work. My depression is not because my life is so horrible; rather it is because my brain chemistry is out of whack." What the world sees is a woman who exudes confidence, humour and compassion. That takes a lot of work for Pam to maintain: "Inner me and outer me do a lot of talking to hold it together, and so far it seems to be working. When I am unstable most people wouldn't notice because my shell is pretty impressive. If I ever do take my life, and I cannot rule the possibility out, people will be saying, 'but she seemed so happy.'"

Her growing awareness of suicide and depression has turned Pam into an advocate — for people who live with suicide every day and for herself, because she knows there are thousands like her who need help.

Stakeholder Engagement Findings

PROCESS

ESPAC members wanted to ensure the strategy is informed by the wisdom of the community. To that end, three separate engagement sessions were held for:

- Groups who are concerned about suicide in their own particular communities
- Community based organizations who have contact with at-risk individuals
- Professionals dealing directly with individuals at specific risk of suicide

Eighty people attended the sessions in total. In addition, one-on-one interviews were conducted with people who have lost a loved one to suicide or who have considered suicide themselves.

WHAT WE HEARD

Participants were in agreement that the protective and risk factors identified by ESPAC are the right ones, according to their experience with suicide. They were also asked to share recommendations for action. The following is a synopsis of key themes that emerged from the conversations:

1. Use of the media and social media to spread public awareness – Participants talked about educating the public on suicide: what the protective and risk factors are; the connection with mental health; the importance of dispelling the stigma with frank, frequent conversation.
2. Educating and training of professionals and gatekeepers – While awareness is important, many participants also talked about training: gatekeepers assisting Edmontonians who might be at risk; health professionals to identify people struggling with mental health and suicide and provide supports empathetically; and then specific suicide prevention training for relevant professionals.
3. Educating children – The advice was to start the conversation early: age appropriate workshops in elementary schools, for example, involving parents would begin a practice of open dialogue.
4. Coordinated service delivery – Coordination between community based service providers and government is essential in order to ensure timely access to supports and navigation through the system.
5. Shift in thinking – The focus needs to shift, participants said, from a focus on 'suicidal behaviours' to the underlying root causes, from a medical response to one that recognizes suicide is a result of trauma, discrimination and pain, and from 'fixing' the individual to empowering community and systemic responses.

A more detailed account of the engagement sessions can be found in the Edmonton Suicide Prevention Strategy Stakeholder Engagement: What We Heard document.

Additional Considerations

The development of the Edmonton Suicide Prevention Strategy has taken into account research, local statistics and stakeholder insights. It is also important to consider the local context. Of particular relevance are the community and government activities for which alignment opportunities exist and the role of the media.

STRATEGIC ALIGNMENT

As of 2016, Canada does not have a national suicide prevention strategy in place. Efforts are underway to address suicide locally and provincially. This strategy recommends continuing alignment with these initiatives as by doing so, there exists the prospect of leveraging opportunities that can achieve greater collective impact.

Alberta Health's – Valuing Mental Health: Report of the Alberta Mental Health Review Committee

The Valuing Mental Health report calls for the transformation of Alberta's addiction and mental health system. On February 22, 2016, the Minister of Health accepted, in principle, the report and its call for transformation, and indicated six priorities for implementation. Ministry staff are currently working on the full response from the Government of Alberta.

One of the priorities was the establishment of an Implementation Team within Alberta Health to lead work with other partners to implement the intent of the report. Establishing the Child, Youth and Families Integration Committee is part of this work.

Alberta Health Services (AHS) Suicide Prevention Action Plan

This action plan will facilitate joint planning, priority-setting and resource advocacy at the AHS Provincial and Zone levels in the development of coordinated suicide prevention resources, programs and services. Examples of some of the key focus areas of the action plan include developing priority initiatives to address gaps, building internal capacity for suicide prevention, monitoring and surveillance and supporting policy development.

Coordinated Mental Health Action Plan for Edmonton and Area

Beginning in 2014, the City of Edmonton, United Way of the Alberta Capital Region and over 30 community and government organizations have collaborated to build a strategy to develop a more seamless and comprehensive community-based mental health system. The intention is to create a strategic plan for multidisciplinary services so they are better able to collaborate, coordinate and communicate effectively. The recommendations made will focus on pragmatic shifts in practice that will result in individuals and families having access to appropriate, timely, positive mental health promotion, prevention, intervention and follow-up services.

The City of Edmonton's Urban Isolation/Mental Health Initiative

This Council initiative recognizes that there is a strong link between social connectedness and well-being. Activities that take place within this initiative are intended to encourage people to feel connected to a supportive community as they will be less likely to experience stress, depression, loneliness and isolation. The work of the Edmonton Suicide Prevention Advisory Committee in developing a suicide prevention strategy takes place within this initiative.

End Poverty Edmonton

Launched in 2015, the End Poverty Edmonton Strategy aims to end poverty in Edmonton in a generation. In identifying access to mental health services as a 'Game Changer,' End Poverty Edmonton recognizes that people with mental illness are at greater risk of living in poverty. However when mental health services are in place, their economic outcomes improve.

To advance the goals of the End Poverty Edmonton Strategy, and to implement the initial priorities for action a five year Road Map was developed. Addressing suicide was identified as Action 26, which seeks to advance partnerships to support and ultimately resource the implementation of the Edmonton Suicide Prevention Strategy within the City of Edmonton's Urban Isolation/Mental Health Initiative.

Government of Canada

The Public Health Agency of Canada (PHAC) is currently developing a federal framework for suicide prevention that will endeavor to better align federal activities. It also seeks to complement work initiated at the provincial and territorial level as well as with Indigenous organizations, non-governmental organizations and the private sector. The three strategic directions are to reduce stigma and raise public awareness, connect Canadians with information and resources and to accelerate the use of research in suicide prevention activities.

Current federal initiatives include support for Mental Health Commission of Canada (MHCC) that works with partners across Canada to facilitate conversations about suicide prevention, including sharing information about best practices. With the support of the federal government, the MHCC also developed the National Standard for Psychological Health and Safety in the Workplace.

Also in conjunction with the MHCC, the Public Health Agency of Canada co-chairs the National Collaborative for Suicide Prevention.

Additional federal activities include the co-development of The National Aboriginal Youth Suicide Prevention Strategy and *Strengthening the Forces*, a health promotion program with the Canadian Armed Forces, which has a module entitled Mental Fitness and Suicide Awareness.

Toward a Better Tomorrow, Addressing the Challenge of Aboriginal Youth Suicide, Office of the Child and Youth Advocate, Alberta

After the Office of the Child and Youth Advocate completed an Investigative Review regarding the suicides of seven Aboriginal youth, it released its report in April of 2016. The report identified the significant risk factors for Aboriginal youth that are associated with their higher rates of suicide. The report outlined three areas that are in need of systemic improvement: pursuing community-led strategies to address Aboriginal youth suicide, addressing Aboriginal youth suicide holistically and building on protective factors. Twelve recommendations were made as means of achieving this necessary improvement.

The University of Alberta's Suicide Prevention Strategy

The University of Alberta is engaged in developing a suicide prevention strategy that seeks to address the particular challenges and opportunities that exist in the student population.

MEDIA REPORTING GUIDELINES

Media has a powerful role in shaping attitudes and influencing policies. How suicide is covered by the media can make a positive difference and so it is important that there be sound media guidelines in place.

In the past, many media outlets have made a decision not to cover suicide, unless there was an overriding public interest in doing so. Media reports, it was thought, have the potential to spread the contagion of suicide among adolescents and young adults in particular. Some media outlets covered high profile suicides in a sensational way that was not constructive for informed debate. With that in mind, the Canadian Association for Suicide Prevention developed guidelines for media reporting on suicide.

AVOID	PRESENT
• Details of the method • The word 'suicide' in the headline • Photo(s) of the deceased • Front page coverage • Sensational language, particularly phraseology such as 'committed suicide' • The idea that suicide is unexplainable: "he had everything going for him" • Romanticized reasons for the suicide	• Alternatives to suicide, such as calling the Distress Line • Resources for those with suicidal ideation • Examples of a positive outcome of a suicidal crisis • Warning signs of suicidal behaviour and what to do

A group of Canadian journalists has also started a website for other journalists which encourages reporting on suicide, with coverage that is factual, complete and does not contribute to stigma. **Mindset–mediaguide.ca**, sponsored by CBC News, the Mental Health Commission of Canada and the Canadian Journalism Forum on Violence and Trauma is a valuable resource that prepares journalists to cover suicide as a public health issue, requiring safe, nuanced and accurate reporting.

The Edmonton Suicide Prevention Strategy 2016–2021

THE STRATEGY

The Edmonton Suicide Prevention Strategy promotes a universally preventative approach that seeks to enhance access to the protective factors that decrease the risk of suicide.

VISION

A suicide free Edmonton.

MISSION

All citizens of the city of Edmonton share a role in educating, increasing hope and promoting healing in order to prevent suicide in the city.

INTENDED AUDIENCE

All Edmontonians should be able to see a role for themselves in this strategy. The responsibility for ending suicide does not lie with one government department or one set of health professionals. Rather, it is a community responsibility.

GOALS

1. To provide awareness and education that promotes positive mental health and reduces the stigma of suicide.
2. To ensure the whole continuum of services — positive mental health promotion, prevention, intervention, postvention — is fully accessible.
3. To address the needs of higher risk populations.

Each goal area contains a number of outcomes and recommended actions.

GUIDING PRINCIPLES

1. A collaborative, coordinated and community-wide approach is essential to the strategy.
2. The strategy is to have strong local relevance, and Edmontonians can be engaged in implementation.
3. The recommended actions should accelerate protective factors, while mitigating risk factors.
4. A shift is necessary from a strictly medical response to a holistic, trauma-informed one.
5. Diversity competency is crucial as diverse Edmontonians are understood in the full context of their environment and culture.
6. Emphasis is placed on evidence informed practices.

CATALYSTS FOR CHANGE

Six priorities were identified as catalysts for change, as they are intended to galvanize the community to move forward in a sustained manner and to have the greatest impact in preventing suicide.

1. The establishment of a community-based implementation team that is properly resourced and whose primary focus includes developing an implementation plan, followed by championing, stewarding and monitoring the plan.

2. The development and implementation of a training program for family physicians and health care professionals, to ensure that they are better able to assess, identify and appropriately respond to patients experiencing suicidal feelings.

3. The development of collaborative and coordinated practices that are instituted as deliberate shifts in practice to achieve truly integrated care.

4. The establishment of discharge and transition planning procedures in the Emergency Room and other mental health service delivery systems to ensure all relevant supports are leveraged for a comprehensive discharge plan. Nobody who has been admitted for a suicide attempt or who is at risk for suicide will be discharged without a plan in place.

5. The commitment to create and build on existing best practices for men and boys that foster the creation of the meaningful social connections that are known to be protective against suicide.

6. The development of procedures that ensure initiatives and policies are driven and measured by data which is up to date and shared between relevant stakeholders[1]. This will require the collection of complete demographic data and information that leads to a better understanding of the circumstances leading to a suicide.

[1] Data collected on Indigenous people should be OCAP (Ownership, Control, Access and Possession) compliant.

SCOPE OF THE EDMONTON SUICIDE PREVENTION STRATEGY

This strategy serves as a collation of baseline data, experiences and initiatives concerning suicide in Edmonton. It also offers a set of goals, outcomes and recommended actions to move forward with suicide prevention. The strategy is to be broad-based, and that while recognizing the importance of tackling the prevalence of suicide among middle aged men, the Edmonton Suicide Prevention Advisory Committee also strongly advocates for action in supporting other high risk populations.

This strategy is to be followed by the development of an implementation plan. The identified outcomes and the recommended actions are to serve as the foundation and framework for the implementation process.

IMPLEMENTATION PLAN

The Edmonton Suicide Prevention Advisory Committee is confident that given the broad-based level of support achieved thus far, there is the community will to move to action. Everyone concerned about suicide wants to make a difference; the strategy provides the framework to coordinate efforts and recommendations to create meaningful change in the city of Edmonton.

The implementation plan that follows this strategy will outline the tasks required to move the strategy towards action.

> Men who are thinking about suicide need compassion and empathy.
>
> *– Stakeholder Engagement Participant*

Goal 1 – To provide awareness and education that promotes positive mental health and reduces the stigma of suicide.

OUTCOME 1

Edmontonians are fully literate in mental health and its connection to suicide.

RECOMMENDED ACTIONS

Promote mental health and educate Edmontonians about mental illness and its connection to suicide, using a variety of population-focused tools including print materials, online resources and program activities.

Ensure audience-specific suicide awareness training is standardized and available for professionals and community members, including children.

Develop a public awareness campaign using both traditional and social media where the goals are to openly discuss suicide, reduce stigma and encourage help-seeking behaviours for people feeling suicidal.

Work with the media to:

- Update guidelines around suicide and respectful terminology to use when discussing at-risk populations.
- Ensure media understand the full context for suicide.
- Develop a media package.

OUTCOME 2

Edmontonians experience reduced isolation through active engagement in community life.

RECOMMENDED ACTIONS

Partner with the Mental Health/Urban Isolation Initiative to foster a community-led campaign that encourages community connections and a feeling of belonging.

Goal 1 – To provide awareness and education that promotes positive mental health and reduces the stigma of suicide.

OUTCOME 3

Edmonton schools, communities and workplaces promote a safe environment and healthy relationships.

RECOMMENDED ACTIONS

Promote the psychological health and safety standards developed by the Mental Health Commission of Canada.

Collaborate with local school boards to support students who wish to create peer-support networks that contribute to a welcoming, caring, respectful and safe learning environment that respects diversity and fosters a sense of belonging.

Work with relevant bodies to ensure supports are available for those who are vulnerable during transition times, such as during job loss, retirement or changes to psychiatric medications.

Ensure that bullying elimination policies and programs are part of the creation of a positive culture in schools, communities and workplaces.

Explore ways of reducing access to means in the physical environment.

OUTCOME 4

Initiatives and policies are driven and measured by data and shared between relevant stakeholders.

RECOMMENDED ACTIONS

Enhance data collection to ensure effective surveillance and monitoring.

Goal 2 – To ensure the whole continuum of services – prevention, intervention, postvention – is fully accessible.

OUTCOME 1

Every door into the addiction and mental health system is the right door.

RECOMMENDED ACTIONS

Incorporate suicide prevention and positive mental health promotion into existing addiction and mental health initiatives.

Train community 'gatekeepers' or pivotal people to be aware of mental illness and suicide.

Utilize technology to assist access to the addiction and mental health system: for example work on the LINKYEG app to expand resources to suicide prevention supports.

OUTCOME 2

Edmontonians involved in the social service and/or health systems are continuously supported by the most appropriate practitioner.

RECOMMENDED ACTIONS

Link the work of this strategy to other work under way on system navigation.

Develop comprehensive referral and bridging protocols that ensure "a warm hand-off," where relationships of support are maintained.

Coordinate discharge and transition planning in the Emergency Room and other mental health service delivery systems to ensure all relevant supports are leveraged for a comprehensive discharge plan. No one who has been admitted for a suicide attempt or who is at risk for suicide should be discharged without a plan in place.

OUTCOME 3

Families of Edmontonians who have died by suicide, or who have attempted suicide, receive the help they need.

RECOMMENDED ACTIONS

Ensure postvention options are available for each family and their community members, including relevant stakeholders and that they are available for as long as needed.

Goal 2 – To ensure the whole continuum of services – prevention, intervention, postvention – is fully accessible.

OUTCOME 4

Professionals supporting Edmontonians struggling with suicide and suicidal ideation are equipped to care for each person with empathy and the most effective treatments.

RECOMMENDED ACTIONS

Ensure that training and system supports are offered to health professionals, in particular family physicians and key health care practitioners, so that they are better able to assess, identify and appropriately respond to patients experiencing suicidal feelings.

Identify opportunities for collaborative training, particularly in the areas of trauma informed practice.

OUTCOME 5

A suicide prevention community-based implementation team champions, stewards and monitors implementation of the strategy.

RECOMMENDED ACTIONS

Provide the community-based implementation team with adequate resources to carry out the implementation plan.

Goal 3 – To address the needs of higher risk populations.

OUTCOME 1

Everyone working with at-risk populations is properly trained on suicide awareness and prevention.

RECOMMENDED ACTIONS

Ensure that organizations who work with those at-risk of suicide have training guidelines in their policies and procedures which involve determining which front-line staff (e.g. social workers, teachers, health professionals) need what level of suicide assessment and prevention training using a consistent, evidence-based program.

Embed the appropriate level of suicide prevention training in various curricula for relevant professionals.

Promote collaborative practice as a deliberate shift in practice so that care becomes truly integrated.

OUTCOME 2

Higher risk Edmontonians are involved as full stakeholders in developing skills to promote resiliency and increase protective factors.

RECOMMENDED ACTIONS

Coordinate with community agencies to promote healthy brain development and positive attachment for at-risk families.

Build on existing best practices for men and boys that foster the creation of the meaningful social connections that are protective against suicide.

Promote help-seeking behaviour, using language that encourages and resonates, and use success stories.

Seek and incorporate meaningful input from members of higher risk groups.

Goal 3 – To address the needs of higher risk populations.

OUTCOME 3

Communities of practice share tools and resources.

RECOMMENDED ACTIONS

Encourage and provide concrete supports for high risk populations to come together in a formal way to create capacity for self-efficacy.

Encourage professionals to create communities of practice in the area of suicide prevention.

Promote long-term mentoring relationships.

OUTCOME 4

Best practices are developed and promoted through rigorous data collection and outcome measurement.

RECOMMENDED ACTIONS

Ensure initiatives and policies are driven by the most current research.

Develop protocols so that data and measurements can be shared between relevant stakeholders.

OUTCOME 5

Everyone involved with higher risk populations understands the connection between suicide and the Social Determinants of Health and can incorporate this understanding into assessment, care and planning.

RECOMMENDED ACTIONS

Include education and training about the Social Determinants of Health and role they play in mental health and in suicide for service providers.

Include the Social Determinants of Health in risk assessments.

Incorporate the Social Determinants of Health in service provision and treatment planning for those at higher risk of suicide.

Moving to Action

The establishment of a community-based implementation team will be essential in moving forward, to act as the champion of suicide prevention in Edmonton. That team will oversee implementation, coordinate community efforts in prevention and promote collaboration.

Monitoring and evaluation will be particularly important. Data collection on deaths by suicide, suicide attempts and the outcomes of prevention initiatives will grow a body of evidence to adapt the strategy and refine practices.

In developing the strategy the conversation about suicide in the city of Edmonton has broadened. The responsibility for action does not just reside with health and social service systems; rather everyone can play a role by spreading awareness of the facts surrounding suicide. In so doing, an educated and compassionate public can be created to ensure those affected by suicide will seek and receive the help they need.

Conclusion

The Edmonton Suicide Prevention Advisory Committee has come together to better understand the occurrence of suicide in Edmonton and to develop prevention strategies. A framework has been provided that contains goals, outcomes and recommendations for action, developed according to the best data available. As a universally preventative approach, the emphasis is on raising awareness and using the whole community to increase the protective factors that play a role in preventing suicide.

The suicide prevention strategy is a beginning: it shines the spotlight on a painful reality in Edmonton. In developing the strategy the committee has created momentum and built expectations. The conversation, although tentative at first, is gathering increasing support as community members look for action.

> It is so important to listen – there is always a story if we take the time to listen.
>
> *– Stakeholder Engagement Participant*

Bibliography

1. Alberta Health, (2013). *Interactive Health Data Application.*
2. Alberta Centre for Injury Control & Research, (2012). Suicide and Attempted Suicide/Self-Inflicted Injuries in Alberta. Alberta Centre for Injury Control & Research.
3. Alberta Health Services, (2014). *Literature Review, Suicide Prevention Strategies.*
4. Alberta Health Services, (2011). *Towards an Understanding of Health Equity: Glossary.*
5. American Association of Suicidology, (2014). *Depression and Suicide Risk.*
6. American Association of Suicidology, (2012). *Survivors of Suicide Loss Fact Sheet.*
7. Amir, M., Kaplan, Z., Efroni, R., & Kotler, M., (1999). Suicide risk and coping styles in posttraumatic stress disorder patients. *Psychotherapy and Psychosomatics*, 68, 76-81.
8. Bauer, G., Boyce, M., Coleman, T., Kaay, M., Scanlon, K., &Travers, R., (2010) Who are trans people in Ontario? *Trans PULSE e-Bulletin.*
9. Beck, A & Steer, R., (1989). Clinical predictors of eventual suicide: a 5- to 10-year prospective study of suicide. *J Affect Disord*, 17(3):203-9.
10. Bombay, A., Matheson, K., & Anisman, H., (2009). Intergenerational Trauma: Convergence of Multiple Processes among First Nations peoples in Canada, *Journal of Aboriginal Health*, 5(3).
11. Canadian Mental Health Association. *Meaning of Mental Health.*
12. Centre for Suicide Prevention, (2012). *Gay and Suicidal: Sexual and Gender Minorities and Suicide.*
13. Chandler, M., & Lalonde, C., (1998). Cultural Continuity as a Hedge against Suicide in Canada's First Nations, *Transcultural Psychiatry* (35) 191-219.
14. Corrigan, P., Druss, B., & Deborah A. Perlick. *The Impact of Mental Illness Stigma on Seeking and Participating in Mental Health Care*, Association for Psychological Science.
15. Edmonton Social Planning Council, (2015), *A Profile of Poverty in Edmonton.*
16. Egale Canada Human Rights Trust.
17. Felittie, V., Anda, r., Nordenberg, D., Williamson, M., Spitz, A., Edwards, V., Koss, M., Marks, M., (1998). Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in adults: The Adverse Childhood Experiences (ACE) Study, *American Journal of Preventative Medicine.*
18. Hamilton Suicide Prevention Strategy. 2010.
19. Injury Prevention Centre, (2015).
20. Johnson, J., Oliffe J., Kelly, M., Galdas, P., & Ogrodniczuk, H. (2011). Men's discourses of help-seeking in the context of depression.

21. King SD. Midlife and older gay men and their use of physical and mental health services: Exploring the effects of health enablers, health need, psychosocial stress and individual health coping. (2010), Ohio State University. Corrigan, P., Druss, B., and Deborah A. Perlick. *The Impact of Mental Illness Stigma on Seeking and Participating in Mental Health Care,* Association for Psychological Science

22. Kumar, Mohan B., (2016). Lifetime suicidal thoughts among First Nations living off reserve, Metis and Inuit aged 26 to 59: *Prevalence and associated characteristics.* Statistics Canada.

23. Mental Health Commission of Canada. (2012). Changing Directions, Changing Lives: the Mental Health Strategy for Canada.

24. Meyer IH. Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. Psychological Bulletin. 2003; 129(5):674–697.

25. Office of the Child and Youth Advocate. (2016). Toward a Better Tomorrow: Addressing the Challenge of Aboriginal Youth Suicide.

26. Pitman, A., Osborn, D. Rantell, K., & King, M., (2016). Bereavement by suicide as a risk factor for suicide attempt: a cross-sectional national UK-wide study of 3432 young bereaved adults, *BMJ Open.*

27. Rosenberg, L., (2011). We must do More. *National Council Magazine.*

28. Sanderson, M. (2016). The Epidemiology of Suicide in Alberta.

29. Sareen, J., Cox, B., Stein, M., Afifi, T., Fleet, C., & Asmundson, G., (2007). Physical and mental comorbidity, disability, and suicidal behavior associated with posttraumatic stress disorder in a large community sample. *Psychosomatic Medicine.* 69, 242–248.

30. The Tema Conter Memorial Trust.

31. Thompson, B., Molina, Y., Viswanath, K., Warnecke, R., & Prelip, M., (2016). Strategies To Empower Communities To Reduce Health Disparities, *Health Affairs*,(35) 1424–1428.

32. Van der Feltz-Conelis, C., Sarchiapone, M., Postuvun, V., Volker, D., Roskar, S., Grum, A., Carli, V., McDaid, D., O'Connor, R., Maxwell, M., Ibelshauser, A., Audenhove, C., Scheerder, G., Sisak, M., Gusmao, R. & Heferl, U., (2011). Best Practice Elements of Multilevel Suicide Prevention Strategies. Hogrefe Publishing, (32).

33. Werk, C.M., Vendenberghe, C., McLean, B., & Hanson, T. (2014). An Overview of Factors Related to Suicide and of Suicide Related Intervention Program in Alberta. *Alberta Centre for Child, Family & Community Research.*

34. World Health Organization. (2010). Towards Evidence-based Suicide Prevention Programmes.

APPENDICES

Appendix I – Glossary of Terms

EDMONTONIANS

Anyone who is in Edmonton, whether or not they permanently reside in the city.

GATEKEEPERS

Individuals trained to identify persons at risk of suicide and refer them to treatment or supportive services.

HIGH RISK POPULATIONS IN EDMONTON

These are groups of people who have higher rates of suicide rates than the general population.

MENTAL HEALTH

A state of well-being where individuals realize their potential, can cope with normal stress of life, work productively and contribute to their community. (23)

MENTAL HEALTH LITERACY

Knowledge and beliefs about mental disorders which aid their recognition, management or prevention.

MENTAL ILLNESS

The full range of patterns of behaviour, thinking or emotions that bring some level of distress, suffering or impairment in areas such as school, work, social and family interactions or the ability to live independently. (23)

MENTAL HEALTH PROMOTION

The focus of health promotion is to strengthen and enhance the capacity for health that already exists; the focus of prevention is to avoid illness, which is seen as a lack of health. (11)

PROTECTIVE FACTORS

Factors that make it less likely a person will develop a disorder; protective factors may encompass biological, psychological or social factors in the individual, family and environment.

RISK FACTORS

Factors that make it more likely a person will develop a disorder; like protective factors, risk factors may encompass biological, psychological or social factors in the individual, family and environment.

SOCIAL DETERMINANTS OF HEALTH

The social conditions and processes that promote and/or undermine the distribution of health outcomes among population groups (4): income, education, employment, early childhood development, food security, housing, social inclusion.

SUICIDE ATTEMPT

A non-fatal, self-directed, potentially injurious behaviour with an intent to die as a result of the behaviour; might not result in injury.

SUICIDE CONTAGION

A phenomenon whereby susceptible individuals are influenced towards suicidal behaviour through knowledge of other people's suicidal acts.

SUICIDAL IDEATION

Thinking about, considering or planning suicide.

SUICIDE PREVENTION

Activities directed toward the reduction of suicidal behaviour. There are four levels:

- **primary prevention** refers to activities that create healthy and supportive environments where risk factors are minimized and protective factors are increased e.g. building youth self-esteem, parenting programs.
- **secondary prevention** refers to activities that prevent the onset of suicidal crises with individuals who are identified as at risk e.g. gatekeeper training.
- **intervention** refers to activities aimed at the immediate management of the suicidal crisis as well as longer term care and treatment of individuals at-risk e.g. crisis lines, individual therapy, protocols for inter-agency collaboration for at risk individuals.
- **postvention** refers to activities that deal with the aftermath of a suicide e.g. interdisciplinary emergency debriefing teams or bereavement support groups (18), and community mobilization for awareness/development of protocols between agencies.

TRAUMA INFORMED CARE

A systematic approach which ensures that all people receive services that are sensitive to the impact of trauma. Services are provided in ways that recognize needs for physical and emotional safety, as well as choice and control in decisions affecting one's treatment. (27)

Appendix II – Risk and Protective Factors

INDIVIDUAL (BIOPSYCHOSOCIAL)	
Risk Factors	**Protective Factors**
• Mental illness • Physical illness (especially when causing chronic pain and/or disability) • Addictions • Previous suicide attempts • Family history of suicide • Admission and discharge from healthcare institutions • Adverse Childhood Experiences (ACEs) • Trauma and/or abuse history • Job loss and unemployment • Major life transitions, changes and losses • Personality and cognitive factors (such as poor problem solving skills, neuroticism, impulsivity and hopelessness) • Homelessness and insecure housing • Conflict with the law • Incarceration and loss of freedom	• Comfort with help seeking behaviour • Positive coping skills • Skills in problem solving and conflict resolution • Reasons for living and a sense of purpose • Good health • Participation in physical activity • Employment (especially full-time) • Cultural connection • Spiritual beliefs

SOCIAL (FAMILIAL, RELATIONAL AND COMMUNAL)	
Risk Factors	**Protective Factors**

• Social isolation and lack of social support
• Unstable or negative family environment
• Violence and abuse in the home
• The loss of a close relative
• Being bullied or harassed
• Local clusters of suicide
	• Family connectedness, cohesion and warmth
	• Healthy relationships
	• Social support and cohesiveness
	• Opportunities for participation in community
	• Access to culturally appropriate spaces and land
	• Cultural and religious beliefs that discourage suicide and support self-preservation
	• Access to mental health treatment by a health professional
	• Knowledgeable helping professionals
	• Support for help seeking behaviours
	• For youth,
	  • Parental connectedness and support (including early attachment with parent(s))
	  • Active parental supervision
	  • Support from non-parent adults
	  • Caring and supportive friends
	  • Healthy peer modeling
	  • A positive school environment that fosters connections, a sense of belonging and engagement and has bullying and anti-harassment policies
	  • A consistent health professional who has a relationship with the youth

STRUCTURAL AND ENVIRONMENTAL	
Risk Factors	**Protective Factors**
• Social and economic disadvantage • Depressed or faltering economy • Oppression and discrimination (based on race, gender and class) • Social exclusion • Social injustice • Community marginalization • Access to lethal means • Exposure to and influence of others who have died by suicide • Stigma associated with help-seeking behaviour, mental illness and suicide • Barriers to accessing care for mental health and addictions	• Social justice • Social capital (networks of social relationships) • Easy and ongoing access to a variety of clinical interventions and support for help-seeking • Effective clinical care for mental, physical and substance use disorders • Restricted access to highly lethal means of suicide • Reduced stigma related to mental illness and suicide

Appendix III – Suicide Prevention Resources in Edmonton

Suicide Prevention Resources in Edmonton

CRISIS

Canadian Mental Health Association – Edmonton Region

- Distress Line

Alberta Health Services – Addiction and Mental Health

- Community Urgent Services and Stabilization Team
- Children's Mental Health Crisis Line

NON-CRISIS

Alberta Health Services

- Community Mental Health Clinic
- Child and Adolescent Mental Health Intake
- Health Link (811)
- University of Alberta Hospital, Psychiatric Treatment Clinic

Boyle McCauley Health Centre

- Counselling

Boyle Street Community Services

- Counselling

CASA Child, Adolescent and Family Mental Health

- Assessment and treatment

City of Edmonton – Individual and Family Wellbeing

- Counselling and support groups

Canadian Mental Health Association – Edmonton Region

- Applied Suicide Intervention Skills Training (ASIST)
- Community Education
- Suicide Awareness for Everyone (safeTALK)
- Mental Health First Aid
- Suicide Grief Support Program
- Wellness Network

Edmonton Mennonite Centre for Newcomers

- Settlement and Support Services – The Centre for Survivors of Torture and Trauma

Family Centre

- Counselling and support groups

Institute for Sexual Minority Studies and Services

- Individual and Family Counselling

Momentum Walk in Counselling

- Counselling and support groups

Pride Centre of Edmonton

- Counselling and support groups

Psychologists Association of Alberta

- Referral

University of Alberta – Faculty of Education

- Clinical Services

For a complete list of Mental Health Resources, call 211

Appendix IV – Development of the Strategy

THE EDMONTON SUICIDE PREVENTION ADVISORY COMMITTEE

During City Council debates in the fall of 2014 concerning barriers on the High Level Bridge as a suicide prevention initiative, it was recognized that coordinated and upstream suicide prevention approaches are needed. A diverse set of stakeholders were invited to form the Edmonton Suicide Prevention Advisory Committee (ESPAC) which consists of representatives of the City of Edmonton, Alberta Health, Alberta Health Services, Alberta Human Services, the University of Alberta, first responders from the Edmonton Police Service and from Emergency Medical Services. Representatives from community agencies and the private sector were also identified as key stakeholders.

The Edmonton Suicide Prevention Advisory Committee has come together to shine a spotlight on suicide in the Edmonton context, recognizing that stigma around suicide must be dispelled. It is time for a public conversation, rooted in a truly collaborative community approach to suicide prevention that recognizes the unique needs of Edmontonians who are most at risk. Most importantly, it is time to take action.

ESPAC MANDATE

Develop a suicide prevention strategy for Edmonton that is:

- Integrated with existing preventative efforts
- Coordinated with Alberta Health Services, government and community stakeholders
- Universally applicable while emphasizing the particular needs of higher risk populations
- Rooted in a multifaceted public health approach

INITIAL GUIDING PRINCIPLES

These six principles were informed by the 2014 Alberta Health Services Literature Review of Suicide Prevention Strategies (3). They provided a guide for ESPAC as it developed the strategy:

1. High-level, broad-based support – Support for the strategy from all orders of government, multiple sectors and from the public can help lend validity and credibility to suicide prevention; inspire involvement from a range of sectors and segments of society; generate and sustain the momentum and resources necessary for formulating, implementing and evaluating the strategy; and contribute to the cultural transformation necessary for suicide prevention, such as shifts in core values.

2. Collaboration and coordination – A strategically coordinated, collaborative and cooperative approach can help maximize the effectiveness of suicide prevention measures and help ensure resources are used most effectively and efficiently.

3. Local relevance, engagement and implementation – Building processes into the strategy that will facilitate adaptation, implementation and coordination at the regional or local level can help foster local commitment and endorsement of the strategy. It also ensures suicide prevention activities already underway in the community are recognized, supported and built.

4. Diversity competency – Because there are significant cultural differences in understandings of suicide and approaches to its prevention, broad-based suicide prevention strategies must be designed in such a way that they are acceptable to, relevant and effective for diverse populations.

5. Relevance of the Social Determinants of Health – Social and economic deprivation is associated with higher rates of suicide and suicide attempts. Tackling the broader determinants of health and mental health, including social isolation, employment disruption and poverty, through changes to macro-level social and economic policies is recommended as part of a comprehensive approach to suicide prevention.

6. Emphasis on evidence informed practices – The selection of interventions for suicide prevention should be based on the best available knowledge and evidence. However, it is also widely recognized that evidence for 'what works' in the prevention of suicide is lacking. Few empirical studies have tested interventions for their effectiveness, and this is considered one of the most challenging concerns in suicide prevention.

Notes