A Framework for the Development of a

Suicide Prevention Strategy

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LONDON-MIDDLESEX

Suicide Prevention Council

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OVERVIEW

The purpose of this document is to provide recommendations or strategies aimed at the prevention of suicide in London-Middlesex. Five key recommendations are identified and delineated:

- ☑ Improve intervention and treatment for those at risk of suicide.
- ☑ Improve intervention(s) and support for those affected by suicide (family and friends of someone who has died by suicide).
- ☑ Increase efforts to reduce access to lethal means of suicide.
- ☑ Increase research activities.
- ☑ Improve coordination of educational and suicide prevention activities.

Special population groups considered at higher risk for suicide in London-Middlesex are also discussed.

BACKGROUND

Canada has a wealth of experience, knowledge and expertise to approach suicide as a public health issue and as a preventable problem. Realistic opportunities exist for saving many lives.

The Canadian Association for Suicide Prevention (CASP) has developed a National Strategy for Suicide Prevention that has become a catalyst for action in nearly every province and territory across Canada. It has become a model for provincial and community suicide prevention strategies.

Communities across Ontario are being asked to provide input into a provincial strategy. Local Suicide Prevention Councils have been tasked with identifying gaps and issues as they relate to suicide intervention, prevention, and awareness in their own communities. The intent is to inform and support the development of a provincial strategy.

In April of 2010, the London-Middlesex Suicide Prevention Council hosted a community consultation for this purpose.

Meeting were 56 participants representing 30 different services in the sectors of mental health, addictions, education, justice, elder care, violence against women, community development, community support and treatment, hospital, faith communities, academic, public health, business, and families (suicide survivors).

The group discussions and information sharing of that day formulated the basis for this document. Special appreciation is extended to the participants (see Appendix 1). Building on that work, the London-Middlesex Suicide Prevention

Council gathered additional data and input into the development of this document.

Local Coordinating Efforts of the London-Middlesex Suicide Prevention Council

Locally, the London-Middlesex Suicide Prevention Council has operated since 1990. The Council aims to reduce suicide and suicidal behaviour, and its impact on individuals, families, and communities by:

- Providing public awareness, community education, and advocacy in regards to suicide risk and prevention.
- Providing opportunities for skill development that address suicide awareness, intervention, support, and treatment.
- Supporting the appropriate allocation of resources to support a full range of consumer-centered services to individuals and families.
- Addressing stigma and discrimination experienced by individuals who have attempted suicide or the family members of those who have died by suicide.
- Promoting and supporting collaboration among service providers.

SUICIDE IN LONDON-MIDDLESEX

Locally, statistics of deaths by suicide are kept both by the Coroner's Office as well as by the London Police Services. For purposes of this report, the London Police Services provided statistical data for the City of London for 2000-2010 (current to Sept. 2010). The Coroner's Office provided statistical data for 2006 and 2007 for both the City of London and Middlesex County.

The statistics for police and the Coroner's Office often do not match due to defined geographical boundary differences or to recording anomalies. The actual numbers, however, generally do not tell the story, but rather the discernable trends and comparisons with provincial and national statistics.

Deaths by Suicide in the City of London

For the period 2000 to 2010 statistics recorded by the London Police show:

- There has been an average of 34 deaths by suicide in the last 10+ years; ranging from 26 to 47 deaths per year.
- 75% of the deaths by suicide are males; 25% are females.
- The average age for females is 51 years; ages range from 20 to 94.
- The average age for males is 44 years; ages range from 15 to 85.

The following tables and graphs provide an overview of recorded deaths by suicide broken down by gender and age for the City of London and Middlesex County.

Table 1: Deaths by Suicide by Gender
in the City of London 2000-2010
(Provided by the Police Services, City of London)

	YEAR										
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010 to date
Male	20	24	19	32	31	24	29	22	32	25	25
Female	6	10	11	6	16	8	11	11	5	5	9
Total	**26**	**34**	**30**	**38**	**47**	**32**	**40**	**33**	**37**	**30**	**34**

Figure 1: Deaths by Suicide Broken by Age and Gender
in the City of London, 2000-2010
(Provided by the Police Services, City of London)

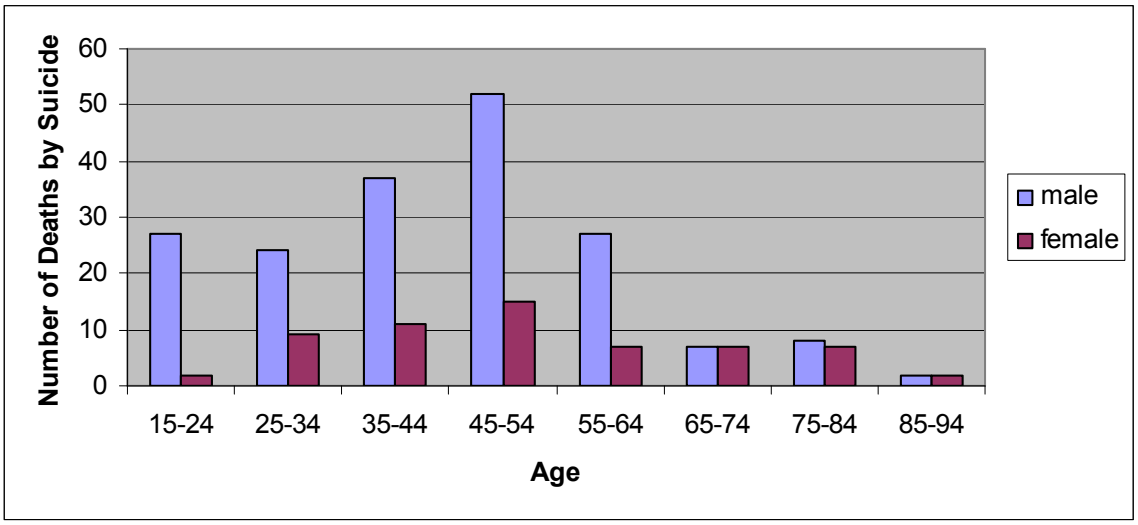
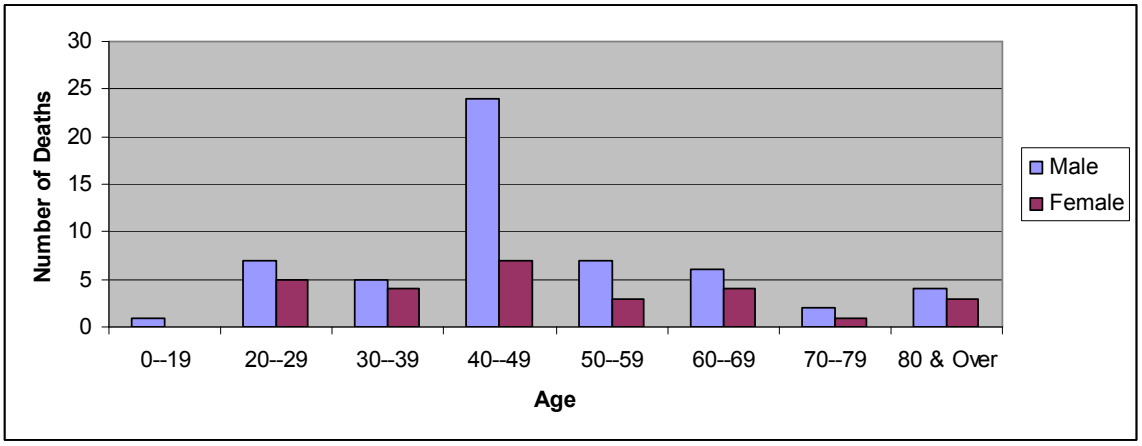


Table 2: Deaths by Suicide for 2006 and 2007 by Gender in the City of London
(Provided by the Office of the Chief Coroner)

		Year	
		2006	2007
Male		30	26
Female		14	13
Total		**44**	**39**

Figure 2: 2006 and 2007 Age Distribution of Deaths by Suicide for London, Ontario
(Provided by the Office of the Chief Coroner)

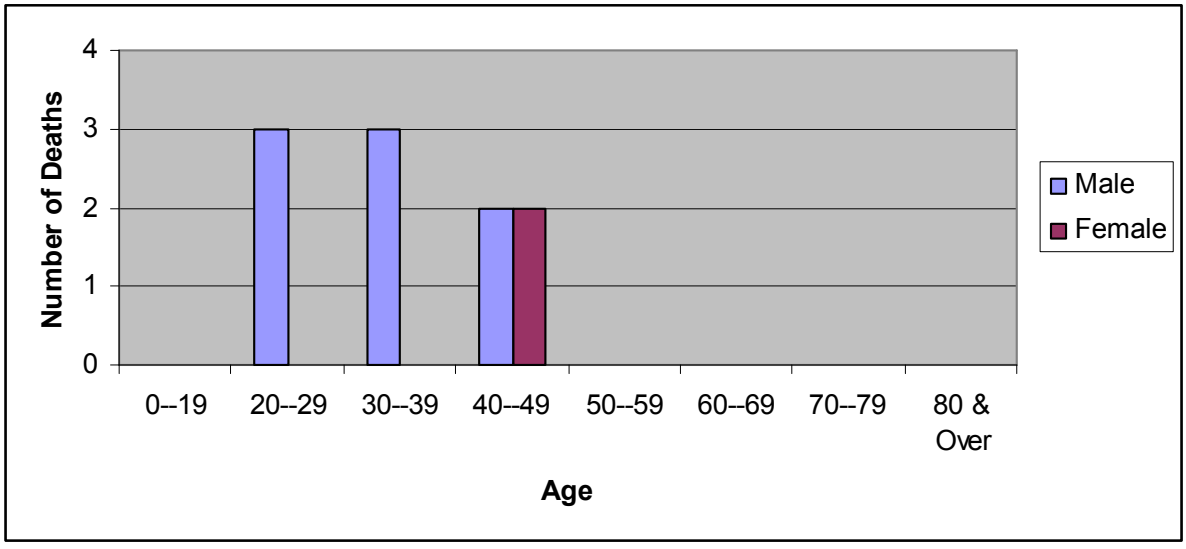


Deaths by Suicide in Middlesex County

Table 3: Deaths by Suicide for 2006 and 2007 by Gender in the Middlesex County
(provided by the Office of the Chief Coroner)

		Year	
		2006	2007
Male		6	2
Female		2	0
Total		**8**	**2**

Figure 3: 2006 and 2007 Age Distribution of Deaths by Suicide for Middlesex County



IDENTIFIED LOCAL PRIORITIES

1. **Improve identification, intervention, and treatment for those at risk of suicide.**

    a) Ensure there are readily accessible follow up, community-base support, and treatment services.
        - Provide follow up care from hospital discharge or emergency visit for those at high risk (example: Follow-up within twenty-four hours of discharge or other transition of care for everyone deemed to be high risk and ensure there is face-to-face contact within a maximum of seven days)
        - Develop individual care plans to specify action to be taken if a person is deemed to be high risk and does not attend follow-up/aftercare or is unable to follow the care plan as originally designed
        - Ensure availability of community supports that have no/limited waitlists
        - Ensure access to community supports is coordinated following inpatient and/or emergency care
        - Provide services to meet the particular needs of youth, seniors, aboriginals, and rural populations
        - Provide linkages to primary care

    b) Coordinated and ongoing suicide intervention and awareness training for first-responders (i.e., police, nurses, doctors).

    c) Improved urgent care and emergency responses.
        - Improve care in emergency departments for those in crisis
        - Enhance urgent geriatric services
        - Improve accessibility to crisis lines (minimize busy lines)

2. **Improve intervention(s) and support for those affected by suicide (family and friends of someone who has died by suicide).**

    a) Improve awareness of where to get help and support.
        - Ensure first responders have information that they can give families in regards to available resources, services
        - Develop guidelines and information packages for funeral directors, churches, schools, healthcare settings and other community resources to improve services, education and support to those bereaved by suicide

    b) Increase availability of support services.

    c) Consider family need for information/support when loved one is accessing crisis/treatment services.
        - Develop guidelines and protocols to actively seek out and respectfully utilize collaborative input from families and friends

- Review and reform mental health care legislation to facilitate appropriate involvement of caring family and community members in aftercare

3. Increase efforts to reduce access to lethal means of suicide.

a) Shut down internet sites that promote suicide (i.e., “how to” sites).

b) Establish treatment policies/procedures that restrict access to potentially lethal mixtures/amounts of drugs for those at risk of suicide.

4. Increase research activities.

a) Develop a provincial research strategy that focuses on improving our understanding of suicidal behaviour, suicide intervention and prevention strategies, and supports for people affected by suicide.
   - Ensure there are communication linkages to local research and organizations working in suicide prevention

5. Improve coordination of educational and suicide prevention activities.

a) Enhance awareness, knowledge of existing resources/services.
   - Information distributed broadly to libraries, doctor’s office, agencies, etc.

b) Ensure there is a broad, coordinated suicide intervention and awareness training that includes:
   - Media awareness strategy for general public
   - Targeted sector specific training (medical, first responders, teachers/guidance counsellors, front line staff in agencies)
   - Workplace training (human resources, unions)
   - Training for parents, caregivers of persons who are considered at risk for suicide
   - Training that is included in the curriculum for professions such as nursing, social work, and medicine

c) Reduce barriers to seeking help by ensuring suicide intervention and awareness education is aimed at decreasing stigma associated with suicide/suicide behaviour.
   - Strategies must be able to reach those most at risk

AT RISK GROUPS

A simple review of local statistics identifies two particular at risk groups for suicide:

Middle Aged Males
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School-Aged Teen Males/Young Adult Males

- Our local statistics mirror National and Provincial statistics that show that males complete suicides 4 times more often that females.

- In terms of age, suicide accounts for 24 percent of all deaths among 15-24 year olds and 16 percent among 16-44 year olds in Canada. Suicide is the second leading cause of death for Canadians between the ages of 10 and 24. Seventy-three percent of hospital admissions for attempted suicide are for people between the ages of 15 and 44. (CMHA, Ontario Division, Fact Sheet)

While our local statistics do not delineate at risk groups other than by age and gender, we do know that the following groups are at risk for suicide based on Provincial and National data. These groups were also identified in our consultation process:

Aboriginal Peoples
- There are five First Nations Communities in Southwestern Ontario; two of which are in Middlesex County (Chippewa's of the Thames and Munsee-Delaware).
- The 2006 Census indicates that there are 6,580 indigenous people living in Middlesex County.
- City of London has the 4th Largest Indigenous Urban Population in Ontario. (London Homeless Coalition, 2007).
- Statistically, indigenous peoples are a young population; birth rates are 2 to 3 times higher than the national average (2001 Census), mortality rates indicate that indigenous people die 10 years younger than national average (2001 Census).
- Aboriginal people suffer from the same mental health problems as the general population. However rates for suicide, substance abuse, depression, and domestic violence are significantly higher.
- The rates for suicide of aboriginals is double than that of the national average. Young males are most at risk.

Gay, Lesbian, bisexual, transgendered, two-spirited, queer individuals (GLBTTQ)
- LGBTTQ community is estimated to be approximately 10% of the general population.
- LGBTTQ youth and youth who are questioning their sexual orientation or gender identify face many social factors that put them at higher risk for suicide.

Families

- Prevention strategies must take into consideration that those who have experienced the suicide of a loved one are at an increased risk of suicide themselves. (Centre for Suicide Prevention, 1999).

Elderly

- Chronic health issues, decreased functioning, social isolation, and depression are four factors that put the elderly at higher risk for suicide.

Diagnosed with a Mental Illness

- "People with mood disorders are at a particularly high risk of suicide. Studies indicate that more than 90 percent of suicide victims have a diagnosable psychiatric illness, and suicide is the most common cause of death for people with schizophrenia. Both major depression and bipolar disorder account for 15 to 25 percent of all deaths by suicide in patients with severe mood disorders." (CMHA, Ontario Division, Fact Sheet)

Previous Suicide Attempters

- One of the best predictors of a future suicide attempt is previous suicidal behaviour. A previous suicide attempt puts an individual at a higher risk for continued suicidal behaviour.

Others:

- Other groups considered to be at risk, but not specifically identified in our consultation process are:
  - homeless,
  - chronically or terminally ill,
  - in custody,
  - substance abuse and problem gambling,
  - victims of family violence

NEXT STEPS

The London Middlesex Suicide Prevention Council intends to use the information in this document to develop an action plan that addresses a number of the key strategic priorities. Our intent is to engage stakeholders that will help to facilitate or move these local priorities forward.

Appendix 1

Community Consultation Participants

Marilyn Beach
Patricia Dennis
Marilyn Evans
Gabriel Klett
Penny Knapp
Melanie (Knapp) McLeod
Garry Ninham
Paula Skikvich
Wendy Sickles, At Lohsa
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Kathleen Pasquini, Catholic Women's League
Mike Anderson, Canadian Auto Workers 520
Kim Bond, Children's Aid Society
Sharon Howard, Dale Brain Injury
Tara McElroy, Dale Brain Injury
Margaret Zaczek, Family Service Thames Valley
Mary Patterson, Lifting the Silence Walk, Committee Member
Elise Barrette, London District Catholic School Board
Volker Hocke, London Health Sciences Centre
April Mullen, London Health Sciences Centre
Ken Boe, London Health Sciences Centre
Cathy-Lee Benbow, London Health Sciences Centre
Shelly Parmley, London Health Sciences Centre
Jared Coyne, London Health Sciences Centre
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Sherry Frizzell, Regional Mental Health Care
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Jacquie Morrissey, Southwest Aboriginal Health Access Centre
Eileen Hagar, Southwest Aboriginal Health Access Centre
Rebecca Clark, St. Leonards
Tracy D'Angelo, St. Leonard's
Ann Finigan, St. Joseph's Health Care
Bill Beggs, Thames Valley District School Board
Catherine Joyes, United Way of London and Middlesex
Gloria Mulcahy, University of Western Ontario
Jane Hartley, Victim Services of Middlesex County
Nici Hamilton, VON
Brian Dyck, West Elgin Community Health Centre