

Request to Speak to a Committee of Council

If your request is for a specific committee meeting, this form must be received by NOON the day before the scheduled committee meeting. Requests for Monday meetings must be received by NOON the Friday before the meeting. Requests for meetings scheduled for the day after a statutory holiday must be received by NOON the last business day before the meeting. For summer meeting requests (July/August), please contact the City Clerk's Office at (905) 546-4408 for further information.

Committee Requested

Kindly indicate which Committee: *

Board of Health

If you selected Advisory/Sub-Committee from the above list, please indicate name of Committee:

Requestor Information

Name of Individual: * Renee Wetselaar / Kerry Cranston

Name of Organization: City of Hamilton LGBTQ Advisory Committee

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Reason(s) for delegation request: * Suicide Prevention Strategy Wish to present at the June 17, 2013 Board of Health meeting

Will you be submitting a formal presentation?*

☒ Yes

☐ No

Overhead projector required for the presentation

☒ Yes

☐ No

Power Point required for the presentation

☒ Yes

☐ No

Are you a lobbyist ?

☐ Yes

☒ No

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If your answer is Yes to the lobbyist question, who are you representing? :

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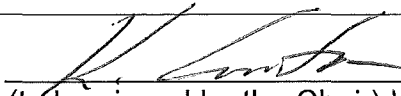
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Hamilton

CITIZEN COMMITTEE REPORT

To:	Chair and Members Board of Health
From:	Marlon Picken LGBTQ Advisory Committee  (to be signed by the Chair) Kerry Cranston Vice-Chair
Date:	June 17, 2013
Re:	Suicide Prevention Strategy (Report LGBTQ 13001)

Recommendation:

- (a) That the Public Health Services Department give consideration to the feedback provided to the Suicide Prevention Council in their work in the mental health and suicide prevention fields;
- (b) That the City of Hamilton LGBTQ Advisory Committee request that public health nurses and public health staff working with community members take positive space training.

Background:

At the March, 2012 meeting of the LGBTQ Advisory Committee, a representative of the City's Public Health Department attended and outlined the role being played by Public Health on the Suicide Prevention Roundtable. Public Health has a collaborative partnership with the Hamilton Suicide Prevention Partnership Council, which allows them to work together on awareness initiatives such as stigma reduction and conduct better outreach. The high number of youth suicide and attempts was noted, as well as the many community partners who are working to address this issue from varying perspectives, including Youthnet and the Health Action Teams in the schools. The Advisory Committee had discussions regarding this topic at subsequent meetings.

Members of the LGBTQ Advisory Committee noted that the many avenues in people's lives that bring them resiliency (family, friends, etc.) are not necessarily safe or available for LGBTQ youth, adults and members of the Trans community. It was acknowledged that the particular concerns and realities of members of the LGBTQ community were not as well addressed in the strategy as they could be. Despite resource availability and services for youth, a large segment of the LGBTQ community remains underserved. These include LGBTQ adults and members of the Trans community, who often feel isolated, excluded, marginalized and face harassment, bullying and discrimination. Protective factors against suicide such as access to housing, healthcare, supports and mental health and substance abuse services are

SUBJECT: Suicide Prevention Strategy (Report LGBTQ 13001) - Page 2 of 3

not always available to members of the LGBTQ community in a positive way. There is difficulty in finding LGBTQ positive counselling; not all schools have positive spaces; there is often difficulty with family relationships or faith communities.

The Suicide Prevention Community Council of Hamilton outlined various risk factors for suicidal behaviour including biopsychosocial, environmental and socio-cultural. Biopsychosocial risk factors include mental disorders, particularly mood disorders, schizophrenia, anxiety disorders, certain personality disorders, alcohol and other substance use disorders¹. Environmental risk factors include loss of place to live, unemployment, social barriers and relational loss². Socio-cultural risk factors include lack of social support, sense of isolation, marginalization and stigma associated with help-seeking behaviour³. Economic factors such as poverty and unemployment are also risk factors for suicidal behaviour⁴. Members of the LGBTQ community face tremendous difficulty accessing services such as LGBTQ positive counseling, which underscores the fact that "over 90% of people who die by suicide have diagnosable mental illness or substance use disorder at the time of death"⁵.

The LGBTQ Advisory Committee discussed a recommendation for Positive Space Training for Public Health staff working in the schools and public health staff in general, as a useful resource to enable staff to be well-informed, and connect better with youth, LGBTQ adults and the Trans community, as connection is a critical protective factor in suicide prevention. Increased awareness could simplify access to timely and socially aware treatment and effective help for suicidal individuals in Hamilton. It could also help eliminate barriers faced by members of the LGBTQ community in accessing services and receiving mental health treatment.

The Advisory Committee believes that it is critical that the Public Health staff that participate in the programs which form part of the community safety net for suicide prevention need to be fully aware of the additional challenges and risks faced by members of the LGBTQ community, particularly youth, as well as the need for consideration of alternate strategies to support community members who do not necessarily have access to safe supports which could provide them with resiliency.

Analysis/Rationale:

Positive space training will be beneficial for Public Health nurses and suicide prevention staff to broaden their understanding of the LGBTQ community, issues impacting individuals within the community, facilitate connection and interaction, which could subsequently assist staff to formulate more comprehensive suicide prevention strategies and initiatives that address the specific challenges and realities in the LGBTQ community. The positive space training would assist staff in being more proactive, aware, respectful, non-judgemental, and prepared to address the specific unique needs of LGBTQ community members without stigma. Subsequently, staff

¹ Hamilton Suicide Prevention Strategy (2010), First Edition, p.4, Retrieved from www.spcch.org

² Hamilton Suicide Prevention Strategy (2010), First Edition, p.5, Retrieved from www.spcch.org

³ Hamilton Suicide Prevention Strategy (2010), First Edition, p.5, Retrieved from www.spcch.org

⁴ Hamilton Suicide Prevention Strategy (2010), First Edition, p.9, Retrieved from www.spcch.org

⁵ Hamilton Suicide Prevention Strategy (2010), First Edition, p.4, Retrieved from www.spcch.org

SUBJECT: Suicide Prevention Strategy (Report LGBTQ 13001) - Page 3 of 3

would be more effective, knowledgeable and informed when serving LGBTQ youth, adults and Trans community.

Canada faces approximately 400 suicide related deaths each year⁶. Ontario loses one person to suicide every 10 hours⁷. Suicide related deaths are on the rise in many cities, especially impacting the LGBTQ community, and Hamilton is no exception⁸. Suicide is a leading cause of death in Hamilton, claiming more lives than motor vehicle collisions and homicide⁹. Hamilton lost 2 youth and 42 adults to suicide in 2011¹⁰. LGBTQ and questioning youth are up to four times more likely to attempt suicide than their heterosexual peers¹¹. LGBTQ and questioning youth from a rejecting family are up to nine times more likely to attempt suicide than their heterosexual peers¹².

Despite the continuing increase in suicide each year, there is no national or provincial strategy for suicide prevention¹³. Hamilton is fortunate that a Suicide Prevention Council and Strategy has been formulated. The LGBTQ Advisory Committee note that the strategy and its implementation needs to go further in recognizing the particular challenges faced by the LGBTQ community in accessing LGBTQ-positive and safe community supports.

Specific feedback provided to the Hamilton Suicide Prevention Council on the Hamilton Suicide Prevention Strategy (provided in advance of the discussion with Public Health staff) is attached for the information of the Board of Health as Appendix A. A copy of the Suicide Prevention Strategy is attached as Appendix B.

⁶ LGBTQ Advisory Committee Meeting Notes, March 15, 2012. Public Health Presentation

⁷ LGBTQ Advisory Committee Meeting Notes, March 15, 2012. Public Health Presentation

⁸ LGBTQ Advisory Committee Meeting Notes, March 15, 2012. Public Health Presentation

⁹ LGBTQ Advisory Committee Meeting Notes, March 15, 2012. Public Health Presentation

¹⁰ LGBTQ Advisory Committee Meeting Notes, March 15, 2012. Public Health Presentation

¹¹ LGBTQ Advisory Committee Meeting Notes, March 15, 2012. Public Health Presentation

¹² LGBTQ Advisory Committee Meeting Notes, March 15, 2012. Public Health Presentation

¹³ LGBTQ Advisory Committee Meeting Notes, March 15, 2012. Public Health Presentation

LGBTQ Comments on Hamilton Suicide Prevention Strategy July, 2011

The LGBTQ Advisory Committee for the City of Hamilton discussed the Hamilton Suicide Prevention Strategy on July, 2011. Kerry Cranston presented the findings of her review to the committee who concurred with the comments and suggestions. The following is a summary prepared to assist in the dialogue with the Suicide Prevention Community Council of Hamilton.

General Comments – there are many positive aspects of the strategy, but the particular risks, challenges and factors faced by the LGBTQ community and corresponding solutions are not reflected throughout the document.

Page i Crisis Numbers – There was nothing specific noted about the supports for the LGBTQ community or youth. The Lesbian, Gay, Bi-sexual and Trans Youth Line was not noted; they serve youth 26 years of age and under in Ontario at (800) 268-9688 from Sunday to Friday 4 p.m. to 9:30 (a.m. or p.m.). Further information can be found at www.youthline.ca

The Kids Help Phone would also be a helpful addition at (800) 668-6868.

Risk Factors for Suicide – p. 4 & 5 – The report notes that “over 90% of people who die by suicide have diagnosable mental illness or substance use disorder at the time of death...” This type of statement may play into the stereotype of LGBTQ members being “sick”, confused” or dependent on drugs.

Environmental risk factors – “Loss of place to live (see homeless youth) should be added to the environmental factors.

Social-cultural factors – “bullying/harassment” should be added

- the bullet point on “Barriers to accessing health care, especially treatment for mental health and substance abuse disorders” – does not address the barriers to health care for trans community – this should be added
- the bullet point on “Exposure to, including through the media, and influence of others who have died by suicide” – does not address the exposure to negative stereotypes in the media

Protective Factors against Suicide – p.5 – it should be noted that some of the protective factors against suicide are not available to LGBTQ community members – i.e. access to housing, not all schools have positive spaces, not all counseling is LGBTQ competent and there is difficulty in finding LGBTQ positive counselling; there is often difficulties with family relationships, being raised in a faith that does not support LGBTQ rights

Diversity Characteristics – p. 8 – the second paragraph notes linguistic, cultural and other barriers – it should specifically include “social” barriers

- the last paragraph notes that LGBTQ youth face many social factors – this should say “social factors and barriers”

The last paragraph notes the risks for LGBTQ youth only. It does not speak at all about the risks for LGBTQ adults. Suicide is also an issue for LGBTQ adults who feel isolated/excluded, face harassment and discrimination. The trans community face frustration at barriers for services and programs.

Suicide Mortality in Ontario and Hamilton – p. 18 – The data on the comparison between deaths by suicide and deaths by transport collisions and deaths by assault would have been more effective in a chart than text. In addition, the percentages are noted but not the #s. The #s would also be instructive.

Need for the Suicide Prevention Strategy for Hamilton – p. 23 – The intent of the strategy is to focus on specific activities – more specific language around activities and the LGBTQ community would be helpful

- For example, the activity noted as “Simplify access to timely and effective help for suicidal individuals in Hamilton” should include “culturally and socially aware treatment” for suicidal individuals
- An additional activity should be added : Eliminate barriers LGBTQ members face in receiving mental health treatment
- Add recognition that friends/loved ones from LGBTQ community are not always available as supports – they may be estranged from family members

Hamilton Suicide Prevention Strategy – Principles – p. 24 – The principles are good; it is noted that they include diversity, being respectful of gender diversity, and sexual orientation

Strategy Objectives and Actions – F. Advocacy p. 28 – the 7th bullet point about “the provision of culturally competent mental health services” should also note “& socially diverse”

Additional note – There is no mention of the LGBTQ Wellness Centre as a support to the LGBTQ community.



**Suicide Prevention
Community Council of Hamilton**

Hamilton Suicide Prevention Strategy



Hamilton Suicide Prevention Strategy

September 10, 2010
First Edition

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The *Hamilton Suicide Prevention Strategy* is available at www.spcch.org.

**IF YOU ARE FEELING HOPELESS, DISTRESSED OR HAVING
THOUGHTS OF SUICIDE, HELP IS AVAILABLE.**

If you are in crisis, call your local crisis or emergency number.

24-hour assistance:

- Emergency 911
- COAST(Crisis Outreach and Support Team) 905-972-8338 www.coasthamilton.ca
- Hospital Emergency Room
- Salvation Army Suicide Crisis Line 905-522-1477
- Telecare Burlington 905-681-1488 www.telecareburlington.com

FORWARD

A community suicide prevention strategy is foremost an expression of our commitment to compassion and to caring. Compassion for those of us who have suffered the profound loss of someone we love. Caring for those of us who experience or live with suicidal thoughts or behaviours.

A strategy confirms our commitment to every member of our community, to every neighbour, to every friend, to every family member, because suicide prevention is everybody's business.

In many ways, the *Hamilton Suicide Prevention Strategy* reflects the fundamental values of ourselves as people – our respect for life, our fear of permanent loss, our strongest resolve to do good and to relieve suffering. And as members of the Hamilton community, we communicate our commitment, our compassion, our caring to each other and to all Canadians through our Strategy by joining together in this work to prevent suicide.

The *Hamilton Suicide Prevention Strategy* responds both to the unique needs and goals of the City of Hamilton, while speaking to the overriding need to unite community organizations, mental health services and resources to prevent death by suicide, and to assist, educate, and to comfort. In doing so, it speaks to all Canadians and to all communities. Through its purpose of guiding the development of an integrated, coordinated, comprehensive suicide prevention strategy, it reflects its aim of preventing deaths and reducing the suffering of suicidal behaviours.

I thank and congratulate Jacqui Candlish and Jenn Brasch, the Core Writers who also served as Co-Chairs of the Strategy Committee, and all members of the Committee. We all benefit enormously from the thousands of hours of volunteer work you have contributed, and from the excellence of the Strategy you have given to Hamilton.

Adrian Hill

Past President,
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Editor – The CASP Blueprint for a
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The *Hamilton Suicide Prevention Strategy* is the product of the collaboration and dedication of many people. The Suicide Prevention Community Council of Hamilton would like to thank the members of the Strategy Committee, their community organizations and the many other contributors for sharing their time, experience and expertise in the development of this important document.

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Message from the Strategy Committee Co-Chairs

Numerous people in Hamilton gave valuable direction to us in the development of the *Hamilton Suicide Prevention Strategy*. We are grateful to everyone who has helped to breathe life into the purpose behind this document by supporting the efforts and work of the Strategy Committee and the Suicide Prevention Community Council of Hamilton. Our vision is that this Strategy will serve as a foundation to foster hope and as a tool to reduce the impact of suicide for all people living in Hamilton. This document is the beginning, and there is much more work ahead.

Jennifer Brasch and Jacqui Candlish

EXECUTIVE SUMMARY

Suicide is a leading cause of death in Hamilton and claims more lives annually than motor vehicle collisions and homicide. Between 2001 and 2005, there were 222 suicide deaths in Hamilton:^{1 2}

- Almost two times as many deaths by suicide as deaths by motor vehicle collision
- Almost six times as many deaths by suicide as deaths by assault

Death by suicide represents only the “tip of the iceberg” of suicide related suffering. For every death there are an estimated twenty suicide attempts³ and many more people who experience thoughts of suicide. Every suicide loss forever changes the lives of those left behind. Although Hamilton has a number of programs and services to prevent suicide, the city needs a coordinated approach to suicide prevention to reduce suffering and increase access to help.

The *Hamilton Suicide Prevention Strategy* was developed using a collaborative approach involving members of the Suicide Prevention Community Council of Hamilton (SPCCH). The SPCCH examined the *Blueprint for a Canadian National Suicide Prevention Strategy* developed by the Canadian Association for Suicide Prevention and determined that Hamilton needed a suicide prevention strategy. In 2007, the Strategy Committee was formed and later expanded to include representatives from hospitals, school boards and several community agencies.

The **purpose** of the *Hamilton Suicide Prevention Strategy* is to guide the development of an integrated, coordinated, comprehensive suicide prevention approach in the Hamilton community. The **aim** of the strategy is to help prevent deaths due to suicide and reduce the suffering related to suicidal ideation, attempts and those bereaved by suicide.

The **intent** of the strategy is to focus on the following activities in Hamilton:

- Improve coordination of mental health services to promote suicide prevention
- Simplify access to timely and effective help for suicidal individuals in Hamilton
- Provide guidance in identifying specific assessments and interventions that may reduce suicide attempts and deaths
- Increase the percentage of Hamiltonians with the knowledge of the warning signs for suicide to promote earlier intervention
- Increase awareness of the need for postvention care
- Reduce stigma about mental illness and suicide
- Advocate for positive changes to modifiable risk factors
- Develop or improve policies and practices for suicide prevention in businesses and organizations
- Advocate for greater supports and follow-up for individuals with mental health problems

The **objectives** of the strategy are:

- A. Commitment:** To increase community commitment to participate in the *Hamilton Suicide Prevention Strategy*
- B. Awareness:** To increase awareness in every part of our community that suicide is a significant health problem and that it is preventable through community action
- C. Stigma and Discrimination:** To reduce stigma and discrimination associated with suicide and suicidal ideation
- D. Prevention:** To increase community capacity to identify and assist people in all aspects of suicide prevention
- E. Training and Education:** To increase the capacity of the community to identify and respond to risk factors for suicide
- F. Advocacy:** To advocate for community change to improve the care of and responsiveness towards persons affected by suicide behaviours and suicide loss

A *Suicide Prevention Roundtable* will be established to implement these objectives and related actions for suicide prevention.

The *Hamilton Suicide Prevention Strategy* provides a framework to enhance existing community capacity in suicide prevention. We hope it will create a community that is more proactive, aware and skilled in prevention, intervention and postvention activities.

TABLE OF CONTENTS

1	INTRODUCTION.....	1
2	BACKGROUND INFORMATION	2
	A Snapshot of Hamilton	2
	Suicide Prevention Community Council of Hamilton.....	2
	Development of the Suicide Prevention Strategy	3
3	RISK AND PROTECTIVE FACTORS	4
	Risk Factors for Suicide.....	4
	Protective Factors against Suicide	5
4	SCOPE OF THE ISSUE.....	6
	A Profile of Select Risk Factors for and Protective Factors against Suicide in Hamilton	6
	Data from Hamilton Community Crisis and Support Services	13
	Suicide Mortality Rates: National, Provincial and Local Perspectives	16
	Suicide Mortality in Canada: the National Perspective	17
	Suicide Mortality in Ontario and Hamilton	18
5	NEED FOR A SUICIDE PREVENTION STRATEGY FOR HAMILTON	23
6	HAMILTON SUICIDE PREVENTION STRATEGY.....	24
	Principles	24
	Purpose	24
	Aim	24
	Strategy Objectives and Actions.....	25
	A. Commitment	25
	B. Awareness	25
	C. Stigma and Discrimination	26
	D. Prevention	26
	E. Training and Education.....	27
	F. Advocacy	28
	Next Steps.....	29
7	APPENDICES	30
	Appendix A: Suicide Prevention and Related Services in Hamilton.....	30
	Appendix B: Suicide Prevention and Related Resources	31
	Appendix C: Glossary	34
	Appendix D: About the Data Sources used in this Report	37
8	ENDNOTES	39

1 INTRODUCTION

Suicide is the triumph of pain, fear and loss over hope. Suicide is most often the result of pain, hopelessness and despair. It is almost always preventable through caring, compassion, commitment and community.⁴

~ Canadian Association for Suicide Prevention

The Suicide Prevention Community Council of Hamilton (SPCCH) developed this strategy to address issues of suicide prevention in our community. For the purpose of this document, suicide prevention encompasses mental health promotion, stigma reduction, early identification, intervention, treatment, and bereavement support. The strategy was developed through a collaborative effort of the members of the SPCCH and a broad spectrum of representatives from social, health, education, and justice agencies in Hamilton along with Hamilton residents who have an interest in the issues of suicide and suicide prevention. The strategy is meant to be a flexible tool that should be reviewed as initiatives are implemented, as objectives are met or as new challenges arise.

The SPCCH considered the unique characteristics of Hamilton and the needs of the residents of Hamilton in identifying the need for a suicide prevention strategy. Hamilton does not have a strategy despite being a centre for mental health care in the region.

The strategy will unite community organizations, mental health services and resources across Hamilton with the SPCCH to work effectively together to prevent death by suicide and to assist, educate and comfort those who have been impacted by suicide-related behaviours.

2 BACKGROUND INFORMATION

A Snapshot of Hamilton

The City of Hamilton ("Hamilton") is located at the west end of Lake Ontario, between Niagara Falls and Toronto. In 2006, Hamilton was the ninth largest city in Canada and the fourth largest city in Ontario, with a population of 504,560 residents.⁵

As one of Ontario's oldest cities, Hamilton has a distinct character and a rich historical heritage. Hamilton's proximity to both natural resources and retail markets, as well as the fact that it is accessible by various modes of transportation, helped make Hamilton a major industrial centre in Canada. The local economy has traditionally been led by steel and heavy manufacturing industries, but within the last decade, there has been a shift towards the service sector and health sciences in particular.⁶

Hamilton is rich in services. It is home to two major hospital systems: Hamilton Health Sciences (HHS); and St. Joseph's Healthcare Hamilton (SJHH). Hamilton Health Sciences is comprised of six unique hospitals and a cancer centre. St. Joseph's Healthcare Hamilton includes the Charlton, West 5th, and King Street campuses. These two hospital systems serve a combined population of about 2.2 million. St. Joseph's Healthcare Hamilton is the lead agency in providing adult psychiatric and addiction services in the city, including inpatient, outpatient and community-based services. The McMaster Children's Hospital, part of HHS, is the lead agency for child and youth mental health care in Hamilton and the surrounding area. Hamilton also has a multitude of community agencies that support or provide services in child, youth and adult mental health. Mohawk College and McMaster University are post-secondary educational institutions that train large numbers of health care professionals in Hamilton and surrounding areas.

Suicide Prevention Community Council of Hamilton

The Suicide Prevention Community Council of Hamilton (SPCCH) is a not-for-profit organization involving professionals and individuals from the community who are interested in suicide prevention and its related issues. The Council was established in 1980 and continues to function through the commitment of volunteers and various agency representatives. The council was recently incorporated and granted charitable status. In 2008, a Board of Directors was established to oversee the Council at large, and guide the working committees (Education & Awareness, Conference, Fundraising and Strategy).

Development of the Suicide Prevention Strategy

The *Hamilton Suicide Prevention Strategy* was developed using a collaborative approach involving members of the SPCCH. The SPCCH examined the *Blueprint for a Canadian National Suicide Prevention Strategy* developed by the Canadian Association for Suicide Prevention and determined that Hamilton needed a suicide prevention strategy. In 2007, the Strategy Committee was formed and later expanded to include representatives from hospitals, school boards and several community agencies.

Steps used to develop the strategy included:

- a review of existing suicide prevention strategies from Canadian, American, and other Common Law countries and communities
- a review of academic literature dealing with suicide and suicide prevention coupled with specific topics of particular relevance to Hamilton's unique socio-demographic, health and well-being profiles (see Scope of the Issue)
- an invitation to community agencies and interested community individuals to join the Strategy Committee to seek input into strategy goals and objectives (April 2008)
- an internet search to identify agencies and organizations in Hamilton that provide suicide-related services
- a survey of the Hamilton service provider community concerning knowledge of existing services, capacity of existing services, and ideal services for a comprehensive suicide prevention strategy

3 RISK AND PROTECTIVE FACTORS

Risk Factors for Suicide

Suicide is a complex problem for which there is no single cause and no single reason. It results from an interaction of biological, genetic, psychological, social, cultural, and environmental factors.⁷ Individuals with suicidal behaviour experience intense emotional pain with feelings of sadness, hopelessness, and helplessness, and the belief that life is unbearable.

Suicide is not an illness or a condition but an intentional action that ends in death. Many people have thoughts about suicide that exist on a continuum from ideas to suicide attempts. Suicidal behaviour is not itself a mental disorder but is highly correlated with mental illness and addiction. Over 90% of people who die by suicide have a diagnosable mental illness or substance use disorder at the time of death⁸, although the disorder may not have been recognized prior to the suicide. Suicide can be a devastating consequence of mental illness.

People who die by suicide come from all social and demographic groups in Canada. There are many risk factors that may lead to or being associated with suicide. People with one or more of these risk factors are at greater potential for suicidal behaviour.⁹ It is important to identify risk factors in order to target prevention programs. Risk factors are not warning signs. See [Appendix B](#) for a link to the warning signs mnemonic *IS PATH WARM*.

The following is a brief overview of risk factors for suicidal behaviour from the World Health Organization and the Suicide Prevention Resource Centre.

Risk Factors for Suicidal Behaviour¹⁰

Biopsychosocial Risk Factors

- Mental disorders, particularly mood disorders, schizophrenia, anxiety disorders and certain personality disorders
- Alcohol, other substance use disorders and gambling
- Comorbidity of alcohol and substance use disorders with mood disorders, personality disorders and other psychiatric disorders
- Hopelessness
- Impulsive and/or aggressive tendencies
- History of trauma or abuse
- Some major physical illnesses (including illnesses causing chronic pain and/or disability)
- Previous suicide attempt
- Family history of suicide

Environmental Risk Factors

- Job or financial loss
- Relational or social loss
- Easy access to lethal means
- Local clusters of suicide that have a contagious influence

Social-Cultural Risk Factors

- Lack of social support, sense of isolation and marginalization
- Stigma associated with help-seeking behavior
- Barriers to accessing health care, especially treatment for mental health and substance use disorders
- Certain cultural and religious beliefs (for instance, the belief that suicide is a noble resolution of a personal dilemma)
- Exposure to, including through the media, and influence of others who have died by suicide

Protective Factors against Suicide

Fatal and non-fatal suicidal behaviours result from interactions between the risk factors and the lack of protective factors across a person's lifespan. Protective factors reduce the likelihood of suicidal behaviour and work to improve an individual's ability to cope with difficult situations.¹¹

Protective factors that enhance resiliency against suicidal behaviour include:

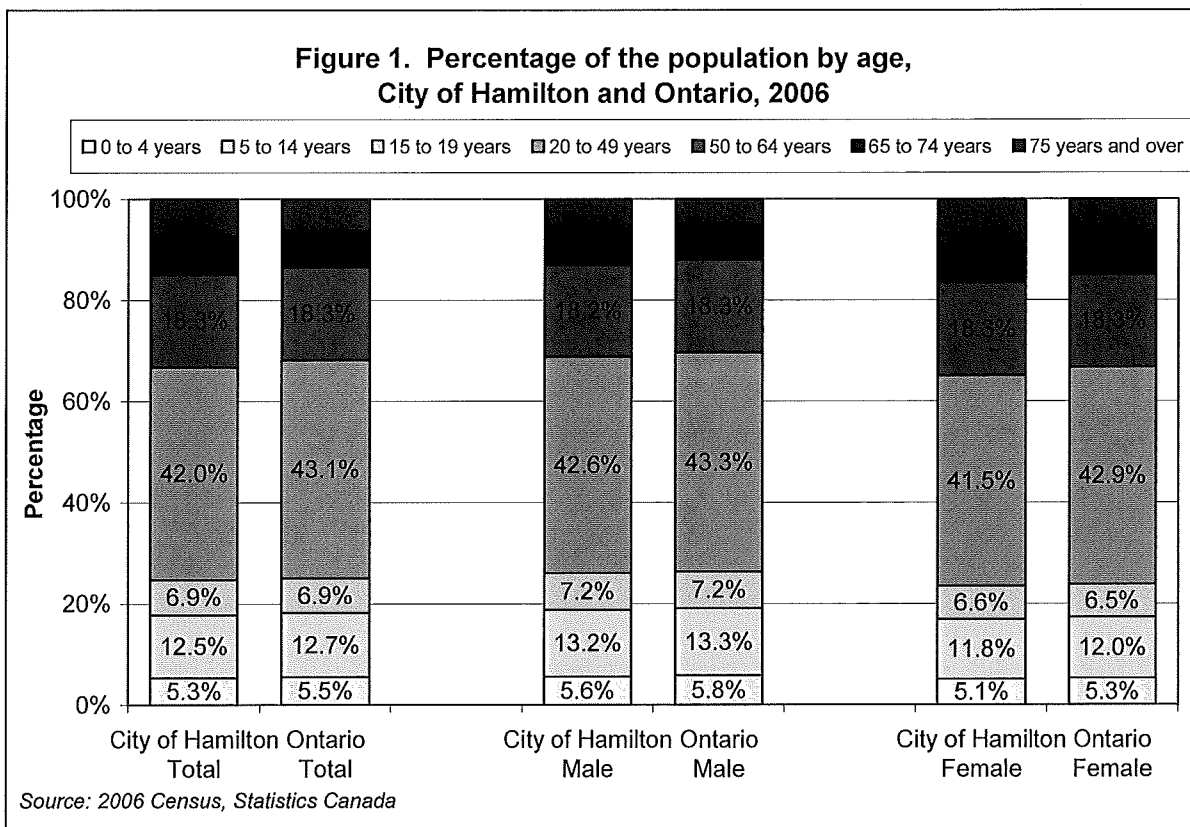
- Access to housing, health care, supports and mental health and substance use services
- Confidence in oneself and one's own situation and achievements
- Family relationships (good relationships with, and support from, family members; early attachment with parent(s))
- Support for "help-seeking" behaviours when difficulties arise, e.g. in school or work
- Hopefulness, reasons for living and optimism
- Marriage and partnership
- Meaningful employment
- Perceptions of positive health
- Skills in problem solving, conflict resolution and nonviolent handling of disputes
- Religious faith and spirituality participation
- Restricted access to highly lethal means of suicide
- Social relationships and social connectedness/integration (positive school experiences; connectedness with peers, staff and other adults; support from relevant people; online support groups; participation in sports, religious associations, clubs and other activities)¹²

4 SCOPE OF THE ISSUE

A Profile of Select Risk Factors for and Protective Factors against Suicide in Hamilton

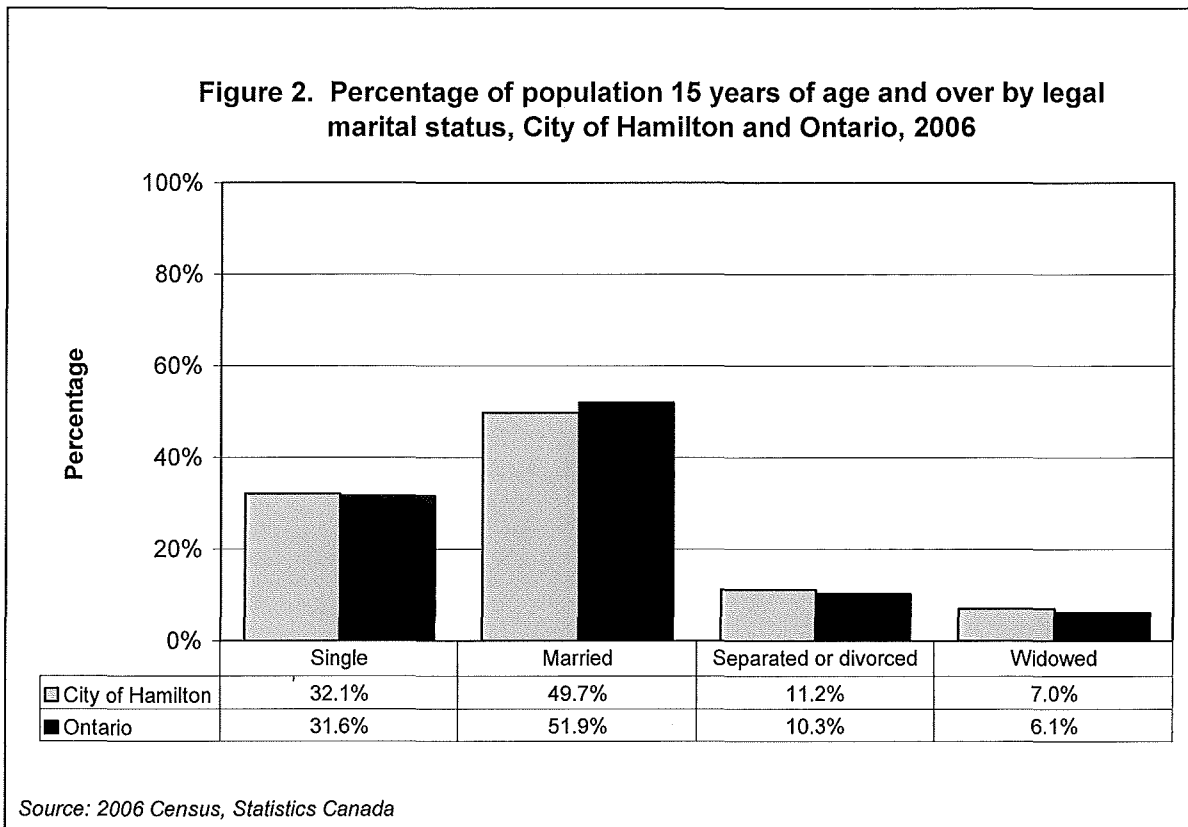
Socio-Demographic Factors

Age and Sex



Suicide is one of the leading causes of death for both male and female adolescents and middle age adults.¹³ In Hamilton, just under 7% (34,895) of the population is between 15-19 years of age, and 42.0% (212,165) of the population is between 20-49 years of age. The age distribution is similar across sexes, except in the 65 years of age and older group, where there are more females than males (Figure 1).

Family Characteristics



Family characteristics, such as living alone or being divorced or widowed, are risk factors for suicidal behaviour.¹⁴ Hamilton has a slightly higher percentage of residents who are single (32.1%), separated or divorced (11.2%) and widowed (7.0%) compared to Ontario overall (Figure 2). Hamilton also has a higher percentage of lone parent families (17.8%) than Ontario overall (15.8%).¹⁵

Diversity Characteristics

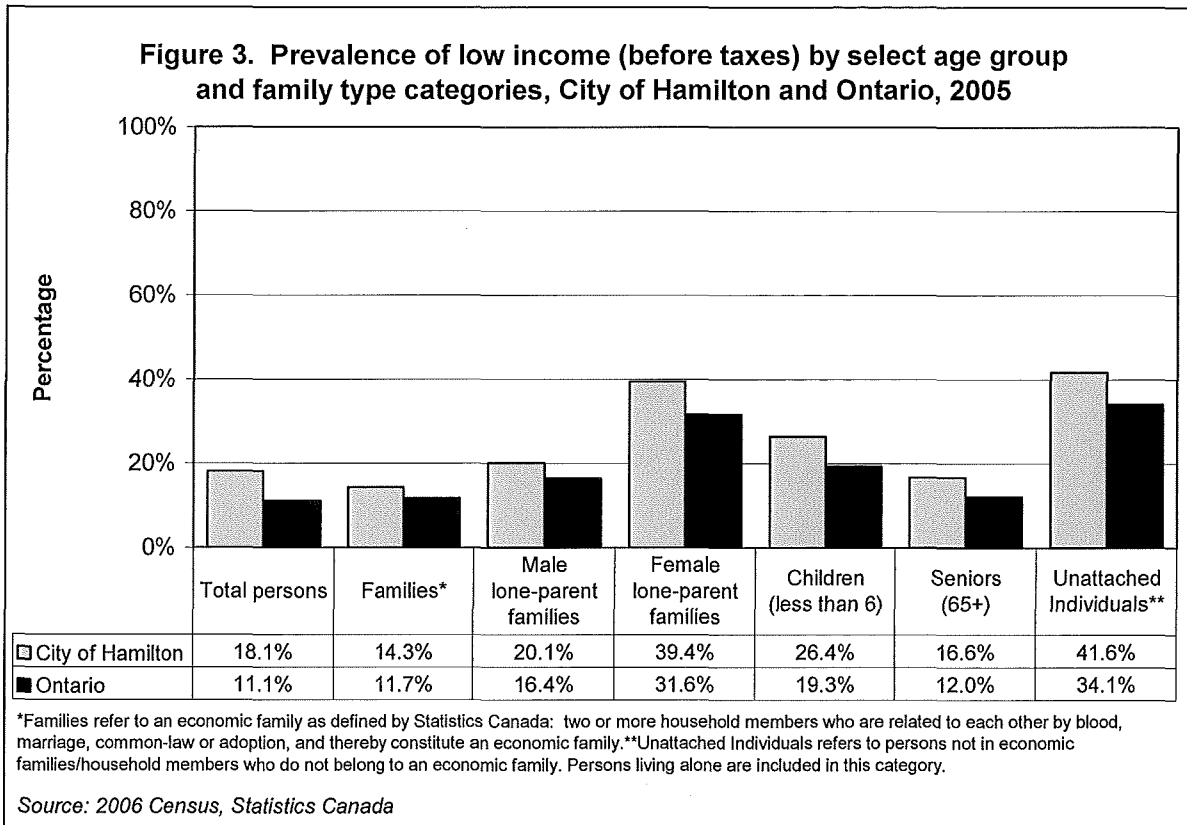
Connectedness, social support and access to health services are protective factors that enhance resiliency against suicidal behaviour.¹⁶ In 2007, 67.1% (± 4.3) of Hamilton residents 12 years of age and older indicated that they felt a very, or somewhat, strong sense of belonging to the community.¹⁷

Hamilton has a diverse population and some residents may face linguistic, cultural or other barriers in accessing the supports that they may need to maintain good health. For example, just under 13% of residents indicated that they spoke a language other than English or French most frequently at home,¹⁸ while most mental health services in the community are offered only in English.

Demonstrating the diversity of the Hamilton community, one quarter (25.4%) of Hamiltonians immigrated to Canada from another country, and just under 17,000 of these residents moved to Canada within the last five years. Another 7,625 Hamiltonians (or 1.5% of the total population) identify with one or more Aboriginal group(s).¹⁹

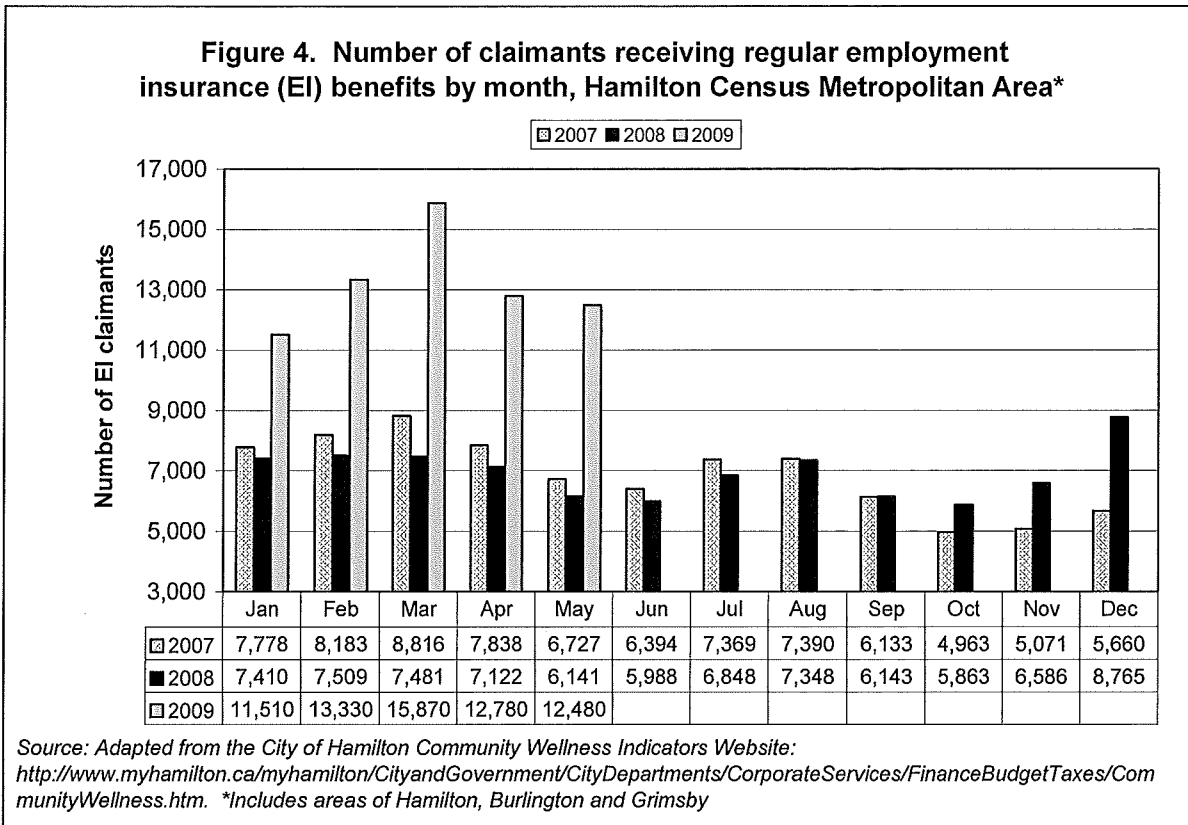
The Lesbian, Gay, Bisexual, Transgender, Queer (LGBTQ) community is estimated to be approximately 10% of the population. That means there are approximately 50,000 people who identify as LGBTQ in Hamilton.²⁰ Sexual orientation and gender identity alone are not risk factors for suicide. However, LGBTQ youth and youth who are questioning their sexual orientation or gender identity face many social factors that put them at higher risk for self-destructive behaviours, including suicide.²¹ LGBTQ and questioning youth are up to four times more likely to attempt suicide than their heterosexual peers.²² LGBTQ and questioning youth who come from a rejecting family are up to nine times more likely to attempt suicide than their heterosexual peers.²³

Income and Employment Characteristics



Economic factors, such as poverty²⁴ and unemployment,²⁵ are risk factors for suicidal behaviour. Nearly 90,000 Hamiltonians (or 18.1% of the total population) lived below the low income cut-off (LICO) in 2005 based on before-tax earnings. Across all age groups and family types, Hamilton has a higher percentage of people living in low income compared to Ontario, overall. Low income is most prevalent in unattached individuals (41.6%) and female-led lone parent families (39.4%) (Figure 3).

Meaningful employment is one protective factor against suicidal behaviour.²⁶ The most recent economic recession has had an impact on residents in the greater Hamilton community. Considerable increases in the number of claimants receiving regular employment insurance (EI) benefits were seen between January-May 2009 compared to the number of claimants in previous years (Figure 4).



Individual Health and Well-Being Factors

General Health and Mental Health Status

Table I. Percentage of population 12 years of age and older reporting good* self-rated health and mental health, City of Hamilton and Ontario, 2007

	City of Hamilton (2007)	Ontario (2007)
Percentage reporting good self-rated health	88.4% (±2.6)	88.3% (±0.7)
Percentage reporting good self-rated mental health	93.9% (±1.7)	92.7% (±0.5)

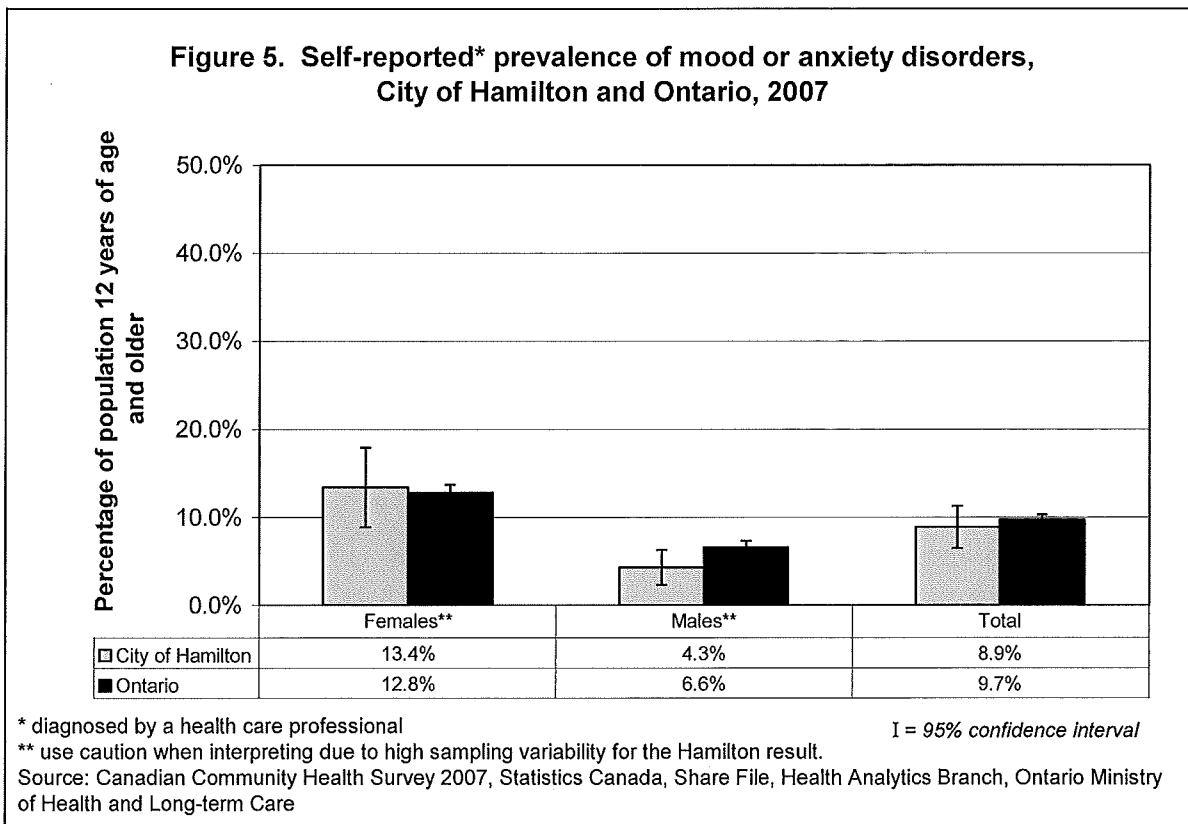
*Defined as excellent, very good and good

Source: Canadian Community Health Survey 2007, Statistics Canada, Share File, Health Analytics Branch, Ontario Ministry of Health and Long-term Care

An individual's perception of positive health is a protective factor against suicidal behaviour.²⁷ In 2007, just over 88.0% of Hamiltonians 12 years of age and over reported that they were in good* health. The vast majority (93.9%) of Hamilton residents 12 years of age and older also rated their mental health as good*. These ratings are similar to ratings of Ontario residents as a whole (Table I).

Perceptions of positive health may be affected by other factors, such as living with a terminal, painful or debilitating illness. When asked about chronic pain, just over 83.0% (± 3.0) of Hamiltonians 12 years of age and over report that they are free from pain or discomfort. But, of those Hamiltonians who experience chronic pain, almost half (48.1% ± 11.8) report that the pain prevents some or most of their activities.²⁸

Prevalence of Mood and Anxiety Disorders



Individuals with pre-existing mental health issues, such as depression or personality disorders, are at greater risk for suicidal behaviour.²⁹ In 2007, 8.9% of Hamilton residents 12 years of age and older reported that they had been diagnosed by a health professional as having a mood or anxiety disorder (mood disorders include depression and bipolar disorder). This is similar to reports of Ontario residents overall (9.7%). In both Hamilton and Ontario overall, females are more likely than males to report having been diagnosed with a mood or anxiety disorder (Figure 5).

Substance Misuse

Substance misuse is a risk factor for suicidal behaviour.³⁰ In 2007, 25.1% (± 4.2) of Hamilton residents 19 years of age and over reported that their alcohol use in the previous week exceeded low risk drinking guidelines (more than 14 drinks/ week for males; more than 9 drinks/ week for females; or more than 2 drinks/ day). Males (34.7% ± 6.6) are more likely than females (16.0% ± 4.6) to report alcohol use in excess of the low risk drinking guidelines.³¹ Information about rates of use of illicit substances is not available for Hamilton, but data from the Local Health Integration Network (LHIN) does not differ from provincial rates.

Suicide Behaviours

A previous suicide attempt puts an individual at a higher risk for continued suicidal behaviour.³² While the number of attempted suicides is known to exceed that of deaths by suicide, it is difficult to determine how many attempts do occur. The World Health Organization estimates that for every suicide death as many as 20 attempts are made.³³ Data from community crisis and support services is one source of information that can provide some insight into the magnitude of the issue in Hamilton.

Data from Hamilton Community Crisis and Support Services

St. Joseph's Healthcare Hamilton

St. Joseph's Healthcare Hamilton (SJHH) is the lead agency in providing mental health care services for adults in Hamilton and the surrounding area. The Mental Health & Addiction Program provides a continuum of services from primary care, through crisis and acute services, to highly specialized tertiary programs. The Psychiatric Emergency Service, located at the Charlton campus, provides emergency psychiatric care to all residents of Hamilton and the surrounding areas. The Psychiatric Emergency Service assesses 250-300 people each month. About 75% of these consultations are requested for assessment of suicide risk.

St. Joseph's Healthcare Hamilton has 95 acute psychiatric inpatient beds which serve the City of Hamilton, Grimsby and the Region of Haldimand. The information in the following table is taken from the Resident Assessment Instrument, a comprehensive assessment tool that is completed on all patients admitted to an acute psychiatric unit within 72 hours of admission.

Table II. Percentage of admissions to acute psychiatric inpatient units related to suicide

	2007	2008
Number of admissions to acute psychiatric inpatient units	1786	1783
Reason for admission was because of concerns about threat to self	54% (961)	57% (1023)
Patients with a history of self-injury (suicide attempt or deliberate self-harm)	44% (785)	42% (757)
Family, care-giver, friend or staff concerned patient at risk for self-injury	37% (668)	38% (682)

Source: Resident Assessment Instrument data set, St. Joseph's Healthcare Hamilton 2009

Crisis Outreach and Support Team (COAST), St Joseph's Healthcare Hamilton

COAST, a program of St. Joseph's Healthcare Hamilton, serves the residents of Hamilton who have serious mental health issues and are in crisis. COAST is a multidisciplinary team consisting of child and youth crisis workers, mental health workers, nurses, social workers and plain-clothes police officers. A mental health worker responds to a call on the 24-hour COAST crisis line and makes a preliminary assessment regarding the mental health concern. The worker determines whether to respond with telephone support or a mobile visit.

The extent to which suicidal ideation and suicidal behaviour is increasingly an issue in Hamilton is illustrated through COAST Hamilton data regarding presenting issues:

- In 2006, suicidal ideation/threat was a presenting issue in 17.5% (600) instances
- In 2007, suicidal ideation/threat was a presenting issue in 20.0% (781) instances
- In 2008, suicidal ideation/threat was a presenting issue in 21.2% (967) instances

Source: COAST, 2009

Salvation Army Suicide Prevention Services Suicide Crisis Line

The Salvation Army Suicide Prevention Services provides a 24-hour Suicide Crisis Line as well as short term crisis counseling, chaplaincy services, post suicide crisis care, suicide risk assessment & intervention, consultation services & advocacy, practical assistance through the Salvation Army Community & Family Services, Resources & Referrals, Education & Training. The Suicide Crisis Line received an increasing number of calls from 2006 to 2008 (Table II).

Table III. Number of calls to the Suicide Crisis Line, Salvation Army Suicide Prevention Services, 2006-2008

	Number of calls
2006	3,491
2007	3,665
2008	4,622

Source: Salvation Army Suicide Prevention Services, 2009

Victim Services

The Hamilton Police Service, Victim Services Branch is a 24 hour per day, 7 days per week crisis intervention agency for victims of crime and trauma serving the residents of Hamilton. Individuals, families businesses and organizations receive critical crisis intervention as well as support, information and referrals necessary to assist victims in dealing with crime and trauma.

- In 2006, Victim Services responded to 33 suicide calls (24 crisis calls* and 9 telephone calls**)
- In 2007, Victim Services responded to 21 suicide calls (15 crisis calls and 6 telephone calls)
- In 2008, Victim Services responded to 26 suicide calls (15 crisis calls and 11 telephone calls)

**Crisis calls are responses to attend the scene immediately following a death by suicide to provide crisis intervention and support.*

***Telephone calls are family/friend related inquiries to a suicide usually looking for information on coroner/post-mortem process or bereavement resources.*

Source: Victim Services, 2009

Hamilton Student Drug Use Survey (HSDUS) Report

Hamilton Public Health Services administered the HSDUS in 2007. A sample of students 12-18 years of age enrolled in a participating school with the Hamilton-Wentworth District School Board or Hamilton-Wentworth Catholic District School Board were asked a series of questions relating to self-esteem, moods, and general mental health. Of those who responded:

- 2.8% rated their mental health as poor
- 9.5% had seriously thought about attempting suicide in the last 12 months
- 3.4% had actually attempted suicide in the last 12 months

Source: Hamilton Public Health Services, Hamilton Student Drug Use Survey (HSDUS) Report, 2008

Youth Net Hamilton

Youth Net Hamilton is a mental health promotion and early intervention program of Hamilton Public Health Services. Results from a 2004-2006 survey of 2073 youth 13-18 years of age who participated in Youth Net Hamilton focus groups showed:

- 14% of females and 6% of males self-reported having ever had serious thoughts of killing themselves
- 7% of females and 4% of males self-reported having ever purposely tried to kill themselves
- 46% of females and 32% of males self-reported having been concerned about their mental or emotional health a few times a month, a few times a week, or all the time over the last 3 months

Source: Youth Net Hamilton Raw Data, April 2004 to March 2006

Suicide Mortality Rates: National, Provincial and Local Perspectives

Suicide behaviour is an important and preventable public health concern. Every year just under 4000 Canadians, or an average of 10 Canadians every day, die by suicide.³⁴ Suicide ranked among the top three leading causes of all deaths in Canada for those 15-44 years of age between 2000 to 2004.³⁵ In fact, suicide claimed the lives of more Canadians than all transport collisions between 2000 and 2005.³⁶

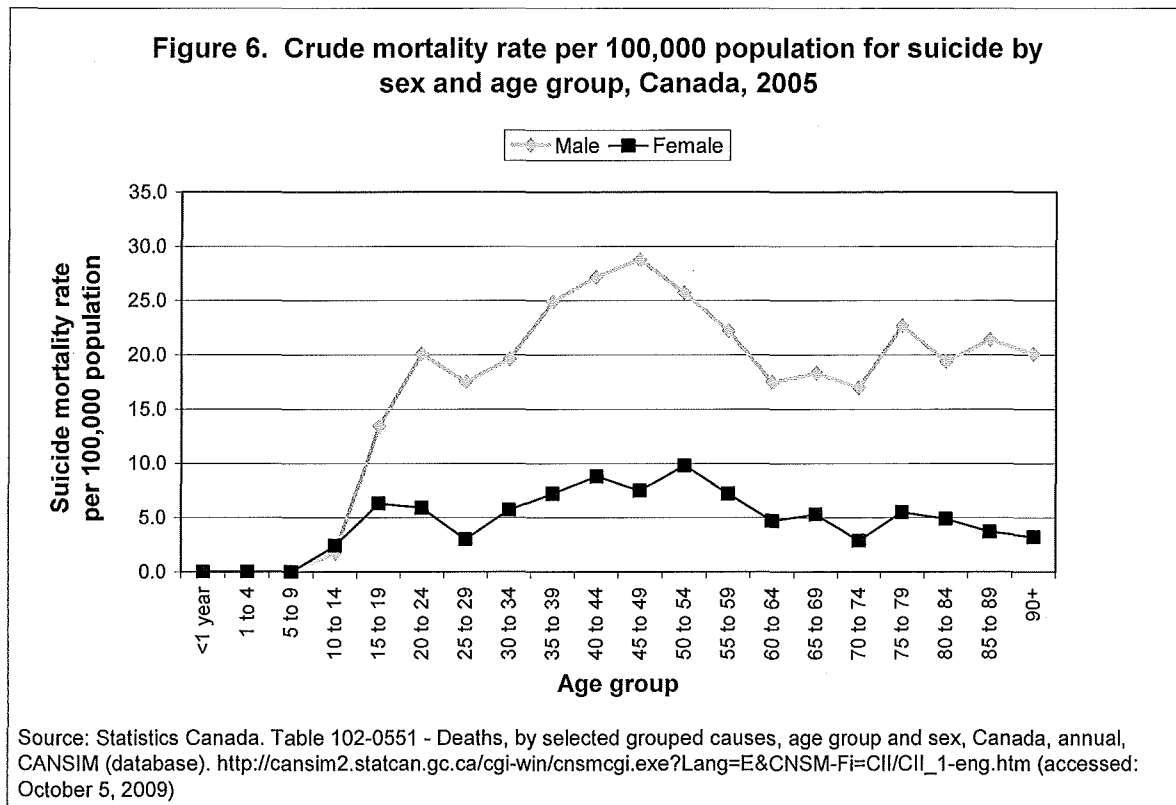
In Ontario, a death is classified as a suicide only if it can be determined that the individual knew that the probable consequences of their actions would end in death. The Ontario Court of Appeal in the case *Beckon v. Young* has given specific instructions regarding the standard of proof required for a finding of suicide (Beckon test). While the legal test to be satisfied is a balance of probability, a determination of suicide can only be made where there is clear and convincing evidence. There is to be a presumption against suicide at the outset, and one must be satisfied on a high degree of probability that the death was a suicide. A death is classified as undetermined if the death is a suicide that does not meet the Beckon test requiring a high degree of probability or the death is an apparent suicide of a child under the age of 10.³⁷

The collection of data regarding suicide and suicidal ideation is limited. The available data for Ontario most likely under-reports the number of deaths by suicide because information about the nature of the death may not become available until after the original death certificate is complete, there is occasional reluctance to identify a death publicly as a suicide, and the standard of proof required for classifying a death as a suicide.

Suicide Mortality in Canada: the National Perspective

In 2005, the crude suicide mortality rate in Canada was 11.6 deaths per 100,000 population. The suicide mortality rate for males (17.9 deaths per 100,000 population) is more than three times higher than the rate for females (5.4 deaths per 100,000 population).³⁸

Suicide mortality rates vary by age, with the rates for both males and females being highest in middle to later-middle age groups (28.8 deaths per 100,000 population for males 45-49 years of age; 9.8 per 100,000 population for females 50-54 years of age). In both males and females, peaks in the rates are also seen in later adolescence (15-24 years of age) and again later in life (70-79 years of age) (Figure 6).



Suicide Mortality in Ontario and Hamilton

Between 2000 and 2005, just under 6,000 Ontario residents died as a result of suicide. Of those, 244 resided in Hamilton at the time of their death (Table IV).

Between 2001 and 2005 in Hamilton there were:³⁹

- Almost two times as many deaths by suicide as deaths by transport collisions
- Almost six times as many deaths by suicide as deaths by assault

Table IV. Number of deaths by suicide by year, City of Hamilton and Ontario, 2000-2005

	2000	2001	2002	2003	2004	2005	Total (2000-2005)
City of Hamilton	22	40	48	46	37	51	244
Ontario	916	956	928	1,031	1,013	1,104	5,948

Source: Deaths, Ontario Ministry of Health and Long-Term Care. IntelliHEALTH ONTARIO, October 2009

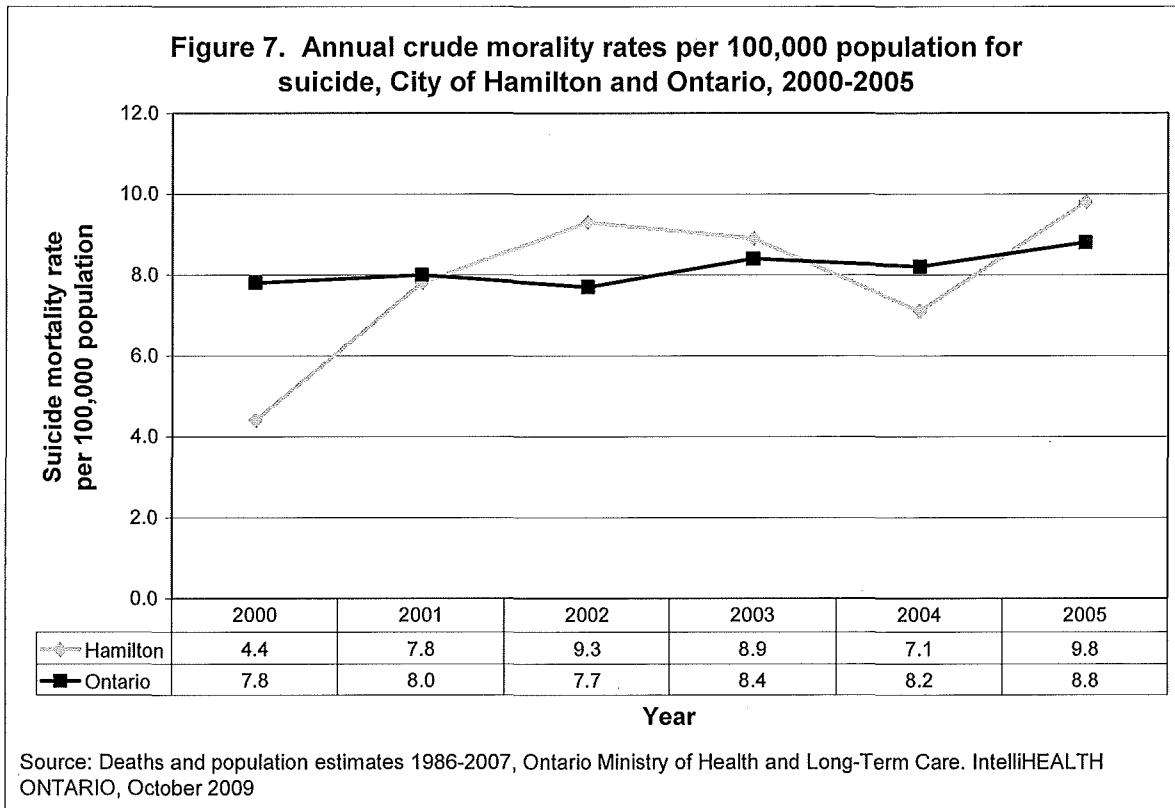
The most common means of suicide in Hamilton and Ontario overall between 2001 and 2005 were: (1) hanging, strangulation and suffocation; (2) poisoning (including overdose); and (3) discharge of firearms.⁴⁰

Annual rates are helpful for understanding trends in suicide mortality, relative to changes in the population overall. The crude suicide mortality rate in Ontario remained relatively stable from 2000-2005, ranging from a low of 7.7 deaths per 100,000 population in 2002 to a high of 8.8 deaths per 100,000 population in 2005 (Figure 7).

During the same time period, the crude suicide mortality rate in Hamilton fluctuated from a low of 4.4 deaths per 100,000 population in 2000 to a high of 9.8 deaths per 100,000 population in 2005 (Figure 7).

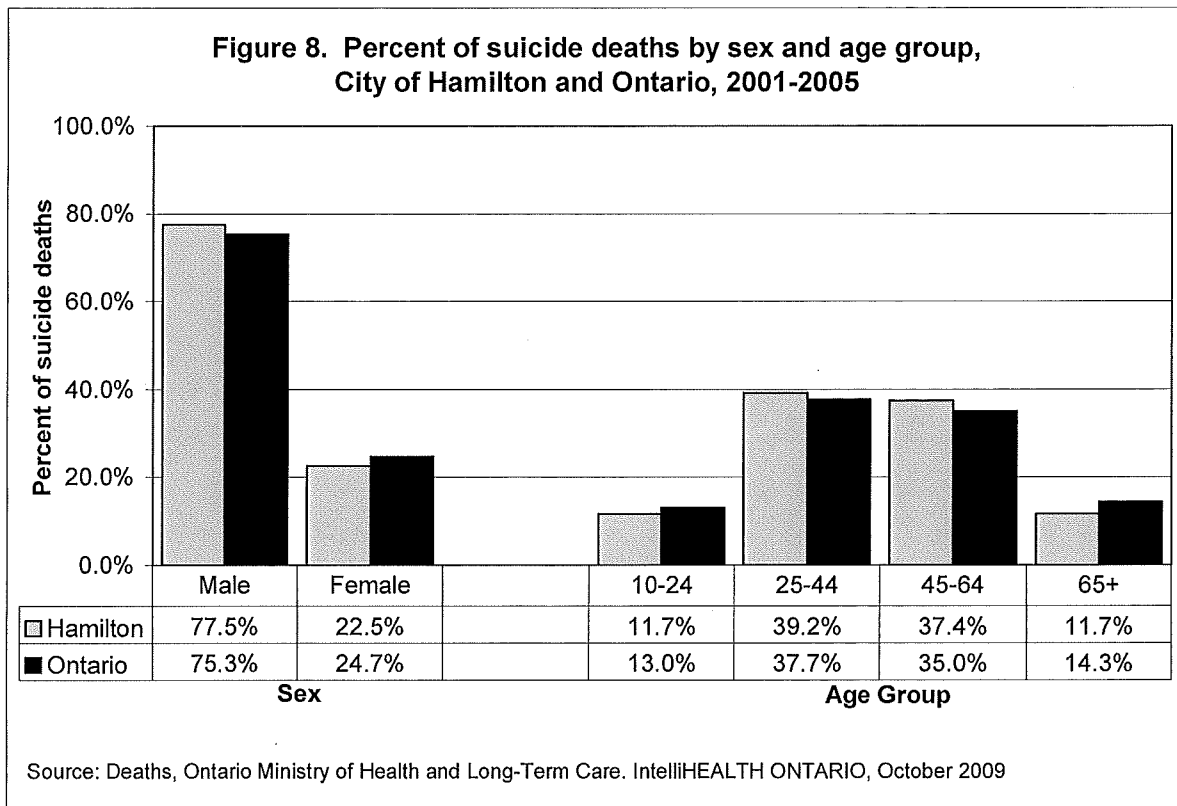
Trends in suicide mortality rates at the municipal level can be difficult to interpret because of effects related to smaller populations and lower numbers of suicide deaths. Slight changes in the number of suicides may cause significant fluctuations in the annual rates. Averaging data across a number of years provides a more stable estimate of the suicide mortality rate for comparison purposes:

- Five-year (2001-2005) average annual crude suicide mortality rates show that the rate in Hamilton (8.6 deaths per 100,000 population) is similar to the rate in Ontario overall (8.2 deaths per 100,000 population).⁴¹



Age and Sex Characteristics

Males accounted for just over 3/4 of deaths by suicide in Hamilton (77.5%) and Ontario overall (75.3%) between 2001 and 2005. During the same time period, the majority of suicide deaths were in individuals 25-44 years of age (39.2% and 37.7% in Hamilton and Ontario, respectively) and 45-64 years of age (37.4% and 35.0% in Hamilton and Ontario, respectively) (Figure 8).



When five-year (2001-2005) average annual age-specific rates are used to account for underlying differences in the total population size of various age and sex groups, some patterns emerge (Table V):

- Suicide mortality rates are higher for males than for females, regardless of age group, in both Hamilton and Ontario
- Suicide mortality rates are highest for both males and females 45-64 years of age in Hamilton and Ontario
- Suicide mortality rates for males and females 25-44 and 45-64 years of age in Hamilton are somewhat higher than those in Ontario overall

Table V. Five-year average annual crude mortality rate per 100,000 population by age and sex, City of Hamilton and Ontario, 2000-2005

	City of Hamilton (Rate per 100,000 population)			Ontario (Rate per 100,000 population)		
	Males	Females	Total	Males	Females	Total
10-24 years	8.4	NR	4.9	7.6	2.8	5.3
25-44 years	17.7	4.7	11.3	15.5	4.5	10.0
45-64 years	19.9	7.0	13.4	17.6	6.3	11.9
65 years of age +	12.3	3.4	7.2	16.2	4.0	9.3
Total (all ages)	13.5	3.8	8.6	12.5	4.0	8.2

NR=not reportable due to small counts

Source: Deaths and population estimates 1986-2007, Ontario Ministry of Health and Long-Term Care. IntelliHEALTH ONTARIO, October 2009

Suicides and Domestic Homicides in Ontario

When domestic violence is present, suicide threats or attempts are recognized as a potential lethal risk to the spouse (victim) and/or the children. These risk factors are identified in clinically tested risk assessment tools and death review reports.⁴²

Between 2002 and 2007, there were a total of 166 domestic violence death cases in Ontario that resulted in 230 deaths involving 142 women, 23 children, and 65 men. Of the 65 male deaths, 52 were suicides by the perpetrator.⁴³

The majority of domestic violence fatalities involved a single homicide (67%), followed by homicide-suicide (25%), attempted homicide-suicide (6%), attempted homicide and related homicide (2 %), i.e. police shooting.⁴⁴

In 2008, sixty percent of domestic homicides included the risk factor of prior threats and/or attempts of suicide by the abusive spouse/partner. Pending or actual recent separation was present in 81% of cases (2003-2008) and 87% in cases for 2008. Depression in the abusive spouse was identified in 58% of the cases (2003-2008).⁴⁵

5 NEED FOR A SUICIDE PREVENTION STRATEGY FOR HAMILTON

The SPCCH and the Strategy Committee identified the following reasons for developing a suicide prevention strategy:

- The World Health Organization has reported that suicide is a major public health problem and public awareness of the problem is very low⁴⁶
- The Canadian Association for Suicide Prevention Blueprint recommends that each city/region have their own strategy that emphasizes local strengths and needs but neither Ontario nor Hamilton have a strategy⁴⁷
- Communities surrounding Hamilton have strategies or action plans (e.g. Waterloo,⁴⁸ Niagara,⁴⁹ Halton Region⁵⁰)
- Hamilton has an active Suicide Prevention Community Council, and the community has demonstrated support of the council's initiatives through participation in their training and educational events, thereby demonstrating community interest and support for the issue
- A clearly defined Suicide Prevention Strategy would provide a framework to enhance existing community capacity creating a community that is more proactive, aware and skilled in prevention, intervention and postvention activities

The intent of the Hamilton strategy is to focus attention on the following activities:

- Improve coordination of mental health services to promote suicide prevention
- Simplify access to timely and effective help for suicidal individuals in Hamilton
- Provide guidance in identifying specific assessments and interventions that may reduce suicide attempts and deaths
- Increase awareness of mental health issues and the risk for suicide behaviours to promote earlier intervention for those struggling with mental health problems and substance misuse
- Increase awareness of the need for postvention care
- Reduce stigma regarding mental illness and suicide thereby diminishing barriers to accessing help for suicidal ideation and mental illness
- Advocate for positive changes to modifiable risk factors such as poverty, lack of housing, limited educational and employment opportunities, access to means, discrimination and stigma
- Promote the strengthening of protective factors such as hopefulness, resilience and connectedness with community, family, school, workplace and religious organizations
- Cultivate positive opportunities (e.g. meaningful activities-sport and recreation, employment, education) for people with mental health problems
- Develop or improve organizational policies and practices for mental health promotion and suicide prevention (e.g. healthcare, schools, businesses, others)
- Advocate for greater supports and follow-up for individuals with mental health problems
- Identify the importance of families and caregivers in supporting people with suicide behaviours

6 HAMILTON SUICIDE PREVENTION STRATEGY

Principles

The *Hamilton Suicide Prevention Strategy* is guided by the following principles:

1. Suicide prevention is everyone's business
2. Suicide is an interaction of biological, psychological, social and spiritual factors and can be influenced by societal attitudes and conditions
3. Services for suicide prevention, intervention and postvention should:
 - a. be respectful, non-judgemental, caring and without stigma or discrimination
 - b. take into account cultural, linguistic, and gender diversity, sexual orientation and the needs of all groups including those with lived experience
 - c. be coordinated and delivered in a collaborative manner providing ongoing feedback
 - d. include, where possible, the appropriate involvement of family and community members in aftercare
 - e. be effective and informed by evidence; reflective of evolving knowledge and recovery-based practices
 - f. be adequately funded
4. Awareness of suicide prevention services available in Hamilton is essential
5. Suicide prevention efforts need to be researched, evaluated, and disseminated in order to ensure a coordinated knowledge transfer to the Hamilton community
6. Many suicide-related deaths are preventable by knowledgeable, caring, compassionate and committed communities

Purpose

The purpose of the *Hamilton Suicide Prevention Strategy* is to guide the development of an integrated, coordinated, comprehensive suicide prevention approach in the Hamilton community.

Aim

The aim of the strategy is to help prevent deaths due to suicide and reduce the suffering related to suicidal ideation, attempts and those bereaved by suicide.

Strategy Objectives and Actions

A. Commitment

Objective: To increase community commitment to participate in the Hamilton Suicide Prevention Strategy.

Actions:

- Obtain formal endorsement of the strategy from key organizations and individuals
- Monitor and report to the community on outcomes related to strategy implementation
- Identify, advocate for and commit resources needed to implement the strategy

B. Awareness

Objective: To increase awareness in every part of our community that suicide is a significant health problem and that it is often preventable through community action.

Actions:

- Engage Hamilton media in recognizing suicide as an important health problem in Hamilton and the need to promote suicide prevention
- Develop and distribute public awareness materials and resource information which will increase knowledge of and sensitivity to suicide and suicide prevention
- Develop a communication strategy on suicide prevention using socially inclusive and culturally sensitive information to increase knowledge of and sensitivity to suicide and suicide prevention to reach specific populations (e.g. youth, seniors, people with mental health issues, LGBTQ and Aboriginal people)
- Support public and private institutions and volunteer organizations engaging in suicide prevention initiatives
- Engage the community in organizing or supporting annual events for World Suicide Prevention Day (September 10th) and National Survivors of Suicide Day (Saturday before American Thanksgiving)
- Increase awareness and access to local postvention care and support

C. Stigma and Discrimination

Objective: To reduce stigma and discrimination associated with suicide and suicidal ideation.

Actions:

- Improve public understanding that breaking the silence surrounding suicide increases realistic opportunities to save lives and reduce suffering
- Engage the community to participate in mental health literacy initiatives
- Improve public understanding that mental health, treatment for depression, other mood disorders and mental illnesses, substance use disorders, trauma and suicide prevention services are fundamental and essential components of health care
- Increase awareness of both internal and external stigma as a barrier to seeking help for mental illness and for suicidal ideation
- Promote factual information to reduce myths and stereotypes about suicide, suicidal ideation, self-harm and mental illness
- Develop a public education campaign aimed at increasing the awareness of resources and the importance of decreasing stigma and seeking help for individuals with suicidal thoughts/behaviours, mental illness and/or addictions
- Support and participate in local and national anti-stigma campaigns that address suicide and mental health
- Recommend less stigmatizing language by promoting the avoidance of stigma related terms such as “committed” or “completed” suicide and promoting the use of terms such as “died by suicide” and “bereaved by suicide”

D. Prevention

Objective: To increase community capacity in Hamilton to identify and assist people in all aspects of suicide prevention.

Actions:

- Develop and maintain a comprehensive list and description of the services available for suicide prevention, intervention and postvention; ensure the list is easily accessible in a variety of media
- Establish a centre responsible for awareness and promotion of suicide prevention resources for the community
- Develop a community protocol that lays out a collaborative process for getting help for people who are at risk for suicide, so that wherever a person enters the system, that person can be assured of connection to all available resources
- Improve access, integration and communication in caring for people with suicide-related behaviours. Create strong linkages between hospital programs, community based services and families. Advocate for improved communication between services for shared clients⁵¹

- Lobby for additional services or increased service capacity as needed
- Encourage and promote community-based suicide prevention, intervention and postvention programs that respect diversity and culture
- Support the use of evidence-informed guidelines for assessment and treatment of suicide-related behaviours among persons receiving care in primary health care settings, emergency departments, hospital wards and mental health and addiction programs
- Support the use of evidence-informed guidelines for assessment and treatment of suicide-related behaviours across the life span including children, youth, adults and the elderly
- Support the Mental Health Commission of Canada's goal of an integrated mental health system that places people living with mental illness at its centre
- Recommend the development of supportive policies, programs and caring services for families living with suicidal people. Acknowledge their roles as caregivers and as contributing members of the care team who may also require care
- Encourage community agencies to offer peer support programs for suicide prevention and postvention
- Increase the number of people who seek and receive care at all levels of prevention, intervention and postvention for suicide-related behaviours
- Improve postvention care by advocating for the development of postvention programs and the expansion of support groups for all bereaved by suicide
- Support the development of programs that promote protective factors and resilience-building

E. Training and Education

Objective: To increase the capacity of the Hamilton community to identify and respond to the risk factors for suicide.

Actions:

- Foster awareness and education in mental health literacy and suicide prevention
- Improve media knowledge regarding suicide and the use of media guidelines in reporting about suicide (the World Health Organization /International Association for Suicide Prevention 2008 Preventing Suicide - A Resource for Media Professionals)
- Make available and accessible consistent, thorough training in the recognition of risk factors, warning signs and at-risk behaviours, and also in the provision of effective intervention and postvention assistance
- Encourage broad participation in service provider training in recognition of symptoms of depression and warning signs of suicide
- Offer education targeting primary care providers (e.g. physicians and nurse practitioners) in the identification, assessment and treatment of depression and suicidal ideation⁵²
- Promote continuing education in the identification of and intervention strategies for a suicidal person for physicians and emergency service personnel

- Support Crisis Intervention Training for police officers, Emergency Medical Services personnel and firefighters. Highlight the potential for suicide in domestic violence situations
- Partner with post secondary educational institutions for improvements in curricula related to suicide prevention (e.g. medical students, nursing students, health care aides, youth workers, social workers, teachers)
- Support preventative programming in schools to address the needs of students at risk for suicide
- Increase the number of gatekeepers trained in Applied Suicide Intervention Skills Training (ASIST) programs (including health care providers, school personnel, corrections workers, clergy, police, volunteers, and service providers)
- Increase the number of employer, professional and other groups that have guidelines or policies for the identification and support of those at risk for or bereaved by suicide
- Advocate for workplace suicide prevention training with annual refresher courses
- Support the development of training programs in evidence-based therapies such as cognitive behavioural therapy, solution-focused therapy and dialectical behavioural therapy
- Support the development of training for health professionals about cultural competency in working with marginalized populations and delivery of health services using an anti-oppressive framework to all individuals seeking help with suicidal ideation/behaviours
- Increase capacity for bereavement training and facilitation

F. Advocacy

Objective: To advocate for community change to improve the care of and responsiveness towards persons affected by suicide behaviours and suicide loss.

Actions:

- Identify and solicit potential funding sources for suicide prevention (e.g. service delivery, administrative aspects of service delivery, research, evaluation)
- Seek out political support for suicide prevention activities in Hamilton
- Support the development of a research and evaluation capacity regarding suicide prevention activities in Hamilton
- Support links and communication between survivors, community resources and researchers to facilitate knowledge transfer and knowledge uptake
- Advocate to address community-level risk factors for suicide (e.g. housing, access to psychiatric care, reduced access to geographic locations that are places often used for suicide or suicide attempts)
- Encourage every member of the community to advocate for those in crisis or affected by suicide
- Advocate for the provision of culturally competent mental health services delivered using an anti-oppressive framework
- Contribute to the development of provincial and national strategies and policies related to suicide prevention

Next Steps

The *Hamilton Suicide Prevention Strategy* is presented as a document to guide suicide prevention activities in Hamilton. It provides a framework to enhance existing community capacity creating a community that is more proactive, aware and skilled in prevention, intervention and postvention activities.

The SPCCH will create a Suicide Prevention Roundtable to oversee the implementation of the Strategy. The Roundtable will include representatives of agencies, organizations, persons with lived experience and volunteers who are all committed to reducing the impact of suicide in our community. The first undertaking will be to set timelines and to identify projects related to specific action items. A key task for the Roundtable will be to ensure that the actions for each objective are prioritized for implementation.

For each project undertaken, it will be important to identify measurable goals and an evaluation process. We will not be able to correlate any changes in the suicide rate in Hamilton with the release or implementation of the Strategy due to the multi-factorial nature of suicide. However, outcome evaluation of the Strategy is possible by setting measurable goals for specific action items when appropriate. It is important to note that each action is significant but not all allow for measurable outcomes.

The Roundtable will collaborate with SPCCH committees (Education & Awareness and Conference) and community organizations. The Roundtable will have no authority and will rely on collaboration and partnerships between organizations and the SPCCH to promote and implement suicide prevention projects. The Roundtable will report regularly to the SPCCH Board of Directors.

The Strategy must be a living document that is reviewed and revised regularly to ensure it continues to reflect current research and to address suicide prevention needs in Hamilton.

We envision that the *Hamilton Suicide Prevention Strategy* will unite Hamilton organizations to work together to prevent suicide through caring, compassion, commitment and community.

7 APPENDICES

Appendix A: Suicide Prevention and Related Services in Hamilton

Refer to Inform Hamilton (www.inform.hamilton.ca) for comprehensive list of mental health and suicide prevention services in Hamilton.

To search for a crisis line in your area, visit:
Centre for Suicide Prevention www.suicideinfo.ca/csp/go.aspx?tabid=77

To search for children and youth mental health services, call Contact Hamilton:
905-570-8888
www.contacthamilton.ca

To search for a mental health service in your area, visit:
Mental Health Service Information Ontario
1-800-531-2600 (24 h)
www.mhsio.on.ca

Alcohol, Drug and Gambling Services Hamilton:
905-546-3606
adgs@hamilton.ca

The Ontario Problem Gambling Helpline information and referral service:
1-888-230-3505 (24 h)
www.opgh.on.ca

The Drug and Alcohol Registry of Treatment (DART) information and referral to services in Ontario:
1-800-565-8603 (24 h)
www.dart.on.ca

Barrett Centre for Crisis Support Hamilton information, referral and support line:
905-529-7878 (24 h)
www.goodshepherdcentres.ca/Programs/barrett.htm

To search for bereavement counselling in Hamilton, visit:
Friends in Grief www.friendsingrief.ca
Bereaved Families of Ontario Hamilton/Burlington www.bfo-hamiltonburlington.on.ca

To find support and services for abused women in Hamilton, visit:
Woman Abuse Working Group www.wawg.ca

Appendix B: Suicide Prevention and Related Resources

To join an association:

1. Suicide Prevention Community Council of Hamilton (SPCCH) is a charitable organization involving professionals and individuals from the community who are interested in suicide prevention and its related issues as well as the promotion of public awareness
2. Ontario Association for Suicide Prevention (OASP) encourages the development of suicide prevention, intervention, and postvention activities
3. Canadian Association for Suicide Prevention (CASP) works towards reducing the suicide rate and minimizing the harmful consequences of suicide by advocating, supporting and educating
4. International Association for Suicide Prevention (IASP) holds a congress every two years that is sponsored by various regional and international suicide prevention organizations

To find information and research:

1. American Association of Suicidology (AAS) promotes research, public awareness programs, education & training for professionals and volunteers
2. Centre for Suicide Prevention specializes in curriculum development, training programs, library and information services
3. Reasons to go on Living is a project and website dedicated to learning how people who once attempted suicide have chosen to go on living
4. Suicide Prevention Resource Center (SPRC) provides prevention support, training, and resources to assist organizations and individuals to develop suicide prevention programs, interventions and policies, and to advance the U.S. National Strategy for Suicide Prevention

To help the community identify suicide prevention as a public health issue of importance, LivingWorks: suicideTALK

To raise awareness and reduce stigma:

1. Great-West Life Center for Mental Health in the Workplace - Helping Raise Awareness & Reduce Stigma
2. Talking About Mental Illness (TAMI)

To promote mental health literacy:

1. Canadian Alliance on Mental Illness and Mental Health: Mental Health Literacy in Canada
2. CAMH Mental Health and Addictions 101 on line tutorials

To promote mental health literacy and stigma reduction in youth, Youth Net Hamilton

To provide media with guidelines and training:

1. WHO – Preventing suicide – a resource for media professionals
2. CMHA - Suicide-responsible media reporting guidelines

To promote training for health practitioners:

1. WHO: Preventing Suicide a Resource for General Physicians
2. WHO: Preventing Suicide a Resource for Primary Health Care Workers
3. suicideCARE for practioners who have been trained in ASIST

To provide gatekeeper training opportunities in order to increase community capacity to identify and refer individuals at risk of suicide:

1. Applied Suicide Intervention Skills Training
2. safeTALK
3. Mental Health First Aid

To promote the use of suicide prevention polices in accordance with Accreditation Canada's Required Organizational Practices within hospital settings, use the patient risk assessment

To support the use of guidelines for assessment and treatment of suicide-related behaviours across the life span:

1. Registered Nurses of Ontario Association: Assessment and Care of Adults at Risk for Suicidal Ideation and Behaviour
2. Canadian Coalition for Seniors Mental Health: National Guidelines for Seniors' Mental Health: The Assessment of Suicide Risk and Prevention of Suicide
3. Warning Signs Mnemonic from the American Association of Suicidology: IS PATH WARM
4. Suicide Prevention Resource Centre: Suicide Risk: A Guide for ED Evaluation and Triage

To support workplaces to adopt and implement suicide intervention policies, Great-West Life Center for Mental Health in the Workplace

To support workplaces to adopt and implement policies that address violence in the workplace, Great-West Life Center for Mental Health – Addressing Workplace Violence

To support Boards of Education to implement mental health and violence prevention curriculum, CMHA: Mental Health and High School Curriculum Guide and 4th R: Relationship Based Violence Prevention

To implement mental health promotion messages, CMHA - Take control of your health. Take care of your mind. Practice Mind + Body Fitness

To promote resilience in youth, BC Ministry of Children and Family Development, Promoting Resilience & Strengthening Environments

To promote mental health:

1. www.ccsmh.ca/en/projects/suicide.cfm Canadian Coalition for Senior's Mental Health: Resources and Publications
2. www.ccsmh.ca/pdf/ccsmh_suicideBooklet.pdf Suicide Prevention among Older Adults: a guide for family members
3. www.communitylifelines.com provides strengths-based approaches to solutions for challenges related to wellness, mental health and suicide prevention.
4. www.honouringlife.ca National Aboriginal Health Organization offers culturally relevant information and resources on suicide prevention for Aboriginal youth
5. <http://training.suicideinfo.ca/default.php> River of Life course about Aboriginal youth suicide is for individuals working with youth ages fifteen to twenty-four
6. www.kidshelpphone.ca offers online information and counselling for children and youth 1-800-668-6868
7. www.mindyourmind.ca is a website for youth created by youth offering information, resources and the tools to help manage stress, crisis and mental health problems
8. www.siso-ham.org provides programs and services for immigrant and refugee communities in the Hamilton area
9. www.sprc.org/library/SPRC_LGBT_Youth.pdf Suicide Risk & Prevention for LGBTQ Youth
10. www.thetrevorproject.org The Trevor Project provides information about suicide prevention for LGBTQ youth
11. www.YOOmagazine.net from IWK Health Centre is an interactive health magazine for schools, youth and parents
12. www.youthnethamilton.ca Youth Net Hamilton is a mental health promotion and early intervention program
13. www.yourlifecounts.org is a website for youth to share thoughts and get help with their problems
14. www.youthline.ca LGBTQ Youth Line 1-800-268-9688

These links to third-party websites are provided solely as a convenience. The SPCCH has no control over these websites or their contents and in no way endorses any linked third-party sites. The SPCCH does not make any representations of any kind regarding such linked content, including the accuracy, completeness, or non-infringement thereof. The SPCCH does not assume any responsibility or risk for use of these links. Use the contents of these websites at your own risk.

Appendix C: Glossary

Within the context of this document, the following terms and definitions are offered to assist the reader.

Affective disorders – see mood disorders

Anti-oppressive framework – a way of thinking that helps to identify and resist oppression. Critical components are anti-racism, anti-sexism, anti-heterosexism, anti-ablism, anti-ageism, and an understanding of class oppression

Bipolar disorder – a mood disorder characterized by the presence or history of manic episodes, usually, but not necessarily, alternating with depressive episodes

Causal factor – a condition that alone is sufficient to produce a disorder

Comorbidity – the co-occurrence of two or more disorders, such as depressive disorder with substance use disorder

Consumer – a person who has lived experience with mental illness

Consumer survivors – consumers who consider themselves survivors of mental health services

Contagion – a phenomenon whereby susceptible persons are influenced towards suicidal behavior through knowledge of another person's suicidal acts

Cultural competence – refers to an ability to interact effectively with people of different cultures. Cultural competence comprises four components: (a) awareness of one's own cultural worldview, (b) attitude towards cultural differences, (c) knowledge of different cultural practices and worldviews, and (d) cross-cultural skills. Developing cultural competence results in an ability to understand, communicate with, and effectively interact with people across cultures

Depression – a constellation of emotional, cognitive and somatic signs and symptoms, including sustained sad mood or lack of pleasure

Effective – prevention programs that have been scientifically evaluated and shown to decrease an adverse outcome or increase a beneficial outcome in the target group more than in a comparison group

Evaluation – the systematic investigation of the value and impact of an intervention or program

Evidence-based – programs that have undergone scientific evaluation and have proven to be effective

Frequency – the number of occurrences of a disease or injury in a given unit of time; with respect to suicide, frequency applies only to suicidal behaviors which repeat over time

Gatekeepers (suicide gatekeepers) – individuals trained to identify persons at risk of suicide and refer them to treatment or supporting services as appropriate

Goal – a broad statement of general purpose to guide planning, focused on the end result of the work

LGBTQ – acronym for lesbian, gay, bisexual, transgender, queer

Means – the instrument or object whereby a self-destructive act is carried out (e.g. firearm, poison, medication)

Means restriction – activities designed to reduce access or availability to means and methods of deliberate self-harm

Methods – actions or techniques which result in an individual inflicting self-harm (i.e., asphyxiation, overdose, jumping)

Mood disorders – mental disorders that are characterized by a prominent or persistent mood disturbance; disturbances can be in the direction of elevated expansive emotional states, or, if in the opposite direction, depressed emotional states. Included are Depressive Disorders, Bipolar Disorders, mood disorders due to a medical condition, and substance-induced mood disorders

Objective – a specific and measurable statement that clearly identifies what is to be achieved in a plan; it narrows a goal by specifying who, what, when and where or clarifies by how much, how many, or how often

Outcome – a measurable change in the health of an individual or group of people that is attributable to an intervention

Personality disorders – a class of mental disorders characterized by deeply ingrained, often inflexible, maladaptive patterns of relating, perceiving, and thinking of sufficient severity to cause either impairment in functioning or distress

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

Public information campaigns – efforts designed to provide facts to the general public through various media such as radio, television, advertisements, newspapers, magazines, and billboards

Rate – the number per unit of the population with a particular characteristic, for a given unit of time

Resilience – capacities within a person that promote positive outcomes, such as mental health and well-being, and provide protection from factors that might otherwise place that person at risk for adverse health outcomes

Risk factors – factors that make it more likely that individuals will develop a disorder; risk factors may encompass biological, psychological or social factors in the individual, family and environment

Substance use disorder– the condition involving the misuse of, dependence upon, or addiction to any substance, including alcohol

Suicidal behaviour – a spectrum of activities related to thoughts and behaviors that include suicidal thinking, suicide attempts, and completed suicide

Suicidal ideation – thoughts of engaging in suicide-related behavior

Suicide – death from injury, poisoning, or suffocation where there is evidence that a self-inflicted act led to the person's death

Suicide attempt – a potentially self-injurious behavior with a nonfatal outcome, for which there is evidence that the person intended to kill himself or herself; a suicide attempt may or may not result in injuries

Suicide prevention – activities directed toward the reduction of suicidal behaviour
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

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

Adapted from Glossary retrieved July, 2009: www.sprc.org/suicide_prev_basics/glossary.asp

Appendix D: About the Data Sources used in this Report

Census

Every five years, Statistics Canada conducts a Census of the Canadian population. The most recent Canadian Census took place in May, 2006. The Census aims to include every adult and child living in Canada on Census day, as well as those Canadians living abroad on a military base, diplomatic mission or on a Canadian-registered merchant vessel. Individuals with a temporary work, study or resident permit and their dependents are also included in the Census.

The Census is regarded as one of the most reliable sources of detailed population data, but does under-represent some groups. Young adults, the homeless and Aboriginals living on reserve are some of the groups 'under-counted' by the Census.

Census data are meant to provide a 'snap shot' of the population at a particular point in time. Census data are likely to become less representative of population over time, especially if mobility rates are high or significant changes take place (for example, a recession) in a community.

Canadian Community Health Survey (CCHS)

The CCHS collects information on health status and determinants, and health care utilization. It surveys a large sample of respondents 12 years of age and older living in private dwellings. Data presented are from the 2007 implementation of the CCHS. Since the CCHS only collects information from community-dwelling residents, indicators do not represent the health status of those individuals living in institutions. Data are self-report so are subject to recall error and do not capture those individuals who are living with illnesses for which they have not received a diagnosis.

95% Confidence Intervals ('±' or 'I') in CCHS Data

Confidence intervals (CIs) are presented for CCHS data. The prevalence of a trait in the actual population is likely to be somewhat different than the estimate derived from the CCHS sample. CIs provide a range that one can be relatively ("95%") certain that the actual population prevalence falls within. Estimates that have wider CIs are less reliable than estimates that have narrower CIs.

CIs also assist with identifying groups in the population that are 'different' from each other. If the CIs around two estimates do not overlap, then it can be assumed that they represent populations that actually differ from each other in terms of a trait. If the CIs overlap, the populations are deemed to be the same (even though the actual estimate may be somewhat different).

Provincial Health Planning Database (PHPDB)/ INTELLIHEALTH ONTARIO

Vital Stats (Deaths)

Unless otherwise cited, data regarding cause of death are based on the main causes of death indicated by data from death certificates from the Ontario Office of the Registrar General. Geographic information is based on place of residence, not where the death occurred. The data presented are based on underlying cause of death (i.e. the disease or injury which initiated the events leading directly to death or the circumstances of the accident or violence which lead to the fatal injury), classified by the Chapters of the International Statistical Classification of Diseases and Health Related Problems 10th Revision (ICD-10) (see <http://www.who.int/classifications/apps/icd/icd10online/>). Deaths by suicide are based on codes X60-X84 and Y87.0 from the ICD-10-CA.

As noted, a death can only be classified as a suicide when the victim's intent is clear and the nature of the death may not become available until after the original death certificate is complete. As a result of these stipulations and other factors, data regarding death by suicide are likely to under-represent the actual number of deaths.

Calculation of Crude Rates for Mortality Data

Mortality data are based on the rate per 100, 000 population. Rates are calculated by:

- summing the number of events in a given time period
- dividing the sum of events by the estimated population at the time period mid-point
- multiplying the resulting number by 100, 000 to create the rate

In some instances, average annual rates (where the number of events is first divided by the number of years of data) are presented to provide a more stable estimate of the rate. Rates based on average counts of less than 5 have been suppressed ('nr').

Hamilton Student Drug Use Survey (HSDUS)

This survey was conducted with students enrolled in the Hamilton-Wentworth District School Board and Hamilton-Wentworth Catholic District School Board schools only. The survey population was restricted to schools where the consent of the individual school principal was obtained. As a result, the number of participating schools per region was much lower than the student population per region and the survey may have under-represented some subgroups of students in some areas. Class participation was not tracked; it is not known if all grades participated from each school. For these reasons, the students surveyed may not be a representative sample of all students 12 to 18 years of age living in Hamilton. As with all self-reported data, there are potential limitations that may include deliberate or accidental under- or over-reporting substance use and other issues.

8 ENDNOTES

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