A CALL TO ACTION

The Alberta Suicide Prevention Strategy

AMHB
ALBERTA MENTAL HEALTH BOARD
. . . Advancing Mental Health

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MESSAGE FROM THE MINISTER

Congratulations on the development and release of the Alberta Suicide Prevention Strategy! It is an accomplishment for which you can be so proud.

The Provincial Mental Health Plan clearly identified the need for an effective suicide prevention strategy for Alberta. This Alberta Suicide Prevention Strategy represents a collaborative effort of survivors, service providers, researchers, government, community agencies and regional health authorities to meet the priority strategy outlined in the Provincial Mental Health Plan.

Suicide prevention is an important part of our efforts to improve mental health services in Alberta. More than 400 Albertans die each year by suicide, and thousands seek medical help for a suicide attempt. Thousands of other Albertans have thoughts of suicide each year.

Suicide is simply a tragedy. It affects individuals, families, communities and ultimately all Albertans. There is hope though, because we know that suicide is preventable.

The strategy within these pages builds on work that is currently underway in Alberta. As a guiding document for provincial and regional programs, service providers, concerned individuals and other stakeholders, the Alberta Suicide Prevention Strategy sets the direction for further suicide prevention efforts in Alberta.

My sincere thanks go to the Alberta Mental Health Board for its leadership on this collaborative effort and to everyone who worked so hard to ensure its completion.

I look forward to the achievements that will occur as the strategy is implemented. Lives will be saved and the mental health of Albertans will improve. For your dedication to achieving this goal, I thank you so very much.

Sincerely yours,

Iris Evans
Minister, Alberta Health and Wellness

I am extremely gratified to write a letter of endorsement for the Alberta Suicide Prevention Strategy. The Province of Alberta has, for over two decades, been a beacon for initiatives in suicide prevention and has impacted the development of suicide prevention strategies nation-wide and worldwide. With the recent development of the Alberta Suicide Prevention Strategy, the province will continue its important leadership in our determination to end the tragedy of suicide for all Canadians.

Across Canada, almost 4000 people die by suicide each year and many more, perhaps 100 times as many, deliberately harm themselves. Suicide is an interaction of biological, psychological, social and spiritual factors and can be influenced by societal attitudes and conditions. In spite of over one hundred years of study, since the time of Durkheim's seminal research, suicide continues to affect us all. Yet we know that suicides are preventable by knowledgeable, caring, compassionate and committed communities and that suicide prevention is everyone's responsibility.

Very significant rays of light are ending the darkness of suicide. The stigma of mental illness and suicide has been driven back by the champions among us who have stepped forward and shared their stories. The impact of sharing these stories cannot be measured.

In Edmonton in October 2004, the Canadian Association for Suicide Prevention (CASP) released the *CASP Blueprint for a Canadian National Suicide Prevention Strategy*. Canada stands alone as one of the few developed nations without a national mental health action plan and without a federally endorsed national strategy for the prevention of suicide. The "Blueprint", available on the CASP website, provides a starting point for the formulation of goals and objectives needed for a national suicide prevention strategy. It also marks an important starting point and guide for the development of local, regional and provincial goals.

Although much work remains to stop the tragedy of suicide, real hope exists through further research, education, advocacy and commitment. We, as a nation, stand poised to advance suicide prevention in each and every community. By following the beacon of light shining from Alberta through development of the Alberta Suicide Prevention Strategy and the implementation of this strategy that will follow, we can brighten our prospects of preventing deaths by suicide. On behalf of the Canadian Association for Suicide Prevention, we send our congratulations and our thanks, Alberta!

Paul S. Links, MD, FRCPC
President, Canadian Association for Suicide Prevention
www.suicideprevention.ca

The Provincial Mental Health Plan identified the need to develop a province-wide suicide prevention strategy. The Alberta Mental Health Board has lead the collaborative development of this Call to Action which outlines an Alberta approach to reduce suicidal behaviour and its impacts over the next 10 years. This Strategy will serve to guide and support efforts at provincial, regional and local levels across Alberta.

Dr. John Read, Chairman
Alberta Mental Health Board

I don't think there's anyone in our society who hasn't been touched by suicide – whether a family member, neighbour or co-worker – we all know someone who has attempted suicide or died by suicide. The Alberta Suicide Prevention Strategy addresses this major societal issue.

Ray Block, President and CEO
Alberta Mental Health Board

EXECUTIVE SUMMARY

Suicide in Alberta

Suicide is consistently a leading cause of death among Albertans. Suicide claims more lives annually than other more openly discussed issues such as motor vehicle collisions, AIDS or homicide. Historically, Alberta has generally had a higher suicide rate than the overall national rate (Alberta Centre for Injury Control and Research, 2000).

According to Alberta Mental Health Board (AMHB), in the 2001/02 fiscal year, 466 people in Alberta died by suicide. But suicide deaths are just the tip of the iceberg. For every death, there were nearly six hospitalizations and more than 15 emergency room visits for self-inflicted injuries in one year alone.

Background

In 2004, *Advancing the Mental Health Agenda: A Provincial Mental Health Plan for Alberta* (PMHP) was released (Alberta Mental Health Board, Provincial Mental Health Planning Project, 2004). The PMHP was developed through a partnership of relevant stakeholders. One of the significant recommendations was the call for AMHB to lead the development of a province-wide suicide prevention strategy which would serve as a framework to guide effective suicide prevention programs among provincial, regional and community stakeholders.

Initial planning work involved reviewing background information, research and other relevant strategies. In December 2004 AMHB held forums and met with interested stakeholders to discuss the development of the strategy and obtain input from across Alberta. A key recommendation was that a provincial group be created to guide the process.

The Alberta Suicide Prevention Strategy Working Group was established early in 2005 to create a strategy. The Working Group was comprised of survivors, service providers, researchers, representatives from relevant provincial and federal government departments, suicide and mental health related agencies, regional health authorities, and other individuals and groups with an interest in suicide prevention.

In May the Working Group circulated a draft *Alberta Suicide Prevention Strategy* to over 200 individuals and groups who were identified as having a stake in suicide prevention. More than 45 responses were received, reflecting the views of countless more since most responses were on the behalf of organizations, groups and committees. The Working Group reviewed the feedback and incorporated it into the final draft.

The *Alberta Suicide Prevention Strategy* will be supplemented by a comprehensive implementation plan to stimulate action across the province.

Overview of the Alberta Suicide Prevention Strategy

The purpose of the *Alberta Suicide Prevention Strategy* is to prevent and reduce suicide, suicidal behaviour, and the effects of suicide in Alberta over the next 10 years. The strategy will target a 19% reduction of the provincial suicide rate. This 19% rate reduction target was adopted from *Framework for a Healthy Alberta* (Alberta Health and Wellness, 2003) which aims for a reduction in the provincial rate from 15.2 to 12.3 per 100,000 population by 2012.

Suicide affects our entire society directly and indirectly. Key strategies and approaches which are aimed at the general population as well as targeted efforts for identified priority groups are essential to providing a comprehensive approach to suicide prevention to provide intermediate and long-term outcomes. During the development of the implementation plan for the *Alberta Suicide Prevention Strategy*, criteria for defining provincial priority groups will be developed. There may also be more specific local priority groups for action, so criteria will also be developed to support individual communities or regions in identifying these.

The following goals and objectives relate to work that will be conducted at the local, regional, and provincial levels.

1. Secure targeted and sustainable funding to implement the *Alberta Suicide Prevention Strategy*.
2. Enhance mental health and well-being among Albertans.
3. Improve intervention and treatment for those at risk of suicide in Alberta.
4. Improve intervention and support for Albertans affected by suicide.
5. Increase efforts to reduce access to lethal means of suicide.
6. Increase research activities in Alberta on suicide, suicidal behaviour, and suicide prevention.
7. Improve suicide and suicidal behaviour-related surveillance systems in Alberta.
8. Increase evaluation and continuous quality improvement activities in Alberta for suicide prevention programs.

An Evaluation Framework will be developed within the first year and will be inclusive of both formative and summative aspects of the *Alberta Suicide Prevention Strategy*. The evaluation will be multi-staged in order to ensure the evaluation of all of the major components of the strategy.

SURVIVING IS SOMETHING YOU MUST DO EVERY DAY WHEN YOU LOSE A LOVED ONE THROUGH SUICIDE. MEN, WOMEN AND CHILDREN WILL GRIEVE, BUT SILENCE WILL BE BROKEN. WE WILL FIND ANSWERS TO OUR QUESTIONS ... AND IN THE END, WE WILL LIVE IN A SOCIETY THAT SEES SUICIDE AS A PROBLEM NOT A SOLUTION.
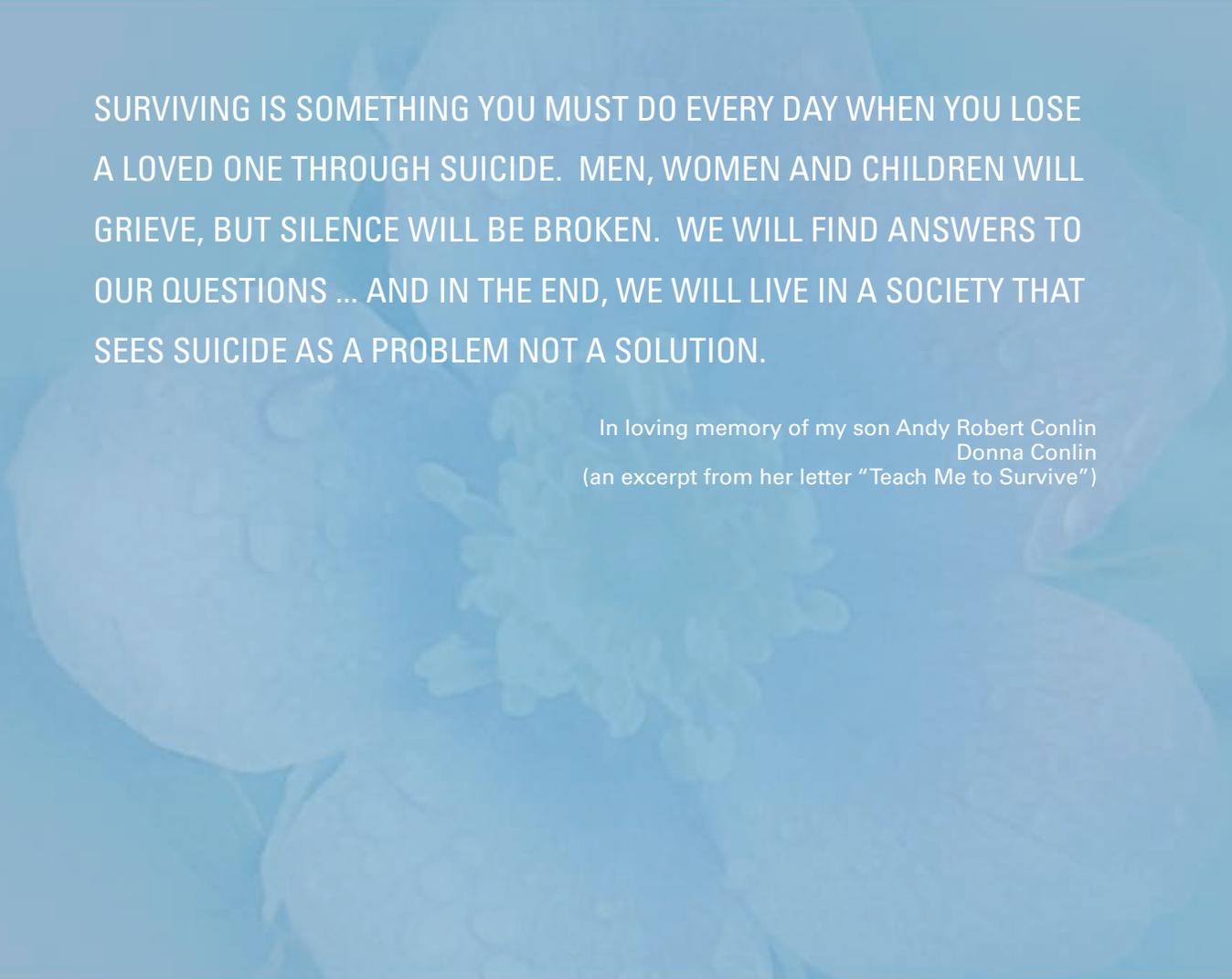
In loving memory of my son Andy Robert Conlin
Donna Conlin
(an excerpt from her letter "Teach Me to Survive")

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INTRODUCTION

Suicide in Alberta

Suicide is consistently a leading cause of death among Albertans. Suicide claims more lives annually than other more openly discussed issues such as motor vehicle collisions, AIDS or homicide. Historically, Alberta has generally had a higher suicide rate than the overall national rate (Alberta Centre for Injury Control and Research, 2000).

According to Alberta Mental Health Board (AMHB), in the 2001/02 fiscal year, 466 people in Alberta died by suicide. But suicide deaths are just the tip of the iceberg. For every death, there were nearly six hospitalizations and more than 15 emergency room visits for self-inflicted injuries in one year alone.

In many respects, Alberta follows international patterns for suicide. In particular, in Alberta and many parts of the world, there are gender differences in suicides and self-inflicted injuries. Men tend to die by suicide more frequently and women tend to be treated for self-inflicted injuries more frequently.

Coordinating Efforts

In 2004, *Advancing the Mental Health Agenda: A Provincial Mental Health Plan for Alberta* (PMHP) was released (Alberta Mental Health Board, Provincial Mental Health Planning Project, 2004). The Plan was developed through a partnership of relevant stakeholders. One of the significant recommendations was the call for AMHB to lead the development of a province-wide suicide prevention strategy to guide effective suicide prevention programs among provincial, regional and community stakeholders.

Initial planning work involved reviewing background information, research and other relevant strategies. In December 2004 AMHB held forums and met with interested stakeholders to discuss the development of the strategy and obtain input from across Alberta. The participants expressed an interest in a suicide prevention strategy and a commitment to the process of its development. A key recommendation was that a provincial group be created to guide the process.

Suicide prevention is becoming recognized as a systemic issue that cannot be the responsibility of one sector alone. There are a wide variety of factors that play a role in one's decision to attempt suicide and no one particular strategy will work for everyone. Issues such as addictions, homosexuality, and culture, and their relationship to suicide are complex and cannot be addressed without the active and meaningful participation of all stakeholders.

In February 2005 the Alberta Suicide Prevention Strategy Working Group met for the first time. The Working Group was comprised of survivors, service providers, researchers, representatives from relevant provincial and federal government departments, suicide and mental health related agencies, regional health authorities, and other individuals and groups with an interest in suicide prevention. For a complete list of Working Group members, see page 5.

The Working Group was responsible for three key tasks. First, it was responsible for preparing a draft suicide prevention strategy in a format suitable for review during a consultation process. Second, it ensured there was an effective consultation process with a broader range of stakeholders occurred across the province. Finally, the Working Group submitted a recommended suicide prevention strategy to the AMHB for consideration.

All of the partners involved in the process to date have been committed to ensuring the draft strategy will clearly link with existing suicide and mental health strategies relevant to Alberta, such as *A Provincial Mental Health Plan for Alberta* (Alberta Mental Health Board, Provincial Mental Health Planning Project, 2004) and the *Blueprint for a Canadian National Suicide Prevention Strategy* (Canadian Association for Suicide Prevention, 2004). The Working Group also utilized other national and international strategic work and their respective documents to guide its efforts, including strategies from Australia (Roxbee et al., 2000), Scotland (Scottish Executive, 2002), England (Department of Health, 2002), Norway (Holten & Norwegian Board of Health, n.d.), and Finland (Upanne & Arinperä, 1993). The Working Group also referred to the United Nations guidelines for the development of suicide prevention strategies (United Nations, Department for Policy Coordination and Sustainable Development, 1996) while developing the strategy.

"The Alberta Suicide Prevention Strategy is a comprehensive document for communities to use as a template for planning local and regional suicide prevention initiatives. The Strategy, model and background information will help to guide survivors, other stakeholders and service providers. It is hoped that new community partnerships will be forged around this strategy, so that we can enhance our work towards the goal of suicide prevention in Alberta."

Barbara Campbell   Suicide Prevention Resource Centre   Grande Prairie, Alberta

In May 2005 the Working Group circulated the draft *Alberta Suicide Prevention Strategy* to over 200 individuals and groups who were identified as having a stake in suicide prevention. More than 45 responses were received, reflecting the views of countless more since most responses were on the behalf of organizations, groups and committees. This feedback was reviewed and incorporated by the Working Group.

An *Alberta Suicide Prevention Strategy* implementation plan will be developed to stimulate action across the province.

Alberta Suicide Prevention Strategy

The *Alberta Suicide Prevention Strategy* begins with a discussion of the purpose and priority groups and then outlines the goals and objectives of the provincial strategy. A glossary of terms is included at the end of the document to explain how various terms were defined for the purpose of this document. An Appendix to the strategy is also available which provides further information about the development of the strategy as well as a detailed report on suicide and self-inflicted injury data.

In addition to the Strategy and Appendix documents, a document containing background information about suicide, risk and protective factors, and international strategic work has been compiled.

To obtain a copy of the Appendix or Background Information, please visit **www.amhb.ab.ca**.

"The comprehensiveness of this strategy reflects the longstanding commitments of many Albertans to make our province a suicide-safer community for everyone."

Dick Ramsay | LivingWorks Education | Calgary, Alberta

ALBERTA SUICIDE PREVENTION STRATEGY

PURPOSE

The purpose of the *Alberta Suicide Prevention Strategy* is to prevent and reduce suicide, suicidal behaviour, and the effects of suicide in Alberta over the next 10 years. The strategy will target a 19% reduction of the provincial suicide rate.

This 19% reduction target was adopted from *Framework for a Healthy Alberta* (Alberta Health and Wellness, 2003) which aims for a reduction in the provincial rate from 15.2 to 12.3 per 100,000 population by 2012.

PRIORITY GROUPS

Suicide affects our entire society directly and indirectly. Key strategies and approaches which are aimed at the general population as well as targeted efforts for identified priority groups are essential to providing a comprehensive approach to suicide prevention to provide intermediate and long-term outcomes.

A Provincial Mental Health Plan for Alberta (Alberta Mental Health Board, Provincial Mental Health Planning Project, 2004) has identified the general population, school-aged children, and vulnerable populations such as Aboriginal youth as priorities for suicide prevention.

During the development of an implementation plan for the *Alberta Suicide Prevention Strategy*, criteria for defining provincial priority groups will be developed. There may also be more specific local priority groups for action, so criteria will also be developed to support individual communities or regions in identifying these.

At-Risk Groups

It is known that there are a number of factors which either protect people or put them at increased risk for suicide. These risk and protective factors exist at all levels, from the individual to their surrounding environments, and help to expose the various intervention strategies that may help prevent suicidal behaviour. Individuals may fit into one or more risk groups. For more information about the factors and the Determinants of Health, see *Alberta Suicide Prevention Strategy: Background Information*.

The following groups are believed to be at risk for suicide and will be considered as priority groups for the *Alberta Suicide Prevention Strategy*.

ABORIGINAL PEOPLES

Aboriginal peoples include a number of specific groups including First Nations, Inuit and Métis.

Although Aboriginal peoples are generally at a higher risk for suicide, not all Aboriginal communities are affected by suicide to the same extent. There are noticeable differences between provinces, regions and even between communities in the same area. Some communities have suffered the loss of many people, including young people, while others are almost untouched by suicide. One Canadian study from the University of British Columbia identified six protective factors that may explain the difference in suicide rates between First Nations communities. This study found that communities involved in self-sustaining activities such as land claims, self-government, education services, police and fire services, health services, or cultural facilities, have fewer suicides (Chandler & Lalonde, 1998).

Suicide is the second leading cause of injury death among the First Nations people in Alberta. When looking at mortality, suicide is among the largest disparities between First Nations people and the Canadian population. Suicide rates among First Nations males are 2.6 times higher than for the Canadian population in general. Among First Nations females the rates are four times higher (Alberta Centre for Injury Control and Research, 2000).

AFFECTED BY THE AFTERMATH OF SUICIDAL BEHAVIOUR OR A SUICIDE DEATH

Family members, significant others, or acquaintances who have experienced the suicide or self-injury of a loved one are at an increased risk of suicide themselves. They may begin to perceive suicide as a way of ending their own problems (Centre for Suicide Prevention, 1999).

CHRONICALLY OR TERMINALLY ILL

As with any suicide risk factor, terminal illness is not believed to be a sole cause for suicide. Suicidal risk may be elevated by physical pain, psychological pain, social isolation and other factors related to being terminally or chronically ill such as a realization that the suffering will not end.

DIAGNOSED WITH A MENTAL ILLNESS

According to data prepared by Information Management at Alberta Mental Health Board, 85.6% of individuals discharged from regional acute hospitals with self-inflicted injuries also had a mental health issue in their diagnosis on discharge. And 61.7% of individuals who visited Emergency Rooms with self-inflicted injuries also had a mental health issue.

ELDERLY

Suicide among the elderly is a concern in Alberta. According to data prepared by Information Management at Alberta Mental Health Board, while the rate for suicide among Albertans aged 65 and older has decreased between fiscal years 1997/98 and 2001/02, the rates increased for the 75 to 79 year age group.

HOMELESS

Homeless adults and youth are at risk for suicide. A study among homeless adults in Los Angeles County revealed that 22% of those surveyed had attempted suicide in their lifetime and 25% reported thinking about suicide that year (Gelberg et al., 1988). In a Canadian study, Eynan et al. (2002) found that 61% of those surveyed reported suicidal thoughts and 34% reported a suicide attempt during their lifetime. A study of street youth revealed that 46% of those interviewed had attempted suicide at least once, and the majority of those had made more than one attempt (Kidd, 2004).

IN CUSTODY

Suicide is common in correctional facilities. It is the leading cause of death for inmates. In 1996/97, the adult inmate suicide rate was more than twice the suicide rate of the adult Canadian population. Some suicide risk factors that are important for those in custody include how one views their imprisonment, the effects of incarceration, the conditions of the correctional facility, one's own history, current life or family situation, and race (John Howard Society of Alberta, 1999).

LIVING IN RURAL AND REMOTE AREAS

Albertans living in rural areas are at an increased risk of dying by suicide. According to data prepared by Information Management at Alberta Mental Health Board, in the 2001/02 fiscal year the rate of suicide per 100,000 population for rural Alberta was 18.0 while the rate for urban Alberta was 13.8. In this analysis, urban Alberta was defined as the Capital and Calgary health regions.

SUBSTANCE ABUSE AND PROBLEM GAMBLING

Research demonstrates that substance abuse is a risk factor for suicide, especially when it is coupled with another mental illness (De Leo & Evans, 2004). There are a variety of substances which have been linked to suicide, although it is believed that alcohol may have the largest impact because of its widespread use across the lifespan (De Leo & Evans, 2004). One study found that the relative risk of suicide was almost seven times higher among alcohol abusers than among non-abusers (Rossow & Amundsen, 1995). According to researchers Bergman and Brismar (1994), one quarter of alcoholic males studied had attempted suicide at least once. Consumption of alcohol and access to some toxic substances and to firearms may also be connected with suicide rates (WHO, 2001a).

Although there are no firm data on suicide deaths due to problem gambling, research shows there is a link between problem gambling and suicide attempts. In a telephone survey of 7,214 randomly sampled participants, Newman and Thompson (2003) assessed lifetime histories of psychiatric disorders and suicidal attempts. They found that, based on the 30 cases of pathological gambling identified, pathological gamblers were four times more likely to attempt suicide than non-pathological gamblers. They further suggest that the common link between problem gambling and suicide may be the association of both to mental illness. A Quebec study by Bourget et al. (2003) examined key characteristics of 75 problem gamblers who died by suicide. They reported that 25.3% of the deceased had previously attempted suicide – lower than what is usually found among the general population. The study also found an increase in suicides related to pathological gambling from six in 1998 to 31 in 1999 and 20 in 2000.

MIDDLE-AGED MALES

In general, more males die by suicide each year as compared to females. According to data prepared by Information Management at Alberta Mental Health Board, middle-aged males appear to be at increased risk. Suicides among males between 35 and 59 years of age have increased over a ten year period between fiscal years 1992/93 and 2001/02.

PREVIOUS SUICIDE ATTEMPTERS

Rates of repeated hospitalizations include those patients who were admitted more than once in a fiscal year for self-inflicted injuries (any self-inflicted injury, not necessarily for the same type of injury). According to data prepared by Information Management at Alberta Mental Health Board, the provincial rate of repeated hospitalizations in fiscal year 2001/02 was 1.1, which indicates that provincially, persons were admitted just over once, on average, to regional inpatient hospitals for self-inflicted injuries.

SCHOOL-AGED TEENS AND YOUNG ADULTS

Suicide among school-aged teens and young adults is a concern in Alberta. Only a small difference exists when comparing the suicide death rate of Albertans aged 15 to 24 years with the general population of Albertans of all ages; those aged 15 to 24 years had a suicide rate of 18.6 per 100,000 population in the 2001/02 fiscal year, while the provincial suicide rate for all ages is 15.2 for the same period. However, the picture is different when looking at self-inflicted injury. The rate of hospitalizations for self-inflicted injuries among 15 to 24 year olds is nearly double the provincial rate for Albertans of all ages, according to data prepared by Information Management at Alberta Mental Health Board. The disparity is even greater when examining emergency room visits where the rate for 15 to 24 year olds is more than two times higher than the provincial rate for all ages.

GAY, LESBIAN, BISEXUAL, TRANSGENDERED AND TWO-SPIRITED YOUTH

Research demonstrates that gay, lesbian, bisexual and transgendered youth are at an increased risk for suicidal behaviour. Over the past 20 years, research results from varied non-random samples of gay, lesbian and bisexual male and female youth have produced incidences ranging from 20% to 42% for having attempted suicide in their lifetime (Remafedi, 1999). A study from Calgary, Alberta reported that homosexually oriented young adult males were at about 14 times more risk for a serious suicide attempt than their heterosexual counterparts (Bagley and Tremblay, 1997).

WORKING IN SPECIFIC OCCUPATION GROUPS

Although the occupation of the deceased is not recorded on every death file, the existing data demonstrate important differences between occupation groups. According to data prepared by Information Management at Alberta Mental Health Board, in the 2001/02 fiscal year, the most common occupations among those who died by suicide were labourer, student, and homemaker. For females, the top three were homemaker, student and waitress. For males, the top three were labourer, student and truck driver.

VICTIMS OF FAMILY VIOLENCE

Experiencing abuse from a parent during childhood is related to suicidal behaviour. A study by Dieserud et al. (2002) found that negative childhood events, including parental abuse, contribute significantly to risk for adult suicidal behaviour.

"The development of a comprehensive provincial suicide prevention strategy is an important first step in addressing the tragic loss of life that touches many Albertans. However, there remains much that we need to understand about the act of suicide and the suicidal state. A commitment to research, in conjunction with the implementation of this strategy provincially, will help to ensure that in the future, Albertans have access to effective services and interventions when they are needed."

Dr. Robin Everall | University of Alberta

GOALS AND OBJECTIVES

The *Alberta Suicide Prevention Strategy* consists of eight goals and their corresponding objectives, all aimed at preventing and reducing suicide, suicidal behaviour, and the effects of suicide over the next 10 years. The following goals and objectives relate to work that will be conducted at the local, regional, and provincial levels. Further details about this will be outlined in the forthcoming Implementation Plan for the strategy.

Goals:

1. **Secure targeted and sustainable funding to implement the *Alberta Suicide Prevention Strategy*.**

2. **Enhance mental health and well-being among Albertans.**

3. **Improve intervention and treatment for those at risk of suicide in Alberta.**

4. **Improve intervention and support for Albertans affected by suicide.**

5. **Increase efforts to reduce access to lethal means of suicide.**

6. **Increase research activities in Alberta on suicide, suicidal behaviour, and suicide prevention.**

7. **Improve suicide and suicidal behaviour-related surveillance systems in Alberta.**

8. **Increase evaluation and continuous quality improvement activities in Alberta for suicide prevention programs.**

Goal 1 Secure targeted and sustainable funding to implement the Alberta Suicide Prevention Strategy.

OBJECTIVES

1.1   Develop an implementation plan and associated cost analysis for the *Alberta Suicide Prevention Strategy*.

1.2   Develop a process for defining priority groups at provincial and local levels.

1.3   Secure funding commitment that is adequate, equitable, and fair to implement the *Alberta Suicide Prevention Strategy*.

Goal 2 Enhance mental health and well-being among Albertans.

OBJECTIVES

2.1 Increase the number of public, private, professional and voluntary organizations that integrate suicide prevention into their ongoing programs and activities, including, but not limited to, education curriculum and private industry.

2.2 Identify and increase the number of provincial and local activities that are proven to enhance developmental and protective factors.

2.3 Identify and increase the number of plans to reduce the stigma attached to accessing mental health services or other suicide prevention supports.

2.4 Identify and increase the number of culturally-sensitive plans to increase public awareness that suicide is a community-wide problem that is preventable.

2.5 Identify and increase the number of culturally-appropriate provincial and local activities that are proven to address common precursors for suicide.

2.6 Increase the number of provincial and local activities that offer a culturally appropriate community development approach to promote the mental well-being of Aboriginal peoples.

2.7 Establish or adopt guidelines and develop training for the accurate and responsible reporting of suicide in the media.

2.8 Increase the proportion of television and news reports that follow the media guidelines.

Goal 3 Improve intervention and treatment for those at risk of suicide in Alberta.

OBJECTIVES

3.1 Increase appropriate and timely access to treatment services for those at risk of suicide.

3.2 Enhance community and regional capacity to develop, implement and evaluate evidence-based intervention and treatment programs that reduce risk for target groups.

3.3 Support and enhance evidence-based training programs for service providers that identify and intervene with those at risk of suicide, including, but not limited to, physicians, mental health workers, clinicians, police, counselors, addictions counselors, teachers, emergency medical services, employee assistance programs, and clergy.

3.4 Develop and implement cross-jurisdictional and system-wide protocols for the consistent and seamless support and treatment of those at risk for suicide.

3.5 Support the development of programs that offer the choice of using traditional healing practices in the treatment of Aboriginal peoples at risk for suicide.

3.6 Develop and disseminate evidence-based screening and intervention guidelines.

Goal 4 Improve intervention and support for Albertans affected by suicide.

OBJECTIVES

4.1 Enhance community and regional capacity to develop, implement and evaluate services and support programs for those bereaved by suicide.

4.2 Support the development of programs that offer the choice of using traditional healing practices for Aboriginal peoples bereaved by suicide.

4.3 Enhance community and regional capacity to develop, implement and evaluate services to support those who care for suicidal persons.

Goal 5 Increase efforts to reduce access to lethal means of suicide.

OBJECTIVES

5.1   Identify provincial areas of priority for reducing access
       to lethal means of suicide.

5.2   Support the development of policies, in partnership with
       relevant industries and service-providers, which will reduce
       access to lethal means of suicide in identified priority areas.

5.3   Support the enhancement of standard treatment policies to
       include educating people who care for those at risk of suicide
       about restricting access to lethal means of suicide.

Goal 6 Increase research activities in Alberta on suicide, suicidal behaviour, and suicide prevention.

OBJECTIVES

6.1 Establish and secure funding for a provincial suicide research agenda that is consistent with the themes identified by the Canadian Institutes of Health Research (see below) and developed in collaboration with the Alberta Research Centre for the Advancement of Mental Health and other applicable research organizations.

Canadian Institutes of Health Research Suicide Themes (Canadian Institutes of Health Research and Health Canada, 2003):

- Data Systems: Improvement and Expansion
- Evidence-Based Practices
- Mental Health Promotion
- Multidimensional Models for Understanding Suicide-Related Behaviours
- Spectrum of Suicide Behaviours, including Suicide Attempters
- Suicide in Social and Cultural Contexts

6.2 Develop strategic partnerships and linkages with national and international organizations working in suicide prevention research.

Goal 7 Improve suicide and suicidal behaviour-related surveillance systems in Alberta.

OBJECTIVES

7.1 Improve the collection, analysis, interpretation and timely dissemination of data on suicide and suicidal behaviour.

7.2 Establish and support partnerships among various health information systems, mental health surveillance systems, and other sources of suicide-related data.

7.3 Increase the connection between provincial death data and health data to allow for links between the deceased and the health services they accessed while alive.

Goal 8 Increase evaluation and continuous quality improvement activities in Alberta on suicide prevention programs.

OBJECTIVES

8.1 Develop and implement an on-going and comprehensive evaluation framework for the *Alberta Suicide Prevention Strategy* including evaluation of activities at local, regional and provincial levels.

8.2 Increase the dissemination of best or promising practices in suicide prevention in collaboration with the Centre for Suicide Prevention, the Alberta Research Centre for the Advancement of Mental Health, and other stakeholders.

EVALUATING THE ALBERTA SUICIDE PREVENTION STRATEGY

The vision statement of the *Provincial Mental Health Plan for Alberta* (Alberta Mental Health Board, Provincial Mental Health Planning Project, 2004) clearly articulates the need for a culture of continuous improvement, evaluation and innovation (p. 11). The Principles of the *Alberta Suicide Prevention Strategy* further reflect this vision by stating that continuous quality improvement through research, surveillance, and evaluation will be an integral part of the *Alberta Suicide Prevention Strategy* models, and inclusion of these activities will be an expectation at both regional/local and provincial levels.

The *Alberta Suicide Prevention Strategy* is a 10-year strategy with accompanying measurable objectives and immediate, intermediate, and ultimate outcomes. An Evaluation Framework will be developed within the first year and will be inclusive of both formative and summative aspects of the *Alberta Suicide Prevention Strategy*. The evaluation will be multi-staged in order to ensure the evaluation of all of the major components of the strategy. Formative strategies will focus on key activities and processes as a means of generating information about the extent to which the strategy is implemented and how implementation can be modified to increase efficiency, improve quality, and better achieve outcomes. Summative strategies will assess effectiveness or the extent to which the immediate, intermediate and ultimate outcomes are achieved. This may or may not require a team of external evaluators.

After formative and summative aspects of the evaluation in each stage are complete, performance measures will be standardized and assessed on an ongoing basis to ensure that a continuous quality improvement cycle is maintained for the duration of the strategy and beyond. The following table illustrates a proposed timeline for the evaluation of the strategy.

ALBERTA SUICIDE PREVENTION STRATEGY EVALUATION TIMELINE

	YEAR										
	1	2	3	4	5	6	7	8	9	10	11+
Development of Evaluation Framework	X										
Collection of baseline data to support the Evaluation Framework	X	X									
Formative evaluation		X	X	X	X						
Summative evaluation		X S	X S	X S	X I	X I	X I	X L	X L	X L	
Development of standardized performance measures for ongoing quality assessment (iterative process) and continuous quality improvement			X	X	X	X	X	X	X	X	X

Key: S - Short-term outcomes   I - Intermediate outcomes   L - Long-term outcomes

GLOSSARY OF TERMS

The Working Group acknowledges that numerous definitions exist for many of the following terms. The definitions listed below come from a variety of sources and were adopted by the Working Group for the development of this strategy and companion documents.

Aboriginal	In section 35 of the Constitution Act, 1982, Aboriginal Peoples of Canada are identified as the *"Indian, Inuit and Métis peoples of Canada"* (Government of Alberta, 2000).
Best Practice	The provision of care and service utilizing evidence-based decision-making and a continuous quality improvement approach focused on best outcome within the context of available resources. It operationalizes evidence-based practice (Alberta Mental Health Board, 2005).
Community Development	A process of social action in which the people of a community come together to identify their common needs and concerns, make plans to meet their needs and solve their problems, and execute the plans with a maximum reliance on community strengths and resources (Gardiner & Gaida, 2002).
Co-morbidity	The co-occurrence of any two illnesses; often used to refer to the coexistence of a mental illness and an addictive disorder within an individual (Alberta Mental Health Board, 2005).
Contagion	A phenomenon whereby susceptible individuals are influenced towards suicidal behaviour through the knowledge of another person's suicidal acts (US Department of Health and Human Services, Public Health Service, 2001).
Contributing Factors	Contributing factors increase the exposure of the individual to either predisposing or precipitating factors. These include physical illness, sexual identity issues, unstable family, physical illness, risk-taking or self-destructive behaviour, suicide of a friend, isolation and substance abuse (Health Canada, 2002).
Crisis	An upset in an individual's baseline level of functioning that is generally thought to last no more than four to six weeks (Callahan, 1994).
Crisis Centers and Hotlines	Provides emergency support for people in crisis including those who are suicidal. Trained volunteers usually staff hotlines (Gardiner & Gaida, 2002).

Crisis Intervention

Brief, focused treatment that is begun when the individual is in crisis. The goal is the resolution of the crisis and the attainment of a state of equilibrium (Callahan, 1994).

Determinants of Health

A number of factors that work together to make people healthy, or not. They include:
- the social and economic environment,
- the physical environment, and
- the person's individual characteristics and behaviours (Canadian Health Network, 2005).

Epidemiology

The scientific study of statistics and trends in health and disease across communities (US Department of Health and Human Service, Public Health Service, 2001).

Evaluation

The systematic investigation of the value and impact of an intervention or program (US Department of Health and Human Service, Public Health Service, 2001).

Evidence-Based Practice

A decision-making process based on the most available and current literature, studies, and expert opinion that is known to have beneficial and effective outcomes. To utilize evidence based decision-making, clinicians are using search skills, critical appraisal skills and clinical judgment. The best evidence must then be applied by a clinician with expertise in considering the patient's unique values and needs. The final aspect of the process is evaluation of the effectiveness of care and the continual improvement of the process (Alberta Mental Health Board, 2005).

Family Support

Provides a variety of services designed to help parents fulfill their childrearing responsibilities. Services such as parent support groups, family counseling or emergency assistance, empower and strengthen parents with the aim of enhancing the overall health and well-being of family systems. By working with the family unit, family support programs aim at reducing risk factors, while enhancing important protective factors such as warm and caring parent-child relationships and the modeling of healthy adjustment by parents (Gardiner & Gaida, 2002).

First Nations

A term that came into common usage in the 1970s to replace the word "Indian," which some people found offensive. Although the term First Nation is widely used, no legal definition of it exists. Among its uses, the term "First Nations peoples" refers to the Indian peoples in Canada, both Status and Non-Status. Some Indian peoples have also adopted the term "First Nation" to replace the word "band" in the name of their community (Indian and Northern Affairs Canada, Communications Branch, 2004).

Formative Evaluation	Measuring the processes of program implementation, deliberation, and decision-making about the forms, modifications, and characteristics of services over time to provide information for program improvement (Fitz-Gibbon & Morris, 1987; Speer, 1998).
Gatekeepers	Individuals in a community who have contact with large numbers of community members as part of their usual routine. These individuals may be trained to identify people at risk of suicide and refer them to treatment or support services as appropriate (US Department of Health and Human Services, Public Health Service, 2001).
Gatekeeper Training	Provide the knowledge, skills and attitudes necessary for individuals to become effective gatekeepers (Gardiner & Gaida, 2002).
Generic Skill-Building	Enhance an individual's personal capabilities so that they may be able to adapt and deal effectively with daily tasks, challenges, and stresses.
	Generic skill building aims at enhancing certain factors that are known to protect against suicidal tendencies including creative problem solving, healthy coping, and interpersonal competence, which in turn contribute to positive self-esteem (Gardiner & Gaida, 2002).
Gestures	Behaviours where the intent is to gesture or communicate with others rather than to die (Linehan, 2000).
Impulsivity	Activities abruptly engaged in without forethought by an individual or consideration of potential consequences (Goldensen, 1984).
Indian	The term "Indian" collectively describes all the Indigenous people in Canada who are not Inuit or Métis. There are three categories of Indians in Canada: Status Indians, Non-Status Indians and Treaty Indians (Indian and Northern Affairs Canada, Communications Branch, 2004).
Intent	What the patient wants to achieve by suicidal acts, whether it is to die or to influence some significant other (Hjelmeland and Knizek, 1999).
Intentional	Injuries resulting from purposeful human action whether directed at oneself (self-directed) or others (assaultive), sometimes referred to as violent injuries (US Department of Health and Human Services, Public Health Service, 2001).
Intervention	A strategy or approach that is intended to prevent an outcome or to alter the course of an existing condition (US Department of Health and Human Services, Public Health Service, 2001).

Inuit	The Aboriginal people of Arctic Canada. Inuit live primarily in Nunavut, the Northwest Territories and northern parts of Labrador and Quebec. They have traditionally lived above the tree line in the area bordered by the Mackenzie Delta in the west, the Labrador coast in the east, the southern point of Hudson Bay in the south, and the High Arctic islands in the north.
	Inuit are not covered by the Indian Act. However, in 1939 the Supreme Court interpreted the federal government's power to make laws affecting "Indians, and Lands reserved for the Indians" as extending to Inuit (Indian and Northern Affairs Canada, Communications Branch, 2004).
Means Restriction	Suicide prevention efforts that reduce access to firearms, drugs, high places and other common means of suicide (Gardiner & Gaida, 2002).
Media Education	Educate the media about responsible suicide reporting practices in an effort to lower the negative and potentially contagious effects that sensational publicity about suicides can have on vulnerable people (Gardiner & Gaida, 2002).
Mental Disorder	A diagnosable illness characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress that significantly interferes with an individual's cognitive, emotional or social abilities; often used interchangeably with mental illness (US Department of Health and Human Services, Public Health Service, 2001).
Mental Health	Cannot be defined as simply the absence of detectable mental disease but a state of well-being in which the individual realizes his or her own abilities, can work productively and fruitfully, and is able to contribute to his or her community.
	The capacity of the individual, the group, and the environment to interact with one another in ways that promote subjective well-being, the optimal development and use of mental abilities (cognitive, affective and relational), the achievement of individual and collective goals consistent with justice and the attainment and preservation of conditions of fundamental equality (Alberta Mental Health Board, 2005).
Mental Health Promotion	A variety of strategies, all aimed at having a positive effect on mental health. The encouragement of individual resources and skills and improvements in the socio-economic environment are among them. Mental health promotion requires multi-sectoral action, involving a number of government sectors such as health, employment/industry, education, environment, transport and social and community services as well as non-governmental or community-based organizations such as health support groups, churches, clubs and other bodies (World Health Organization, 2001b).

Mental Illness	A term that refers collectively to all mental disorders; i.e., "health-related conditions that are characterized by alterations in thinking, mood, or behaviour (or some combination thereof) associated with distress and/or impaired functioning" (Alberta Mental Health Board, 2005).
Methods	Actions or techniques which result in an individual inflicting self-harm (US Department of Health and Human Services, Public Health Service, 2001).
Métis	The by-laws of the MNAA (Métis Nation of Alberta Association) define Métis membership as follows: "Métis means an Aboriginal person who self-identifies as Métis, who is distinct from Indian, and Inuit and (a) is a descendant of those Métis who received or were entitled to receive land grants and/or Scrip under the provisions of the *Manitoba Act*, 1870, or the *Dominion Lands Acts*, as enacted from time to time; and (b) a person of Aboriginal descent who is accepted by the Local Community as a Métis person" (Government of Alberta, 2000).
Organizational Policy	An organizational policy mandates and guides the effective handling of crisis situations within the organization's environment (Gardiner & Gaida, 2002).
Postvention	Activities that occur after a suicidal event, aimed at supporting those bereaved by suicide or the family and friends of someone who has attempted suicide.
Precipitating Factors	Precipitating factors are acute factors that create a crisis, such as interpersonal conflict or loss, pressure to succeed, conflict with the law, loss of stature in society, financial difficulties or rejection by society for some characteristic such as ethnic origin or sexual orientation (Health Canada, 2002).
Predisposing Factors	Predisposing factors are enduring factors that make an individual vulnerable to suicidal behaviour. They include mental illness, abuse, early loss, family history of suicide and difficulty with peer relationships (Health Canada, 2002).
Prevention	The identification of high-risk groups (and the individuals within them), the ready availability of responsive services; the dissemination of information, particularly about prodromal clues; the lowering of taboos so that citizens can more easily ask for help; the sensitization of professionals and ordinary citizens to the recognition of potential suicide, and so on (Shneidman, 1973).

Promising Practice	Incorporates the philosophy, values, characteristics, and indicators of other positive/effective public health interventions.
	• Is based on guidelines, protocols, standards, or preferred practice patterns that have been proven to lead to effective public health outcomes.
	• Is a process of continual quality improvement that:
	  • Accumulates and applies knowledge about what is working and not working in different situations and contexts;
	  • Continually incorporates lessons learned, feedback, and analysis to lead toward improvement/positive outcomes; and,
	  • Allows for and incorporates expert review, feedback, and consensus from the public health field.
	• Has an evaluation component/plan in place to move towards demonstration of effectiveness, however, it does not yet have evaluation data available to demonstrate positive outcomes (Alberta Mental Health Board, 2005).

Protective Factors	Factors that make it less likely that individuals will develop a disorder or engage in suicidal behaviours. These factors may encompass biological, psychological or social factors in the individual, family, society, and environment (US Department of Health and Human Services, Public Health Service, 2001).
Rates of Suicide	The number of actual suicides divided by the number of possible suicides. Rates of suicide are most often presented per 100,000 population (Centre for Suicide Prevention, 1997).
Research	Can be described both as the "systematic investigation to establish facts" and more broadly as "a search for knowledge". The actual methods used to ascertain this information can be varied. Quantitative methods focus on testing of hypotheses, finding generalizable results, measuring outcomes, or proving cause and effect relationships. Qualitative methods concentrate on exploring phenomena, developing theories, formulating hypotheses, and creating or expanding knowledge. Additionally, indigenous ways of knowing also constitute a class of research (Alberta Mental Health Board, 2005).
Resilience	Capacities within a person that promote positive outcomes and provide protection from factors that might otherwise place the person at risk for adverse health outcomes (US Department of Health and Human Services, Public Health Service, 2004).
Risk Factors/ Indicators	Well-defined constructs that are empirically derived and population dependent. Risk factors tend to suggest risk over enduring periods of times. They can be explored individually and have significant meaning, even as isolated variables. Risk factors have limited implications for intervention and clinical practice (Rudd, 2003).

School Climate Improvement	A deliberate and planned process whereby a school takes an in-depth look at certain elements of its climate and then takes steps to positively influence these. The aim of this component is to organize the educational setting in ways that will enhance the well-being and health of students and staff (Gardiner & Gaida, 2002).
Screening	The routine administration of an instrument or procedure in order to find those individuals who are in need of a particular treatment or service. By directly asking people about their emotional state, screening actively seeks out suicidal individuals and ensures that everyone has an equal chance of being identified as to their potential risk status. Screening programs have been designed to identify and provide treatment or other assistance for individuals at high risk of suicide (Gardiner & Gaida, 2002).
Self-Harm	The various methods by which individuals injure themselves, such as self-laceration, self-battering, taking overdoses or exhibiting deliberate recklessness (US Department of Health and Human Services, Public Health Service, 2001).
Self-Mutilation	The direct and deliberate destruction or alteration of body tissue without conscious suicidal intent (Favazza, 1999).
Stigma	An object, idea, or label associated with disgrace or reproach (US Department of Health and Human Services, Public Health Service, 2001).
Suicidal Behaviour	A spectrum of activities related to thoughts and behaviors that include suicidal thinking, suicide attempts, and completed suicide (US Department of Health and Human Services, Public Health Service, 2001).
Suicidal Ideation	Having thoughts about killing oneself (Evans and Farberow, 1988).
Suicide	A conscious or deliberate act that ends one's life (Roxbee et al., 2000).
Suicide attempt	A potentially self-injurious behavior with a non-fatal outcome, for which there is evidence (either explicit or implicit) that the person intended at some (nonzero) level to kill him/her-self. A suicide attempt may or may not result in injuries (O'Carroll et al., 1996).
Suicide Attempt Survivors	Individuals who have survived a prior suicide attempt (US Department of Health and Human Services, Public Health Service, 2001).
Suicide Awareness Education	Provide individuals with the necessary attitudes, knowledge, and skills to be able to identify and help a potentially suicidal friend (Gardiner & Gaida, 2002).

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 (US Department of Health and Human Services, Public Health Service, 2001).
Summative Evaluation	Determining the effectiveness, value, or worth of services through the measurement of program outcomes in order to make basic decisions about whether a program is effective and whether it should be continued (Fitz-Gibbon & Morris, 1987; Speer, 1998).
Support Groups	Bring together vulnerable individuals in a caring and comfortable group environment where they receive the support of peers and practice valuable life skills. Support groups serve the purpose of counteracting a number of early risk factors experienced by vulnerable people, while enhancing important protective factors (Gardiner & Gaida, 2002).
Surveillance	The ongoing, systematic collection, analysis and interpretation of health data with timely dissemination of findings (US Department of Health and Human Services, Public Health Service, 2001).
System Wide Protocols	A joint agreement between key agencies within a geographic area that reflects a coordinated response to people at risk. System wide protocols document the procedures to be followed by each agency in the aftermath of specific situations, such as a youth suicide attempt or cluster suicide in the community (Gardiner & Gaida, 2002).
Transgendered	A person whose gender identity, outward appearance, expression and/or anatomy do not fit into conventional expectations of male or female. Often used as an umbrella term to represent a wide range of non-conforming gender identities and behaviours (Wells & Tsutsumi, 2005).
Treatment Services	Includes screening, assessment and clinical intervention. Linkage to other supports and education is available. Short-term treatment may be sufficient. Longer term rehabilitation and support is needed for others (Gardiner & Gaida, 2002).
Two-spirited	Some Aboriginal people identify themselves as two-spirited rather than as lesbian, gay, bisexual or trans-identified. Historically, in many Aboriginal cultures, two-spirited persons were respected leaders and medicine people and were often accorded special status based on their unique abilities to understand both male and female perspectives (Wells & Tsutsumi, 2005).
Warning Signs	Often poorly defined constructs that suggest imminent risk of suicide demanding specific and probably immediate interventions. They can be clinically identified or derived and can be applied to individual cases. They are of an episodic or transient nature (Rudd, 2003).

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