Winnipeg Health Region Suicide Prevention
3 Year Action Plan 2004 - 2007

Introduction

This report outlines the Winnipeg Health Region (WHR) Suicide Prevention Action Plan. The Winnipeg Regional Health Authority (WRHA) engaged numerous community partners and stakeholders in a process of collaboration to begin to address the problem of suicide across the life span in our health region. An outcome of this collaboration is a 3-year action plan. This plan has been developed by the WRHA however it reflects activities and collaborations that go beyond direct WRHA services and activities. This plan builds on necessary partnerships that are inter-sectoral as we recognize that suicide prevention is everyone’s responsibility and not the exclusive responsibility of any one sector of society or of health services alone.

Scope of the problem

Suicide and suicide attempts are serious population health issues that cut across the life span, gender, culture, income and educational levels. Each year approximately 4000 Canadians die by suicide - that is more than 10 suicides per day. Among people who experience suicidal ideation only a minority actually take their own lives. For every fatal suicide there are a number of non-fatal suicide attempts. About 10 % of those who attempt suicide do eventually kill themselves. For every fatal suicide there are another 5-6 people, “survivors” (family, friends, colleagues) whose lives are profoundly affected emotionally, socially and economically. (Diekstra et al., 1995)

In addition to the enormous personal impact, suicide mortality and morbidity are major costs to the health sectors and to society in general. These costs include:

- Premature loss of life
- The provision of medical, surgical, emergency, mental health and rehabilitative services to those making non-fatal attempts
- Bereavement and other psychological and physical health impacts on family and others closely involved with individuals making fatal and non-fatal suicide attempts
- Loss of productivity for those involved in the suicidal behaviours as well as for those affected by it

Accurate cost evaluations are not available, as they would require long term follow-up. However, in general terms suicide and suicide attempts are estimated to cost billions of dollars each year world-wide.

Suicide is currently the 5th leading cause of death among Canadians and is the second leading cause of death among Canadian children and youth aged 10 –24.

Final revisions completed on December 10, 2004
years. Canadian males had national suicide rates four times higher than females. The rates of suicide for people of Aboriginal descent are at least 2 to 4 times greater than those of the general population and may be as high as 7 times the national average in some communities (Kirmayer, 1994).

Manitoba ranks 6\textsuperscript{th} out of all provinces, with a suicide rate of 13 per 100,000. (Statistics Canada Health Report, 2001) The report “Injuries in Manitoba: A 10-Year Review” which examined injury deaths that occurred from 1992 to 1999, indicated that suicide was the leading cause of injury death in Manitoba. During this period 1,037 Manitobans took their own lives. These deaths represent 35,157 potential years of life lost, or an average of 33.9 potential years of life lost per person. Of those who died, 819 were males and 218 were females.

A recent draft report prepared by the WRHA Population Health and Health Systems Analysis Unit reviewed suicide deaths in the Winnipeg Health Region from January 1, 1990 to December 31, 1999 from Vital Statistics Death Database. During this period 675 residents of Winnipeg took their own lives. These deaths represent 21,615 potential years of lost life. Of those who died, 500 were males and 175 were females. These rates do not account for those deaths where it was underdetermined if the intent was intentional or unintentional.

The following is a profile of suicide deaths in community areas;

\textbf{Suicide Deaths in the Winnipeg Health Region, 1990-1994 and 1995-1999}
\textbf{Counts and rates of death per 100,000 population}
\textbf{Both Sexes, By Community Area}

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<thead>
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<tbody>
<tr>
<td></td>
<td>Count</td>
<td>Crude rate per 100,000</td>
<td>Age-adjusted rate per 100,000</td>
<td>Count</td>
<td>Crude rate per 100,000</td>
<td>Age-adjusted rate per 100,000</td>
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<tr>
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<tr>
<td>St. Boniface</td>
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<td>Transcona</td>
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<td>River East</td>
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<td>37</td>
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<tr>
<td>Inkster</td>
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<td>Point Douglas</td>
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<td>22.8</td>
<td>33</td>
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<tr>
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<td>344</td>
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Produced by: Population Health & Health System Analysis Unit, WRHA, 2004

Final revisions completed on December 10, 2004
Highlights

- The lowest rates of suicide death were found in the Fort Garry CA for both time periods.
- The highest rates were found in the Point Douglas CA for the time period 1990–1994 (t₁) and the Downtown CA in time period 1995-1999 (t₂).
- The following CAs experienced an increase in the suicide death rate between the two time periods: St. James-Assiniboia CA, Fort Garry CA, St. Boniface CA, Transcona CA, and River Heights CA.
- The following CAs experienced a decrease in the suicide death rate between the two time periods: Assiniboine South CA and Point Douglas CA.
- The suicide death rates of the following CAs did not change substantially between the two time periods: St. Vital CA, River East CA, Seven Oaks CA, Inkster CA, and Downtown CA.
- The following CAs had suicide death rates that were higher than that of the WHR (in t₂): St. Boniface CA, Transcona CA, Point Douglas CA, Downtown CA, and River Heights CA. After adjusting the rates for the underlying age distribution of the population, the rates of these CAs remain higher than that of the adjusted WHR rate.
- The suicide death rates of Point Douglas and Downtown CA are substantially higher than the WHR rates (crude and age-adjusted).
Preventing Suicide

Many suicides are preventable. National, provincial and regional attention is required to respond to the problem of suicide. Numerous strategies have been developed in several Canadian provinces and internationally. Many of these strategies are based on a population health approach. A population health approach is designed to organize prevention efforts and resources in such a way that they reach large groups or populations of people systematically and effectively.

Currently there is no Canadian national strategy for suicide prevention. Despite the absence of a national strategy there are many activities and initiatives occurring throughout the country in an effort to carry out prevention, intervention and postvention tasks. The Canadian Association for Suicide Prevention (CASP) has recently developed a national strategy titled “Blueprint for a Strategy to Reduce Suicide and its Impact”. This national strategy is to be released in October 2004 in Edmonton, Alberta at the CASP national conference.

At the present time there is no provincial suicide prevention strategy. However there has been a long history of suicide prevention activities that have primarily been established through grassroots initiatives led by non-profit organizations and family advocates. There have been a number of provincial forums on Suicide Prevention, which led to the formation of the Manitoba Network for Suicide Prevention and the Aboriginal Committee for Suicide Prevention. The Winnipeg Regional Health Authority participates on both of these committees. In July 2004 Manitoba Health – Mental Health and Addictions Branch struck a working group to co-ordinate the development of a provincial suicide prevention document. The WRHA is also a participating member of this group.

Over the past 10 months the WRHA has been working toward the development of a regional strategy in collaboration with numerous partners including; Child and Adolescent Mental Health Program, Addictions Foundation of Manitoba, SPEAK, Klinic Community Health Centre, WRHA Aboriginal Health Services, Manitoba Assembly of Chiefs, and Winnipeg School Division. (See Appendix A for list of committee membership). The committee identified the following long-range goals of the regional suicide prevention strategy:

- Identify mechanisms and processes to facilitate participation from citizens and communities in building resilience, resourcefulness, tolerance and capacity in our communities and in people of all ages
- Promote positive life options for the whole population and in particular, those at risk of suicide.

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The committee also agreed that the strategy should be based on the following principles:

1. Suicide prevention is everyone’s responsibility not the exclusive responsibility of any one sector of society or of health services alone.
2. Suicide is an interaction of biological, psychological, social and spiritual factors and can be influenced by societal attitudes and conditions.
3. Strategies require a diverse approach targeted at the whole population, specific population subgroups and individuals at risk.
4. Prevention programs should be designed to enhance protective factors. They should also work toward reversing or reducing known risk factors.
5. Suicide prevention efforts should be evidence-based, outcome-focused and inclusive of research, surveillance, evaluation and reporting.
6. Partnerships should incorporate community and consumer participation as well as provider involvement and expert opinion.
7. Activities must be accessible, appropriate and responsive to the developmental, social and cultural needs of groups and populations they serve

Numerous suicide prevention strategies from other jurisdictions were reviewed. The WHR Suicide Prevention Strategy was developed based on many of the components outlined in these strategies including the framework used in the Canadian “Blueprint for a Strategy to Reduce Suicide and its Impact”. The following describes the framework used in the WHR Suicide Prevention Strategy. This framework will assist in categorizing suicide prevention activities taking place in the region.

**Mental Health Promotion:** Actions taken to enhance the capacity of individuals, families, organizations or communities to take control over their lives and improve their mental health and well-being by using strategies to create and enhance supportive environments and individual resilience.

**Awareness and Understanding:** Activities that aim to (1) promote awareness that suicide is a population health issue; (2) attempt to reduce the stigma associated with mental illness (3) improve reporting and portrayal of suicide, suicidal behaviour, mental illness and substance abuse in the media.

**Prevention and Intervention:** Activities or programs that identify risk factors and/or distress and work towards minimizing risk and increasing those things that protect and restore well-being.

**Knowledge Development and Transfer:** Activities that improve, expand and support the exchange of knowledge regarding suicide and suicide prevention activities including improving surveillance systems and data collection, evaluation
and research. It is the use of knowledge to make positive change and the use of applied experiential knowledge to inform research.


The WRHA Suicide Prevention Committee utilized the 14 components identified by Gardiner, Laforge et al as a starting point to begin its discussions on identifying priorities for a regional strategy. Although the committee agreed that all 14 components were important there was consensus that decisions would need to be made about what to do first. The committee did a preliminary review of each of the 14 components in the region and identified strengths and gaps. The committee then established a process for prioritizing each component utilizing several questions including:

- Can the activity demonstrate some success or progress within a 3-year timeframe?
- Can the activity be accomplished with available resources and partnerships?
- How strong is the evidence to support the intervention or activity?
- What is the potential impact and can it be measured?
- Is there readiness both internally and externally to do this work?
- Are there opportunities to develop partnerships with other sectors?

Through this process, the committee prioritized three key components to be targeted in the 3-Year Suicide Prevention Action Plan. The three primary components prioritized were generic skill building, suicide awareness education and screening. The committee prioritized these three components because of each component’s emphasis on primary prevention; it’s strength of evidence for effectiveness and the opportunity to address current gaps.
The committee also identified community development, gatekeeper training, system wide protocols, treatment/intervention/postvention and media education as secondary components to be included in the 3 year Action Plan. These components have been identified and are being addressed by other regional initiatives and programming as well as community initiatives. The Suicide Prevention Committee felt that the work being done in these areas could be profiled and strengthened through collaboration, partnering and in some cases leadership from the WHR Suicide Prevention Initiative.

The following chart illustrates the primary and secondary components within the streams of the strategic framework. The 3 primary components are in bold while the secondary components are in regular print.

<table>
<thead>
<tr>
<th>Mental Health Promotion</th>
<th>Awareness and Understanding</th>
<th>Prevention and Intervention</th>
<th>Knowledge Development and Transfer</th>
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<tbody>
<tr>
<td>Generic Skill Building</td>
<td>Suicide Awareness Education</td>
<td>Screening</td>
<td>Ongoing Surveillance</td>
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<td>Community Development</td>
<td>Media Education</td>
<td>Gatekeeper Training</td>
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<td></td>
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<td>Treatment/Intervention/Postvention</td>
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<td>System Wide Protocols</td>
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Please see attached Winnipeg Health Region Suicide Prevention Strategy Three-Year Action Plan, which summarizes the goals and objectives, related to each component outlined above.

Final revisions completed on December 10, 2004