HALDIMAND-NORFOLK HealthSTATS

Mental Health Report with a Focus on Suicide 2009

Introduction

The Haldimand and Norfolk Mental Health Report with a Focus on Suicide 2009 is the first focus report to be completed for Haldimand and Norfolk. This report compares data for Haldimand and Norfolk with data for Ontario, and provides an overview of some of the programs, services, and resources in Haldimand and Norfolk. Moreover, to gain better insight into the suicidal mind, a case study of an adolescent who had suicidal thoughts was also presented in this report.

Statistics

In compliance with the Ontario Public Health Standards and with input from program planners, the following Indicators were examined:

1. Suicide mortality.
2. Suicidal thoughts.
3. Self-perceived work stress.
4. Self-perceived life stress.

Other indicators and risk factors for suicide examined that are not included in the Ontario Public Health Standards include:

1. Emergency room visits for suicide attempts.
2. Alcohol use risk levels.
3. Heavy drinking.
4. Alcohol, cannabis and other drug use among youth.
5. Self-rated poor or fair health.
6. Self-rated poor or fair mental health.
7. Weak sense of belonging.
9. Poverty.

Mental health resource access among persons 15 years of age and older was also examined to determine the proportion of persons who have consulted a health professional about mental and emotional well-being in the past 12 months, and the type of Health Professional consulted.

Other indicators, including self-reported depression prevalence and attempted suicide hospitalization, were not presented here due to data access limitations. Data outlined in this report was the most recent data available. Specifically data for suicide mortality were examined for 2000 to 2004, emergency room visits for suicide (2003-2007), and Canadian Community Health Survey (2007). Information from the Brant, Haldimand, Norfolk Student Health Survey (2003) was also included to give a snapshot of youth mental health in Haldimand and Norfolk. It is important to note that significance testing was not employed, due to time constraints.

Programs, Resources and Services

1. The Suicide Prevention Network of Haldimand and Norfolk
2. Annual Events
3. High school Classroom Presentations
4. Suicide TALK
5. ASIST (Applied Suicide Intervention Skills Training)
6. Suicide Bereavement Support Group
7. Working With a Client who is Suicidal: A Guide for Service Providers
8. Dunnville Secondary School Suicide Intervention team
9. Where to go for help in Haldimand and Norfolk

Case Study: The Story of Sam

The case study is a story of a teenager who was a victim of physical and emotional abuse and his journey to regain his life through the help of community members who were trained in ASIST.

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Acknowledgements

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■ Mental Health Status Report With a Focus on Suicide Highlights

■ SUICIDE

❍ SUICIDE MORTALITY

- From 2000 to 2004, in Haldimand and Norfolk, there were 50 deaths attributed to suicide, of which a higher proportion of deaths occurred in 2002 and 2003.
- The average age-standardized mortality rate from 2000 to 2004 for females was lower in Haldimand and Norfolk compared to females in Ontario (3.1/100,000 and 3.6/100,000 respectively).
- The average age-standardized mortality rate from 2000 to 2004 for males was higher in Haldimand and Norfolk compared to males in Ontario (14.2/100,000 and 11.7/100,000 respectively).
- The average age-standardized mortality rate from 2000 to 2004 for both sexes was higher in Haldimand and Norfolk compared to both sexes in Ontario (8.7/100,000 and 7.7/100,000 respectively).
- In Haldimand and Norfolk, males were four times more likely to complete suicide on average from 2000 to 2004 than females (14.2/100,000 and 3.1/100,000 respectively).

❍ EMERGENCY ROOM VISITS FOR SUICIDE ATTEMPTS

- In Haldimand and Norfolk, from 2003 to 2007, there were 557 emergency room visits for suicidal attempts.
- In Haldimand and Norfolk, from 2003 to 2007, the lowest number of emergency room visits for suicidal attempts was in 2007.
- In Haldimand and Norfolk, from 2003 to 2007, combined the highest number of emergency room visits for suicidal attempts, for both sexes and both sees combined was found in persons 15 to 19 years of age .
- The average age-adjusted rates for emergency room visits for suicidal attempts for females between 2003 and 2007 was lower in Haldimand and Norfolk than in Ontario (1.0/1000 and 1.3/1000 respectively).
- The average age-adjusted rates for emergency room visits for suicidal attempts from 2003 to 2007 for males was the same in Haldimand and Norfolk compared to the rates for males in Ontario (0.9/1000 and 0.9/1000 respectively).
- The average age-adjusted rates for emergency room visits for suicidal attempts from 2003 to 2007 for both sexes was slightly lower in Haldimand and Norfolk than in Ontario (1.0/1000 and 1.1/1000 respectively).

❍ SUICIDAL THOUGHTS

- In 2007, 11.8% of Haldimand and Norfolk residents age 15 and older reported having suicidal thoughts in their lifetime.
- In 2007, more than double the number of Haldimand and Norfolk males age 15 and older had suicidal thoughts in their lifetime compared to Haldimand and Norfolk females (16.9% and 6.3% respectively).
- In 2007, more than double of Haldimand and Norfolk males age 15 and older had suicidal thoughts in their lifetime compared to males in Ontario. (16.9% and 6.5% respectively)

ADULT SUICIDAL THOUGHTS

- In 2007, 12.5% of Haldimand and Norfolk adults reported having suicidal thoughts in their lifetime.
- In 2007, more than double the number of adult males in Haldimand and Norfolk reported having suicidal thoughts in their lifetime compared to adult males in Ontario (18.5% and 6.7% respectively).

YOUTH SUICIDAL THOUGHTS

In 2003, 10% of students in Grades 5,7,9 and 11 in Haldimand, Norfolk and Brant had seriously considered a suicide attempt in the past year, including 20% of Grade 11 females.

- In 2003, females in Grades 5,7,9 and 11 in Haldimand, Norfolk and Brant were more likely to consider committing suicide than males (12% versus 9%).
- In 2003, the percent of students in Grades 5,7,9 and 11 in Haldimand, Norfolk and Brant seriously considering a suicide attempt increased largely between elementary and secondary schools.




■ Selected Risk Factors For Suicide Highlights

■ ALCOHOL

❍ ALCOHOL RISK LEVELS

- In 2007, 52% of Haldimand and Norfolk residents age 20 and older who were current drinkers were at high risk for alcohol-related problems.
- In 2007, a higher percentage of Haldimand and Norfolk residents age 20 and older were at high risk for alcohol-related problems compared to residents of Ontario (52.0% and 42.8% respectively).

❍ ALCOHOL RISK LEVELS, MALES

- In 2007, more than two-thirds (66.8%) of Haldimand and Norfolk males age 20 and older were at high risk for alcohol-related problems.
- In 2007, a higher percentage of Haldimand and Norfolk males age 20 and older were at high risk for alcohol-related problems compared to males in Ontario (66.8% and 49% respectively).

❍ ALCOHOL RISK LEVELS, FEMALES

- In 2007, 24.3% of Haldimand and Norfolk females age 20 and older were at high risk for alcohol-related problems.
- In 2007, a lower percentage of Haldimand and Norfolk females age 20 and older were at high risk for alcohol-related problems than females in Ontario (24.3% and 34.2% respectively).

❍ HEAVY DRINKING

- In 2007, 25.1% of Haldimand and Norfolk residents age 20 and older engaged in heavy drinking in the previous 12 months.
- In 2007, a higher percentage of Haldimand and Norfolk residents age 20 and older engaged in heavy drinking in the previous 12 months compared to Ontario (25.1% and 17.6% respectively).

❍ ALCOHOL, CANNABIS AND OTHER DRUG USE AMONG YOUTH

- In 2003, 40% of students in Grade 11 in Haldimand, Norfolk and Brant who drank alcohol reported binge drinking in the previous month.
- In 2003, the percentage of students using cannabis at least once in their lifetime in Haldimand, Norfolk and Brant doubled between Grade 9 (26%) and Grade 11 (52%).
- In 2003, 18% of students in Grade 11 in Haldimand, Norfolk and Brant used cannabis at least once per week in the previous month.
- In 2003, 13% of students in Grades 7, 9 and 11 in Haldimand, Norfolk and Brant used crack/cocaine, hallucinogens or a designer drug, such as ecstasy or speed, in their lifetime.
- In 2003, the hallucinogen Psilocybin (magic mushroom) was the most commonly used other drug by students in Grades 5,7,9 and 11 in Haldimand, Norfolk and Brant.

■ WELL BEING

❍ SELF-PERCEIVED LIFE STRESS

- In 2007, 19.1% of Haldimand and Norfolk residents age 15 and older reported having high (quite a bit or extreme) levels of stress in their lives in the previous 12 months.
- In 2007, slightly more Haldimand and Norfolk females than males age 15 and older and reported having high (quite a bit or extreme) levels of stress in their lives in the previous 12 months (19.9% and 18.3% respectively).
- In 2007, Haldimand and Norfolk residents age 15 and older (total and both sexes) reported having less stress in their lives compared to residents of Ontario in the previous 12 months.

❍ SELF-PERCEIVED WORK STRESS

- In 2007, in the previous 12 months, 26.4% of Haldimand and Norfolk residents age 20 to 64 reported that they were stressed on most days at work (main job or business).
- In 2007, a slightly higher percentage of Haldimand and Norfolk females (27.3%) than males (25.8%) age 20 to 64 reported that they were stressed on most days at work (main job or business) in the previous 12 months.
- In 2007, a lower percentage of Haldimand and Norfolk residents age 20 to 64 reported that they




were stressed on most days at work compared to Ontario (main job or business) in the previous 12 months. (26.4% and 30%)

❍ SELF RATED HEALTH

- In 2007, 14.5% of Haldimand and Norfolk residents age 12 and older reported having poor or fair health.
- In 2007, relatively the same percentage of Haldimand and Norfolk females and males age 12 and older reported having poor or fair health (14.4% and 14.5% respectively).
- In 2007, a higher percentage of Haldimand and Norfolk residents age 12 and older (total and both sexes) reported having poor or fair health compared to Ontario.

❍ SELF RATED MENTAL HEALTH

- In 2007, 94.2% of Haldimand and Norfolk residents age 12 and older reported having good mental health.
- In 2007, relatively the same percentage of Haldimand and Norfolk females and males age 12 and older reported having good mental health (94.0% and 94.3% respectively).
- In 2007, a higher percentage of Haldimand and Norfolk residents age 12 and older (total and both sexes) reported having good mental health compared to Ontario.

❍ SENSE OF BELONGING

- In 2007, 22.3% of Haldimand and Norfolk residents age 12 and older reported having a weak sense of belonging in their community.
- In 2007, a higher proportion of Haldimand and Norfolk males than females age 12 and older reported having a weak sense of belonging in their community (26.7% and 17.5% respectively).
- In 2007, a higher percentage of Haldimand and Norfolk residents age 12 and older (total and both sexes) reported having a strong sense of belonging in their community compared to Ontario.

■ POVERTY

- In 2005, 5.7% of Haldimand and Norfolk residents lived in poverty. This accounts for 6,143 people (all ages and both sexes).
- In 2005, 7.4% of children and youth (age 17 and below) lived in poverty. This accounts for 1,800 children and youth (both sexes).
- In 2005, compared to Ontario, a lower percentage of children, youth and adults live in poverty in Haldimand and Norfolk.
- In 2005, compared to Ontario, the median income after taxes for Haldimand-Norfolk residents age 15 and older was lower ($22,745 and $24,604 respectively).

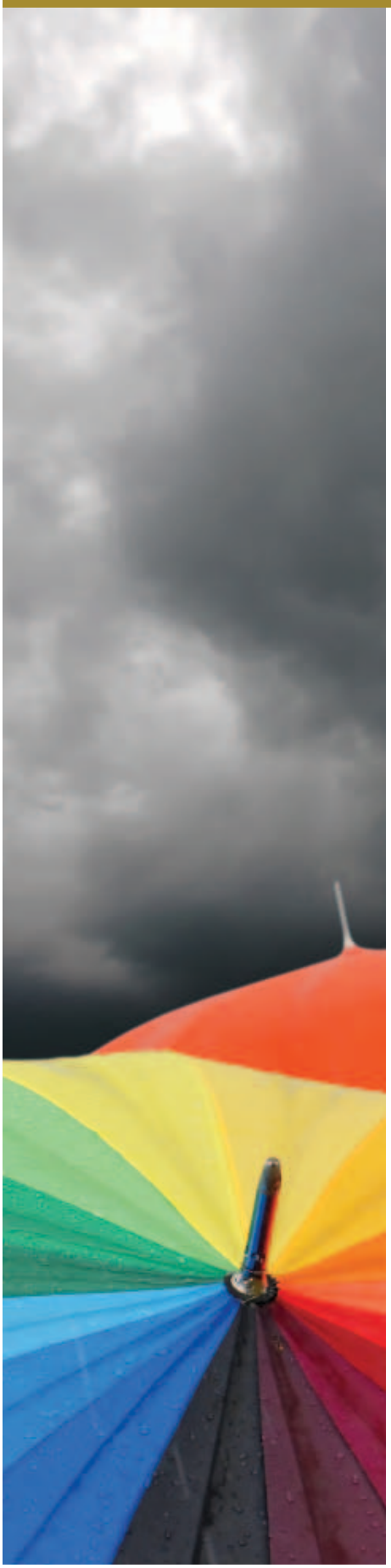
■ Mental Health Resources

■ MENTAL HEALTH RESOURCE ACCESS

- In 2007, 9.2% of Haldimand and Norfolk residents age 15 and older reported consulting with a health professional about their mental or emotional well-being in the previous 12 months. This is slightly lower compared to Ontario (9.2% and 10.3% respectively).
- In 2007, more than one-third of Haldimand and Norfolk residents age 15 and older who consulted with a health professional about their mental or emotional well-being consulted with their family doctor (61%).

❍ MENTAL HEALTH RESOURCE ACCESS AMONG YOUTH

- In 2003, 16% of students in Grades 5,7,9 and 11 in Haldimand, Norfolk and Brant reported trying to get help for feelings of sadness, anxiety, being overwhelmed or thoughts of suicide in the past year. Of these students, a higher proportion sought help from friends and family members. More females sought help than males.
- In 2003, more students in Grade 11 in Haldimand, Norfolk and Brant sought help for mental health reasons than students in any other grade.



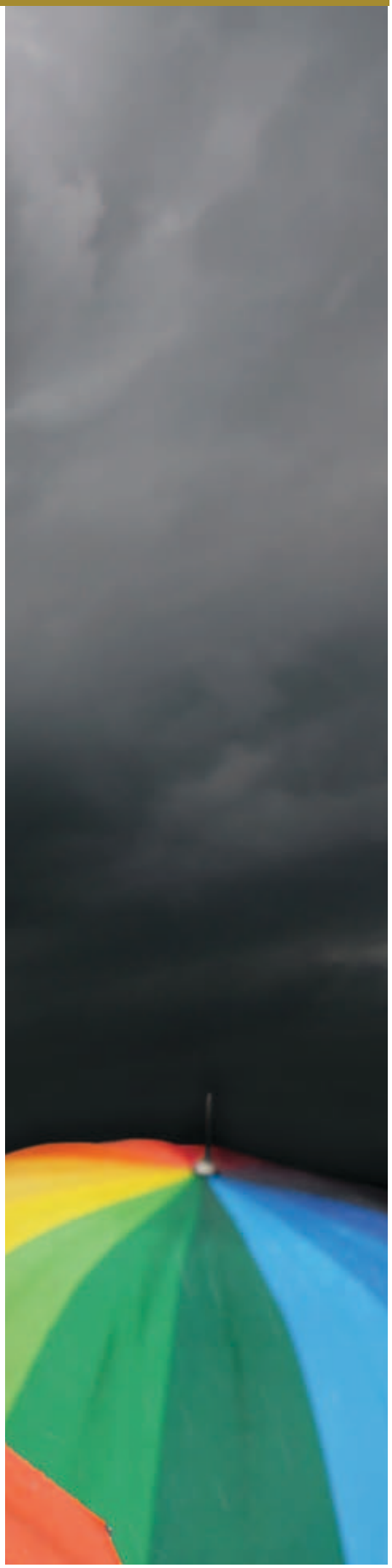
Suicide Introduction

Suicide is defined as an intentional self-infliction of death.[1] Suicide is one of the leading causes of hospitalization and death in Canada and Ontario.[1] Suicides have a profound impact on the Potential Years of Life Lost (PYLL).[1] The study of suicide examines suicidal thoughts, suicidal attempts and completed suicides. Suicide is an indicator of mental illness.[1] Suicidal behaviour may be a result of irrational mental states (distorted perceptions, extreme moods, impaired judgement, loss of interest or pleasure and feelings of hopelessness).[1] Risk factors that contribute to suicide and suicidal behaviour are illustrated in Table 1. High-risk groups or populations of special concern with respect to suicide and suicidal behaviour are illustrated in Table 2. Although, the tables below provides some examples of risk factors contributing to suicide and suicidal behaviours, it is not exhaustive of all risk factors and high-risk groups.

Table 1: Risk Factors Contributing to Suicide and Suicidal Behaviours

RISK FACTORS	DESCRIPTION OF RISK FACTORS
1. Socio-cultural	Social demoralization Fragmentation Permissive social attitudes toward suicide Media attention to celebrity suicides Social isolation from supportive networks Suicide of role models or peers Unemployment Environment that is conducive to suicide, such as one in which guns are available and accessible Income (poverty and wealth)
2. Psychiatric Conditions	Severe depression or mood disorders Bipolar is the most frequent mood disorder Substance abuse disorders (alcohol and other substances) Schizophrenia Personality disorders Anxiety Panic disorder Borderline or anti-social personality disorders Eating disorders
3. Neurological	Deficient neurotransmission of serotonin (i.e. depression, schizophrenia, borderline and antisocial personality disorders)
4. Genetic and Family Background	Psychiatric disturbances in families Some families may have greater probabilities of transmitting psychiatric disorders that increase suicidal risk Poor relationship with parents Death of a parent or child

RISK FACTORS	DESCRIPTION OF RISK FACTORS
5. Life Events	Divorce Losses Interpersonal conflicts (drug or alcohol abuse) Severe conflict with a partner or spouse Serious illness in family Serious illness (hospitalization) or Absence from work (more than one month) Death of a loved one **ADOLESCENTS** Running away from home Dropping out of school Rejection from a social group Physical attack Abortion Pregnancy or fear of pregnancy Broken love relationships Broken friendships Moving to a new home
6. Chronic Conditions and Pain	Coping with chronic conditions and pain
7. Personality and Psychological Influences	Severe depression Hopelessness Anhedonic (losing the capacity for enjoyment) Frantically anxious Inability to adapt with adverse circumstances Poor self-esteem Negative attitudes about oneself Impulsive or aggressive action Academic failure Higher neuroticism Increased irrational thinking Poor problem-solving skills



Source: Mental Health Division Health Services Directorate Health Programs and Services Branch (1994). Suicide in Canada Update of the Report of the Task Force on Suicide in Canada. Retrieved April 7, 2009, from http://www.phac-aspc.gc.ca/mh-sm/pdf/suicid_e.pdf.

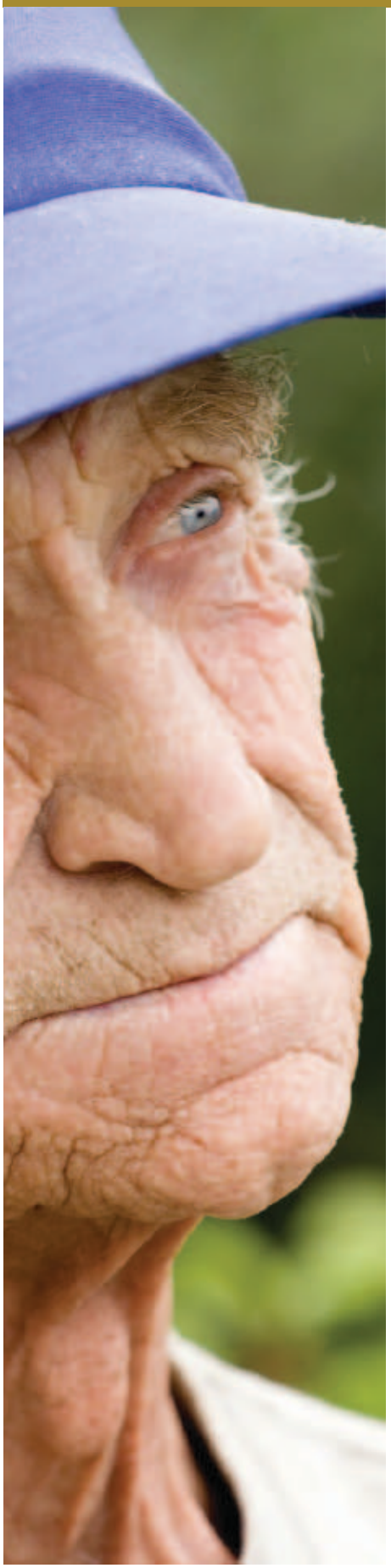
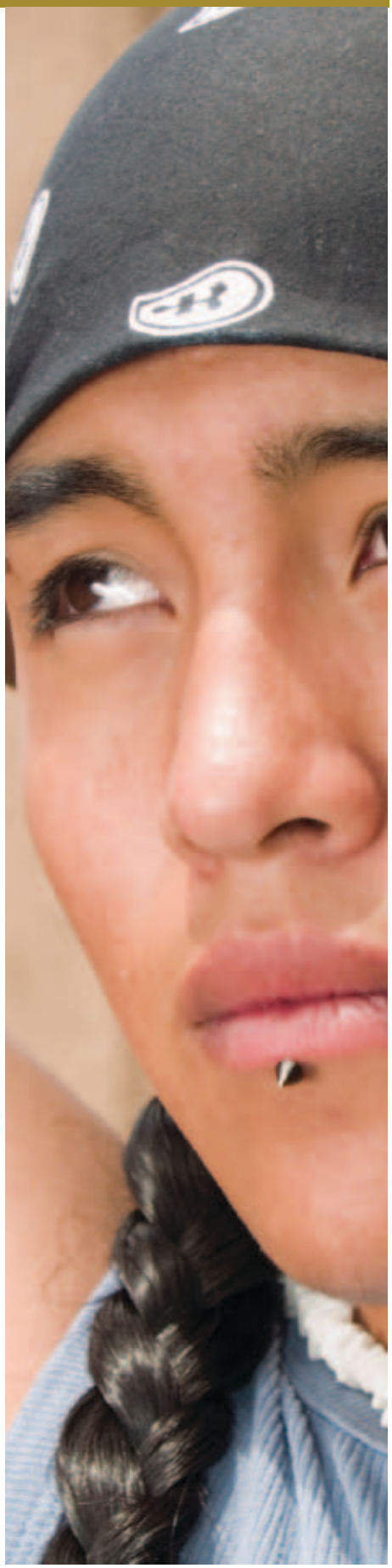


Table 2: High Risk Groups Contributing to Suicide and Suicidal Behaviours

HIGH RISK GROUPS	DESCRIPTIONS OF RISK FACTORS FOR HIGH RISK GROUPS
1. Aboriginal Populations	Associated with community characteristics predominantly on reserves (high number of occupants per household, more single-parent families, fewer elders, low average income and low average education) Alcohol abuse Depression Family instability Lack of social control Loss of dignity Low income Prevalence of firearms **YOUTH** Acculturation (one cultural group adopt the beliefs and behaviours of another group) Resettlement Sense of hopelessness and helplessness Family violence Isolation Delinquent behaviour Rejection by significant others, peers and community
2. Late Middle-Aged and Elderly Persons	Unemployment Isolation Poor health Pain Depression Alcoholism Low self-esteem Feeling rejected or lonely History of mental illness Loss of companions Loss of health Loss of mobility Loss of usefulness to others Loss of independence Low income Elder abuse

HIGH RISK GROUPS	DESCRIPTIONS OF RISK FACTORS FOR HIGH RISK GROUPS
3. Adolescents and Young Adults	**ADOLESCENTS** Emotional disorder and psycho-somatic disorders Family dysfunction Arrest of parents Availability of firearms Media depiction of suicide as heroic Cluster suicides among peers in schools and neighbourhoods **YOUNG ADULTS** Transition to adult roles and relationships (higher education, work, marriage) Timing and onset of mental disorders, mainly schizophrenia Availability and accessibility of alcohol, drugs and firearms
4. Gay Bisexual Lesbian and Transgender (GBLT)	Acknowledging their sexual orientation to their families, communities and themselves Stigmatization and discrimination Internal conflict Conflict with religious beliefs
5. Persons in Custody	Inability to face length of the sentence Actual or perceived victimization of other inmates Lack of communication with their families Receipt of bad news (failure to appeal or concerning home problems) Threats to an important relationship Guilt about the offence Psychiatric illness Isolation during holidays Addictions
6. Suicidal Thoughts and Behaviours	Hostility toward others Feelings of powerlessness Attitudes about social behaviour History of chaotic family life (dissension, separations, divorce or parental death) Unemployment Repeated suicide attempts Previous suicide attempts



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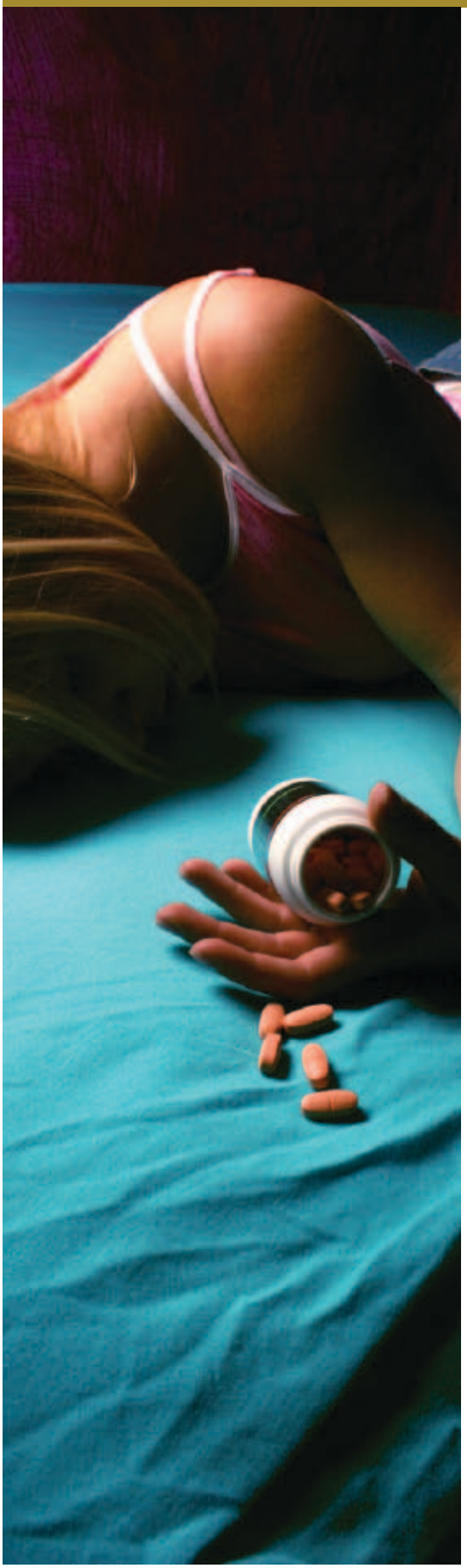


■ Suicide Statistics

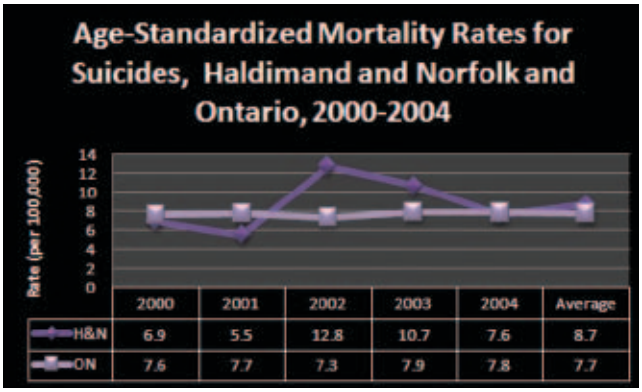
■ SUICIDE MORTALITY

Table 3: Number of Deaths Attributed to Suicide, Haldimand and Norfolk, by Age Group, Total, 2000-2004

	2000	2001	2002	2003	2004	Total
0-4	0	0	0	0	0	0
5-9	0	0	0	0	0	0
10-14	0	0	0	0	0	0
15-19	2	0	1	3	1	7
20-24	0	0	1	2	0	3
25-29	1	0	0	0	1	2
30-34	0	0	2	0	1	3
35-39	0	2	1	1	0	4
40-44	1	1	6	1	1	10
45-49	2	0	1	1	0	4
50-54	2	1	0	0	0	3
55-59	0	1	0	2	2	5
60-64	0	0	0	1	0	1
65-69	0	0	0	0	0	0
70-74	0	1	1	2	2	6
75-79	0	0	1	0	0	1
80-84	0	0	0	0	0	0
85-89	0	1	0	0	0	1
90 +	0	0	0	0	0	0
Total	8	7	14	13	8	50

Source: Haldimand & Norfolk Vital Statistics, Provincial Health Planning Database (PHPDB) (Extracted April 1, 2009).
Data Notes: ICD-10-CA: X60-X84, Y 87.0. Includes Ontario residents with health card number.
"Approximately 75% of elderly individuals who die by suicide visited their primary care physician within the month prior to their deaths." - US Pharmacist

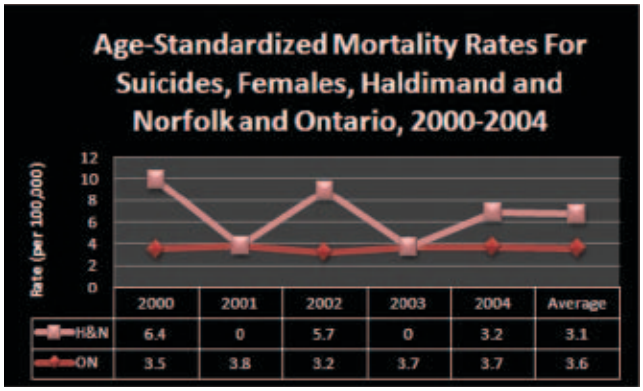
Figure 1: Age-Standardized Mortality Rates for Suicide, Haldimand and Norfolk and Ontario, 2000-2004



Source: Ontario and Haldimand & Norfolk Population Estimates, Provincial Health Planning Database (PHPDB) (Extracted April 1, 2009) and Vital Statistics, Provincial Health Planning Database (PHPDB) (Extracted April 1, 2009).

Data Notes: ICD-10-CA: X60-X84, Y 87.0. Includes Ontario residents with health card numbers.

Figure 2: Age-Standardized Mortality Rates for Suicide, Females, Haldimand and Norfolk and Ontario, 2000-2004



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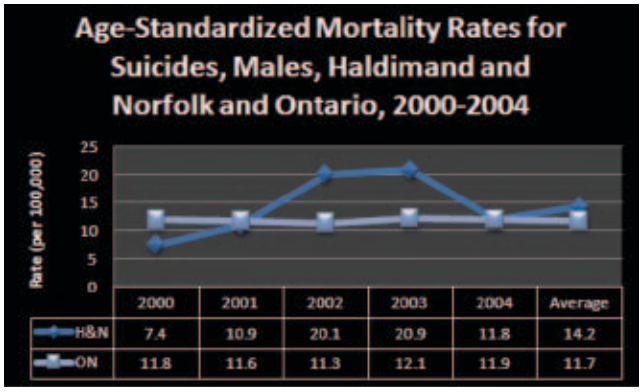
Data Notes: ICD-10-CA: X60-X84, Y 87.0. Includes Ontario residents with health card numbers.

"Suicide is a permanent solution to a temporary problem and suicide prevention is everyone's business."
Suicide Prevention Network of Haldimand-Norfolk

Figure 3: Age-Standardized Mortality Rates for Suicide, Males, Haldimand and Norfolk and Ontario, 2000-2004



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Data Notes: ICD-10-CA: X60-X84, Y 87.0. Includes Ontario residents with health card numbers.

■ EMERGENCY ATTEMPTED SUICIDE VISITS

Table 4: Number of Emergency Room Visits for Attempted Suicides, Haldimand and Norfolk, Both Sexes, Total, 2003-2007

	2003	2004	2005	2006	2007	Total
Females	78	70	75	49	51	**323**
Males	62	53	56	35	28	**234**
Total	**140**	**123**	**131**	**84**	**79**	**557**

Source: Ontario and Haldimand & Norfolk Population Estimates, Provincial Health Planning Database (PHPDB) (Extracted April 1, 2009) and Vital Statistics, Provincial Health Planning Database (PHPDB) (Extracted April 1, 2009).

Data Notes: ICD-10-CA: X60-X84, Y 87.0. Includes Ontario residents with health card numbers. Excludes death after arrival and death on arrival. People can have more than one visit.

Table 5: Number of Emergency Room Visits for Attempted Suicide, Haldimand and Norfolk, by Age Group, and Sex, Total, 2003-2007

	Female	Male	Total	Rank
0-4	0	0	**0**	**15**
5-9	1	1	**2**	**13**
10-14	14	8	**22**	**9**
15-19	**69**	**40**	**109**	**1**
20-24	**42**	**25**	**67**	**2**
25-29	18	12	**30**	**7**
30-34	18	22	**40**	**6**
35-39	**44**	**23**	**67**	**2**
40-44	32	26	**58**	**3**
45-49	36	19	**55**	**4**
50-54	24	21	**45**	**5**
55-59	11	16	**27**	**8**
60-64	7	6	**13**	**10**
65-69	2	9	**11**	**11**
70-74	0	4	**4**	**12**
75-79	2	2	**4**	**12**
80-84	1	0	**1**	**14**
85-89	1	0	**1**	**14**
90 +	1	0	**1**	**14**
Total	**323**	**234**	**557**	

Source: Haldimand & Norfolk Population Emergency Room Visits , Provincial Health Planning Database (PHPDB) (Extracted April 1, 2009).

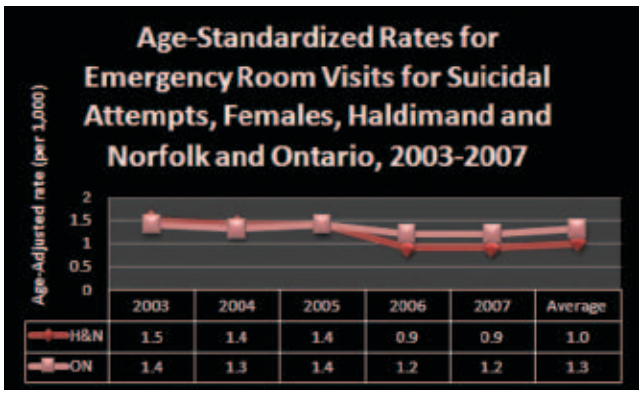
Data Notes: ICD-10-CA: X60-X84, Y 87.0. Includes Ontario residents with health card numbers, excluding residents that are dead on arrival. People can have more than one visit.

Figure 4: Age-Standardized Rates for Emergency Room Visits for Suicidal Attempts, Both Sexes, Haldimand and Norfolk and Ontario, 2000-2004

Source: Ontario and Haldimand & Norfolk Population Estimates, Provincial Health Planning Database (PHPDB) (Extracted April 1, 2009) and Vital Statistics, Provincial Health Planning Database (PHPDB) (Extracted April 1, 2009).

Data Notes: ICD-10-CA: X60-X84, Y 87.0. Includes Ontario residents with health card numbers. Excludes death after arrival and death on arrival. People can have more than one visit.

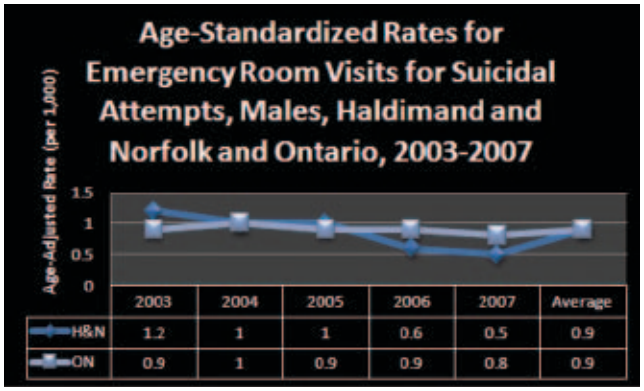
Figure 5: Age-Standardized Rates for Emergency Room Visits for Suicidal Attempts, Females, Haldimand and Norfolk and Ontario, 2003-2007



Source: Ontario and Haldimand & Norfolk Population Estimates, Provincial Health Planning Database (PHPDB) (Extracted April 1, 2009) and Vital Statistics, Provincial Health Planning Database (PHPDB) (Extracted April 1, 2009).

Data Notes: ICD-10-CA: X60-X84, Y 87.0. Includes Ontario residents with health card numbers. Excludes death after arrival and death on arrival. There can be multiple visits to the emergency room.

Figure 6: Age-Standardized Rates for Emergency Room Visits for Suicidal Attempts, Males, Haldimand and Norfolk and Ontario, 2003-2007



Source: Ontario and Haldimand & Norfolk Population Estimates, Provincial Health Planning Database (PHPDB) (Extracted April 1, 2009) and Vital Statistics, Provincial Health Planning Database (PHPDB) (Extracted April 1, 2009).

Data Notes: ICD-10-CA: X60-X84, Y 87.0. Includes Ontario residents with health card numbers. Excludes death after arrival and death on arrival. People can have more than one visit.

■ SUICIDAL THOUGHTS

SUICIDAL THOUGHTS

Table 6: Suicidal Thoughts In a Lifetime, 15 and Older, Haldimand and Norfolk and Ontario, 2007

	H&N 2007 (% ± 95% CI)	ON 2007 (% ± 95% CI)
Suicidal Thoughts	*11.8 ± 4.9	7.5 ± 0.5
Suicidal Thoughts Males	*16.9 ± 9.1	6.5 ± 0.8
Suicidal Thoughts Females	*6.3 ± 3.9	8.5 ± 0.8

Source: Canadian Community Health Survey 2007, Statistics Canada, Share File, Knowledge Management and Reporting Branch, Ontario MOHLTC

*Data Notes:. * High sampling variability, interpret with caution. Non-applicable was excluded. Suicidal thoughts is measured by if the person has ever seriously committed suicide or taking their own life in the past 12 months. Due to small cell counts, the data for H-N was not releasable, so suicidal thoughts in a lifetime was calculated.*

"Ninety per cent of people who engage in suicide-related behaviours are experiencing depression, other mental health issues, or have an addiction."
- St. Joseph and McMaster Hamilton Hospital

ADULT SUICIDAL THOUGHTS

Table 7: Adult Suicidal Thoughts In a Lifetime, 20 and Older, Haldimand and Norfolk and Ontario, 2007

	H&N 2007 (% ± 95% CI)	ON 2007 (% ± 95% CI)
Suicidal Thoughts	*12.5 ± 5.3	7.6 ± 0.6
Suicidal Thoughts Males	*18.5 ± 9.8	6.7 ± 0.8
Suicidal Thoughts Females	**	8.5 ± 0.8

Source: Canadian Community Health Survey 2007, Statistics Canada, Share File, Knowledge Management and Reporting Branch, Ontario MOHLTC

*Data Notes:. * High sampling variability, interpret with caution. ** High sampling variability data is not releasable. Non-applicable was excluded. Suicidal thoughts is measured by if the person has ever seriously committed suicide or taking their own life in the past 12 months. Due to small cell counts, the data for H-N was not releasable, so suicidal thoughts in a lifetime was calculated. Suicidal thoughts for teenagers was not releasable.*

SUICIDAL THOUGHTS AMOUNG YOUTH

FACTORS ASSOCIATED WITH SUICIDAL THOUGHTS IN YOUTH, ONTARIO, 2001

Table 8: Factors Associated with Suicidal Thoughts in Youth, Ontario, 2001

Family Structure

Suicidal thoughts are more common among students living with one parent (16%) compared to two parents (10%)

Relationship with Parents

Suicidal thoughts are more common among students who do not have a good relationship with parents (39%) compared to students who do (10%)

Feeling Safe at School

Suicidal thoughts are more common among students who report that they do not feel safe at school (22%) compared to students who feel safe at school (7%)

Bullying (either being a victim of bullying or bullying others)

Suicidal thoughts are more common among students involved in bullying. The proportion of students reporting suicidal thoughts associated with bullying is as follows: 19% for students who are both bullying victims and bullies themselves, 17% for students who are victims of bullying, 12% for students who are bullies, compared to 8% of students who have no involvement of bullying

Data Source: Center for Addiction and Mental health. One in Ten Ontario Students Contemplates Suicide. CAMH Population Studies eBulletin. 2003 Jan/Feb:18.

Table 9: Fast Facts About Suicidal Thoughts, Grades 5, 7, 9, & 11, Brant, Haldimand and Norfolk, 2003

Fast Facts

- 10% of all students surveyed had seriously considered attempting suicide in the past year, including 20% of Grade 11 females.
- Females were more likely to consider committing suicide than males (12% vs 9%).
- The percent of students seriously considering a suicide attempt increased largely between elementary and secondary schools.

Source: 2003 Brant, Haldimand, Norfolk, Student Health Survey.

■ Risk Factors Contributing to Suicide and Suicidal Behaviours

The risk factors that contribute to suicide and suicidal behaviours were highlighted in the previous tables (see Table 1 and Table 2). The next section will provide an overview of some of the risk factors, including alcoholism, self-perceived life and work stress, self-rated poor or fair health, self-rated poor or fair mental health, a weak sense of belonging and poverty. These indicators were selected based on input from program planners and data availability.

■ ALCOHOL USE

ALCOHOL USE RISK LEVELS

Table 10: Low-Risk Drinking Guidelines

NUMBER OF DRINKS	LOW-RISK DRINKING GUIDELINES
0	Zero drinks = lowest risk of an alcohol-related problem
2	No more than two standard drinks on any one day
9	Women: up to nine standard drinks a week
14	Men: up to 14 standard drinks a week

Data Source: Developed by social researchers from the University of Toronto and the Centre for Addiction and Mental Health (CAMH).

Table 11: Alcohol Use Risk Levels of Current Drinkers, Age 20 and older, Both Sexes, Haldimand and Norfolk, Ontario, 2007

	H&N 2007 (% ± 95% CI)	ON 2007 (% ± 95% CI)
Low Risk for Alcohol-Related Health Problems	48.1 ± 9.7	57.2 ± 1.5
High Risk for Alcohol-Related Health Problems	52.0 ± 9.6	42.8 ± 1.5
Total	100	100

Source: Canadian Community Health Survey 2007, Statistics Canada, Share File, Knowledge Management and Reporting Branch, Ontario MOHLTC.

Data Notes: The low-risk drinking guidelines specify no more than two standard drinks on any day with a weekly limit of up to nine standard drinks for women and 14 for men. Excluded Don't Know, Refused and Not Stated.

ALCOHOL USE RISK LEVELS

Table 12: Alcohol Use Risk Levels of Current Drinkers, Age 20 and older, Males, Haldimand and Norfolk, Ontario, 2007

	H&N 2007 (% ± 95% CI)	ON 2007 (% ± 95% CI)
Low Risk for Alcohol-Related Health Problems	*33.2 ± 12.0	50.9 ± 1.9
High Risk for Alcohol-Related Health Problems	66.8 ± 12.0	49.0 ± 1.9
Total	100	100

Source: Canadian Community Health Survey 2007, Statistics Canada, Share File, Knowledge Management and Reporting Branch, Ontario MOHLTC.

*Data Notes: * High sampling variability, interpret with caution. The low-risk drinking guidelines specify no more than two standard drinks on any day with a weekly limit of up to nine standard drinks for women and 14 for men. Excluded Don't Know, Refused and Not Stated.*

Table 13: Alcohol Use Risk Levels of Current Drinkers, Age 20 and older, Females, Haldimand and Norfolk, Ontario, 2007

	H&N 2007 (% ± 95% CI)	ON 2007 (% ± 95% CI)
Low Risk for Alcohol-Related Health Problems	75.7 ± 10.0	65.8 ± 2.1
High Risk for Alcohol-Related Health Problems	*24.3 ± 9.9	34.2 ± 2.1
Total	100	100

Source: Canadian Community Health Survey 2007, Statistics Canada, Share File, Knowledge Management and Reporting Branch, Ontario MOHLTC.

*Data Notes: * High sampling variability, interpret with caution. The low-risk drinking guidelines specify no more than two standard drinks on any day with a weekly limit of up to nine standard drinks for women and up to 14 for men. Excluded Don't Know, Refused and Not Stated.*

HEAVY DRINKING

Table 14: Frequency of Heavy Drinking, Current Drinkers, in the Past 12 months, 20 and older, Haldimand and Norfolk and Ontario, 2007

	H&N 2007 (% ± 95% CI)	ON 2007 (% ± 95% CI)
Never 5 or More Drinks on One Occasion	50.2 ± 6.5	56.1 ± 1.3
5 or More Drinks on One Occasion Fewer than 12 Times a Year	21.3 ± 6.1	21.9 ± 1.1
5 or More Drinks on One Occasion, 12 or More Times a Year	25.1 ± 7.8	17.6 ± 0.9
Not Stated	**	*0.4 ± 0.2
Total	NC	100

Source: Canadian Community Health Survey 2005 and 2007, Statistics Canada, Share File, Knowledge Management and Reporting Branch, Ontario MOHLTC.

*Data Notes:. * High sampling variability, interpret with caution.**High variability data is not releasable. NC. Not able to compute. Heavy drinking is the consumption of five or more drinks on one occasion, 12 or more times a year.*

ALCOHOL, CANNABIS AND OTHER DRUG USE AMONG YOUTH

Table 15: Fast Facts About Alcohol, Cannabis and Other Drug Use Among Youth, Grades 5,7,9 & 11, Brant, Haldimand and Norfolk, 2003

FAST FACTS - ALCOHOL

- 38% of students in Grades 5 and 7 drank alcohol in the previous 12 months.
- 41% of students in Grades 9 and 11 drank alcohol in the previous four weeks, of which nearly 29% drank on a weekly basis.
- 40% of alcohol users in Grade 11 reported binge drinking during the previous four weeks (i.e., drinking five or more drinks on one occasion).

FAST FACTS - DRUGS

- The proportion of students using cannabis at least once in their lifetime doubled between Grade 9 (26%) and Grade 11 (52%).
- 18% of Grade 11 students used cannabis at least once per week during the previous month.
- 13% of students in Grades 7, 9 and 11 had used crack/cocaine, hallucinogens or a designer drug, including ecstasy or speed, in their lifetime.
- The hallucinogen Psilocybin (magic mushroom) was the most commonly used other drug.
- 86% of students who used cannabis in the previous four weeks also engaged in binge drinking at some point in their lifetime (compared to 25% who had not used cannabis during that time).
- 57% of students who used cannabis in the previous four weeks also used another illicit drug at some point in their lifetime (compared to 3% who had not used cannabis during that time).
- 68% of students in Grades 7, 9 and 11 reported using either alcohol, cannabis or another illicit drug at least once in their lifetime.

Source: 2003 Brant, Haldimand, Norfolk Student Health Survey.

■ WELL-BEING

SELF-PERCEIVED LIFE STRESS

Table 16: Self-Perceived Life Stress, 15 and Older, in the Past 12 Months, Haldimand and Norfolk and Ontario, 2007

	H&N 2007 (% ± 95% CI)	ON 2007 (% ± 95% CI)
Total quite a bit or extremely stressful	19.1 ± 5.1	22.1 ± 0.8
Females quite a bit or extremely stressful	*19.9 ± 6.6	23.7 ± 1.2
Males quite a bit or extremely stressful	*18.3 ± 7.7	20.4 ± 1.2

Source: Canadian Community Health Survey 2007, Statistics Canada, Share File, Knowledge Management and Reporting Branch, Ontario MOHLTC.

*Data Notes:. * High sampling variability, interpret with caution. Non-applicable was excluded. Self-perceived stress is measured by reporting quite a bit or extremely stressful.*

SELF-PERCEIVED WORK STRESS

Table 17: Self-Perceived Work Stress, 20 to 64, in the Past 12 Months, Haldimand and Norfolk and Ontario, 2007

	H&N 2007 (% ± 95% CI)	ON 2007 (% ± 95% CI)
Total quite a bit or extremely stressful	26.4 ± 8.3	30.0 ± 1.3
Females quite a bit or extremely stressful	*27.3 ± 9.7	30.2 ± 1.7
Males quite a bit or extremely stressful	*25.8 ± 11.8	29.8 ± 1.8

Source: Canadian Community Health Survey 2007, Statistics Canada, Share File, Knowledge Management and Reporting Branch, Ontario MOHLTC.

*Data Notes: * High sampling variability, interpret with caution.*

SELF-RATED HEALTH

Table 18: Self-Rated Health, 12 and Older, Total and Both Sexes, Haldimand and Norfolk and Ontario, 2007

	H&N 2007 (% ± 95% CI)	ON 2007 (% ± 95% CI)
Total good health	85.3 ± 5.3	88.3 ± 0.7
Total poor or fair health	*14.5 ± 5.2	11.6 ± 0.7
Female good health	85.6 ± 5.8	87.5 ± 1.0
Female poor or fair health	*14.4 ± 5.8	12.4 ± 1.0
Male good health	85.1 ± 8.1	89.1 ± 0.8
Male poor or fair health	14.5 ± 8.0	10.8 ± 0.8

Source: Canadian Community Health Survey 2007, Statistics Canada, Share File, Knowledge Management and Reporting Branch, Ontario MOHLTC.

*Data Notes: * High sampling variability, interpret with caution. Prevalence of good self-rated health = Good, Very Good or Excellent. Prevalence of fair or poor self-rated health = Fair or Poor.*

SELF-RATED MENTAL HEALTH

Table 19: Self-Rated Mental Health, 12 and Older, in the Past 12 months, Total and Both Sexes, Haldimand and Norfolk and Ontario, 2007

	H&N 2007 (% ± 95% CI)	ON 2007 (% ± 95% CI)
Total good mental health	94.2 ± 3.4	92.7 ± 0.5
Total poor or fair mental health	**	4.8 ± 0.4
Female good mental health	94.0 ± 4.3	93.1 ± 0.7
Female poor or fair mental health	**	5.0 ± 0.6
Male good mental health	94.3 ± 3.8	92.2 ± 0.9
Male poor or fair mental health	**	4.7 ± 0.7

Source: Canadian Community Health Survey 2007, Statistics Canada, Share File, Knowledge Management and Reporting Branch, Ontario MOHLTC.

*Data Notes: ** High sampling variability data is not releasable. Prevalence of good self-rated mental health = Good, Very Good or Excellent. Prevalence of fair or poor self-rated mental health = Fair or Poor.*

SENSE OF BELONGING

Table 20: Sense of Belonging, 12 and Older, Total and Both Sexes, Haldimand and Norfolk and Ontario, 2007

	H&N 2007 (% ± 95% CI)	ON 2007 (% ± 95% CI)
Strong sense of belonging	76.6 ± 5.2	63.0 ± 1.1
Weak sense of belonging	22.3 ± 5.2	33.3 ± 1.1
Female strong sense of belonging	81.9 ± 5.1	64.1 ± 1.4
Female weak sense of belonging	17.5 ± 5.3	32.6 ± 1.4
Male strong sense of belonging	71.8 ± 8.1	61.9 ± 1.5
Male weak sense of belonging	26.7 ± 8.1	34.0 ± 1.5

Source: Canadian Community Health Survey 2007, Statistics Canada, Share File, Knowledge Management and Reporting Branch, Ontario MOHLTC.

Data Notes: Prevalence of strong sense of belonging = Very Strong, or Somewhat Strong. Prevalence of weak sense of belonging = Somewhat Weak or Very Weak.

■ SOCIO-CULTURAL

POVERTY

Table 21: 2005 Low-Income Cut-Offs (LICOs) (before taxes) for rural areas, such as Haldimand and Norfolk

Size of Family	LICO
1 person	$14,303
2 persons	$17,807
3 persons	$21,891
4 persons	$26,579
5 persons	$30,145
6 persons	$33,999
7+ persons	$37,853

Data Notes: Low-Income Cut-Offs are based on the cost of living, family size and place of residence (urban or rural).

LOW-INCOME CUT-OFF (LICO)

Table 22: Percent of Total Low-Income People, Haldimand and Norfolk and Ontario, 2006.

	Total Population in 2006, both sexes (Code1)	% In low income after tax. All persons based on LICO (Code277)	Number of people with low income people after tax. (Total population), based on LICO	Population age 17 and below, 2006 (Code8-12)	Percent in low income after tax. Persons age 17 and below based on LICO (Code279)	Number of people with low income persons age 17 and below, after tax, based on LICO	Income status of all persons in private households, counts (Code275)	Persons 15 years and over with income, counts (Code268)	Median income after tax, persons 15 years and over (Code 270)
H&N	107,775	5.7%	6,143	24,324	7.4%	1,800	105,905	83,690	$22, 745
ON	12,160,282	11.1%	1,349,791	2,719,005	13.7%	372,504	11,926,140	9,340,020	$24,604

Data Source: 2006 Census, Health Unit Profiles. Statistics Canada Website: http://www12.statcan.ca.

Data Notes: (1) In 2005, the total number of people with low income after tax (based on LICO), in Ontario is 1.35 million, which accounts for 11.1% of the total Ontario population (all ages, both sexes).(2) In 2005, the number of people with low income age 17 and below, after tax (based on LICO), in Ontario is 372,504, which accounts for 13.7% of the Ontario population age 17 and below.

Mental Health Resource

MENTAL HEALTH RESOURCE ACCESS

Table 23: Consulted a Health Professional about Mental and Emotional Well-Being, 15 and Older, in the Past 12 Months, Haldimand and Norfolk and Ontario, 2007

	H&N 2007 (% ± 95% CI)	ON 2007 (% ± 95% CI)
Consulted health professional about emotional or mental health	*9.2 ± 3.8	10.3 ± 0.6
Did not consult health professional about emotional or mental health	87.4 ± 4.6	84.5 ± 0.8
Not stated	**	5.2 ± 0.5
Total	NC	100

Source: Canadian Community Health Survey 2007, Statistics Canada, Share File, Knowledge Management and Reporting Branch, Ontario MOHLTC.

*Data Notes: *High sampling variability, interpret with caution. **High sampling variability data is not releasable. Non-applicable was excluded. Not stated includes don't know, refuse and not stated. NC = Not able to compute.*

Table 24: Type of Health Professional consulted about Mental and Emotional Well-Being, 15 and Older, in the Past 12 Months, Haldimand and Norfolk and Ontario, 2007

	H&N 2007 (% ± 95% CI)	ON 2007 (% ± 95% CI)
Family Doctor	61.0 ± 19.7	59.0 ± 0.6
Psychiatrist	**	21.5 ± 2.6
Psychologist	**	15.1 ± 2.3
Nurse	**	4.0 ± 1.1
Social Worker	**	20.5 ± 2.4
Other	**	6.0 ± 1.6

Source: Canadian Community Health Survey 2007, Statistics Canada, Share File, Knowledge Management and Reporting Branch, Ontario MOHLTC.

*Data Notes: Percentages do not add up to 100%. ** High sampling variability data is not releasable. Non-applicable was excluded. Not stated includes don't know, refuse and not stated.*

MENTAL HEALTH RESOURCE ACCESS AMONG YOUTH

Table 25: Mental Health Resource Access Among Youth, Grades 5,7,9 & 11, Brant, Haldimand and Norfolk, 2003

FAST FACTS

- 16% of students reported trying to get help for feelings of sadness, anxiety, being overwhelmed or thoughts of suicide in the previous year.
- Of these students, most sought help from friends and family members.
- More females sought help than males.
- More students in Grade 11 sought help for mental health reasons than students in any other grade.

Source: 2003 Brant, Haldimand, Norfolk Student Health Survey.

■ Summary of Statistics

■ SUICIDE IN HALDIMAND AND NORFOLK

SUICIDE MORTALITY

- From 2000 to 2004, there were 50 deaths attributed to suicide.
- The age-adjusted average mortality rate from 2000 to 2004 was higher in males and both sexes compared to Ontario.
- On average, males were four times more likely to complete suicide than females (2000-2004).

EMERGENCY ROOM VISITS FOR SUICIDE ATTEMPTS

- From 2003 to 2007, there were 557 emergency room visits for suicide attempts.
- From 2003 to 2007, persons age 15 to 19 had the highest number of emergency room visits for suicide attempts for both sexes and both sexes combined.
- The average rates from 2003 to 2007 for emergency room visits was relatively the same compared to Ontario, for both sexes.

SUICIDAL THOUGHTS

- In 2007, 11.8% of people age 15 and older reported having suicidal thoughts in their lifetime.
- In 2007, more than double the number of males than females age 15 and older reported having suicidal thoughts in their lifetime.
- In 2007, 12.5% of adults (20 years of age and older) reported having suicidal thoughts in their lifetime.

■ RISK FACTORS CONTRIBUTING TO SUICIDE AND SUICIDAL BEHAVIOUR

ALCOHOL

- More than 50% of adults were at high risk for alcohol-related problems (age 20 and older).
- More than 50% adult males were at high risk for alcohol-related problems (age 20 and older).
- Less than one-third of females are at high risk for alcohol-related problems (age 20 and older).
- Less than one-third of adults engage in heavy drinking (age 20 and older).

LIFE STRESS

- 19.1% report having life stress (age 15 and older).
- More females than males report having life stress (age 15 and older).

WORK STRESS

- 26.4% of adults age 20 to 64 years report having work stress
- More females than males age 20 to 64 years report having work stress work stress

SELF RATED POOR OR FAIR MENTAL HEALTH

- 14.5% have poor or fair health (age 12 and older).
- 94.2% have good mental health (age 12 and older).

WEAK SENSE OF BELONGING

- 22.3% have a weak sense of community belonging (age 12 and older).
- More males than females have a weak sense of community belonging (age 12 and older).

POVERTY

- 5.7% of residents live in poverty.
- 7.4% of children and youth age 17 and younger live in poverty.
- The median income after taxes is lower compared to Ontario.

■ MENTAL HEALTH RESOURCE

MENTAL HEALTH RESOURCE ACCESS

- 9.2% consulted with a health professional about their emotional or mental health (age 15 and older)
- More than half consulted with a family doctor about emotional or mental health (age 15 and older).

■ HALDIMAND, NORFOLK AND BRANT STUDENT SNAPSHOT (2003)

❍ SUICIDE ATTEMPTS

- 10% of all students surveyed in Grades 5, 7, 9 and 11 had seriously considered a suicide attempt in the previous year, including 20% of Grade 11 females.
- Females were more likely to consider committing suicide than males.
- Seriously considering a suicide attempt increased largely between elementary and secondary schools.

❍ ALCOHOL AND ILLICIT DRUG USE

- In Grades 9 to 11, 41% of students drank alcohol in the previous four weeks, of which 29% drank on a weekly basis.
- In Grade 11, 40% of alcohol users reported binge drinking.
- The number of students who used cannabis at least once in their lifetime doubled between Grade 9 (26%) and Grade 11 (52%).
- Students used Psilocybin (magic mushroom) more than any other drug.
- Of the students who used cannabis in the previous four weeks, 86% also engaged in binge drinking at some point in their lifetime.
- Of the students who used cannabis in the previous four weeks, 57% had also used another illicit drug at some point in their lifetime.

❍ MENTAL HEALTH RESOURCE ACCESS AMONG YOUTH

- Overall, 16% reported trying to get help for feelings of sadness, anxiety, being overwhelmed or thoughts of suicide in the previous year, of which most sought help from friends and family members.
- Students in Grade 11 sought help for mental health reasons than students any other grade.
- More females sought help than males.

Table 26: Selected Health Indicators, Haldimand and Norfolk, Compared to Ontario, 2007

Selected Health Indicators	Higher than Ontario	Lower than Ontario
SUICIDE		
Female Suicide Mortality (2000-2004)		✓
Male Suicide Mortality (2000-2004)	✓	
Both Sexes Suicide Mortality (2000-2004)	✓	
SUICIDE ATTEMPTED EMERGENCY ROOM VISITS		
Female Suicidal Attempts Emergency Room Visits (2003-2007)		✓
Both Sexes Suicidal Attempts Emergency Room Visits (2003-2007)		✓
SUICIDAL THOUGHTS		
Suicidal Thoughts (15+)	✓	
Suicidal Thoughts Males (15+)	✓(More than double)	
Suicidal Thoughts Female (15+)		✓
Adult Suicidal Thoughts (20+)	✓	
Adult Suicidal Thoughts Male (20+)	✓(More than double)	
ALCOHOL		
High Risk for Alcohol-Related Health Problems (20+)	✓	
Male High Risk for Alcohol-Related Health Problems (20+)	✓	
Female High Risk for Alcohol-Related Health Problems (20+)		✓
Heavy Binge Drinking (20+)	✓	

Selected Health Indicators	Higher than Ontario	Lower than Ontario
LIFE STRESS		
Life Stress (15+)		✓
Females Life Stress (15+)		✓
Male Life Stress (15+)		✓
WORK STRESS		
Work Stress (15+)		✓
Female Work Stress (20-64)		✓
Male Work Stress (20-64)		✓
SELF-RATED HEALTH		
Poor or Fair Health (20+)	✓	
Female Poor or Fair Health (20+)	✓	
Male Poor or Fair Health(20+)	✓	
SENSE OF BELONGING		
Strong Sense of Belonging (12+)	✓	
Female Strong Sense of Belonging (12+)	✓	
Male Strong Sense of Belonging (12+)	✓	
POVERTY		
Adults and children and youth living in poverty		✓
Median income after tax list		✓
MENTAL HEALTH AND RESOURCE ACCESS		
Consulted Health Professional about Emotional or Mental Health (both sexes)		✓

Source: Canadian Community Health Survey 2005 and 2007, Statistics Canada, Share File, Knowledge Management and Reporting Branch, Ontario MOHLTC, Haldimand-Norfolk Health Unit. Please see tables in report for further information.

Suicide Prevention

In order to promote a suicide-safe community, suicide prevention is essential. The following table lists some suicide prevention strategies with examples that can assist program planners reduce the prevalence of suicide in Haldimand and Norfolk (see Table 21). Programs, services and resources that promote suicide safer communities are also summarized.

Table 27: Suicide Prevention Strategies

SUICIDAL PREVENTION STRATEGIES	EXAMPLES OF SUICIDE PREVENTION STRATEGIES
1. Improve Societal Conditions (including social disorganization, poverty and unemployment)	• Provide collective resources for coping and adversity • Strengthen social supports • Provide easy access to mental health services
2. Improve Coping and Life Skills	• Develop school programs and peer support programs that help young people develop problem-solving skills to deal with anxiety, depression and various developmental tasks • Implement mental health support programs for all ages
2. Improve Media Relations	• Decrease publicizing the method of suicide and the prominent coverage of these deaths • Implement guidelines for media reporting on suicide
3. Create Public Education Programs	• Develop crisis and suicide prevention centres • Provide community and school-based education programs to reduce the stigma associated with seeking treatment and support for depressive and suicidal crises • An examples of such a program in Haldimand and Norfolk is the Suicide Prevention Network, which promotes the development of suicide-safer communities through education, awareness, training and other initiatives.
4. Reduce the Availability and Lethality of Means	Reduce the availability of lethal agents, e.g., toxic substances, guns, etc.

Source: Mental Health Division Health Services Directorate Health Programs and Services Branch (1994). Suicide in Canada Update of the Report of the Task Force on Suicide in Canada. Retrieved April 7, 2009 from http://www.phac-aspc.gc.ca/mh-sm/pdf/suicid_e.pdf.

■ Programs and Services

❍ THE SUICIDE PREVENTION NETWORK OF HALDIMAND-NORFOLK

The Suicide Prevention Network of Haldimand-Norfolk promotes the development of suicide-safer communities through education, awareness, training and other prevention initiatives. The network consists of several community partners including:

- Community Addictions and Mental Health Services of Haldimand-Norfolk
- Grand Erie District School Board
- Haldimand-Norfolk Health Unit
- Canadian Mental Health Association
- Community Support Centre of Haldimand-Norfolk
- Resource Centre – Simcoe
- Haldimand & Norfolk Women's Services
- Haldimand-Norfolk REACH
- OPP, and
- community members

❍ ANNUAL EVENT

September 10 is Suicide Prevention Day. Every year at this time, the Suicide Prevention Network, holds a suicide-related event.

❍ HIGH SCHOOL CLASSROOM PRESENTATIONS

The high school classroom presentation is a 50-minute discussion about teenage suicide. It includes a discussion of the stressors that teens face in their lives, ways of coping with stress, myths and facts of teenage suicide, warning signs of suicidal behaviour and the dos and don'ts of helping a suicidal friend.

❍ SUICIDE TALK

Suicide TALK is a three-hour presentation that explores the issues in suicide prevention. TALK stands for Tell, Ask, Listen and Keep safe. It is designed to help make our communities aware that something can be done to help prevent suicide. Suicide TALK is facilitated by an ASIST trainer and targets all age groups.

❍ ASIST (APPLIED SUICIDE INTERVENTION SKILLS TRAINING)

The ASIST program is an intensive two-day interactive and practice-dominated course designed to help caregivers recognize risk and learn how to intervene to prevent the immediate risk of suicide. ASIST is offered in high schools as well as the community-at-large. Currently, Haldimand and Norfolk have five ASIST trainers. In the Grand Erie District School Board, all the social workers are trained in ASIST.

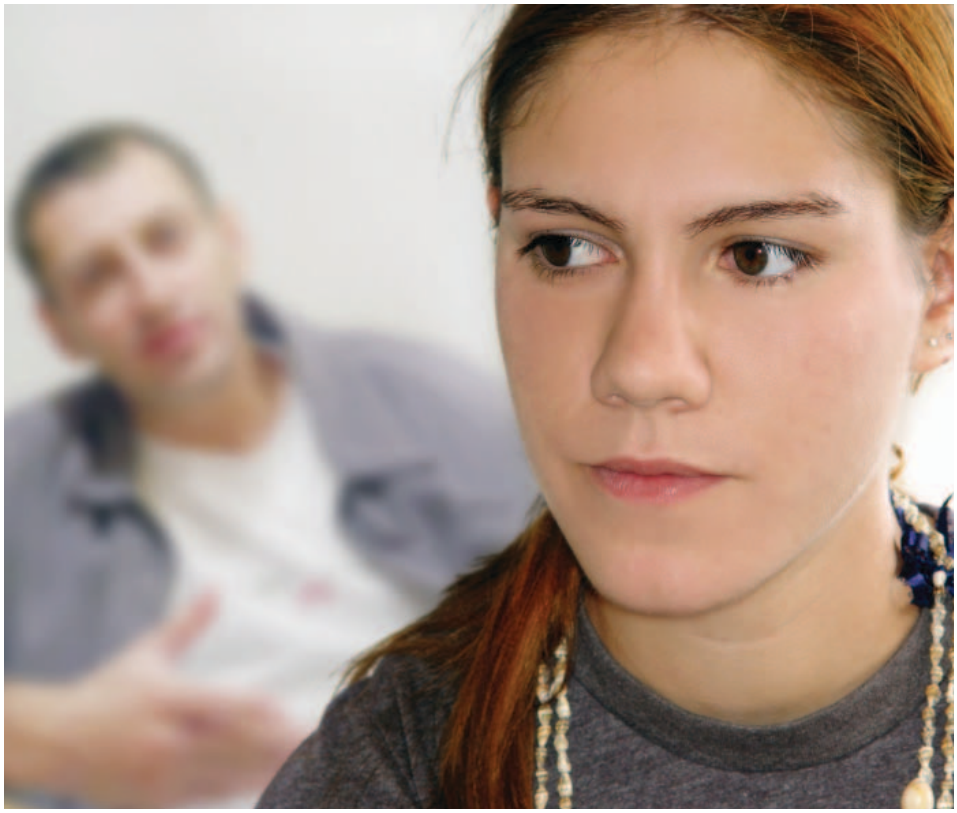
PARTICIPANTS LEARN THE FOLLOWING:

- To recognize invitations for help.
- To reach out and offer support.
- To review the risk of suicide.
- To apply a suicide intervention model.
- To link people with community resources.

❍ SUICIDE BEREAVEMENT SUPPORT GROUP

A support group for people who have lost friends and relatives to suicide has formed in Haldimand-Norfolk.

"Suicide can be prevented with the help of prepared caregivers"-Suicide Prevention Network of Haldimand-Norfolk



■ GUIDE FOR SERVICE PROVIDERS

Working with a Client who is Suicidal is a guide for service providers that provides information about red flags or warning signs, the need to ask questions clearly and directly and lists all the local resources for referral and follow-up (see below).

Working With a Client Who is Suicidal

A Guide for Service Providers

Any patient and/or client threatening suicide, self-injury or reporting an attempt, must be considered high risk for completing the act.

Any patient threatening suicide should not be left alone for any reason.

Warning Signs – Red Flags

Actions

- Withdrawal (family, friends, school, work)
- Loss of interest in life in general
- Abuse of alcohol or drugs
- Extreme behavioral changes
- Impulsivity
- Self-mutilation

Physical

- Lack of interest in appearance
- Change/loss in sex interest
- Disturbed sleep
- Change/loss of appetite/ weight
- Physical health problems

Feelings

- Desperate
- Worthless
- Sad
- Hopeless
- Helpless

Thoughts

- 'I just can't keep my thoughts straight'
- 'I just can't take it anymore'
- 'I wish I were dead'
- 'No one can do anything to help me'

Stressful Events

- With FEELINGS OF LOSS (almost anything depending on how the person feels about it)

YOU have to ask the question – Ask the question directly

'Are you having thoughts of suicide?' 'Are you thinking of killing yourself?'

If answer is YES, assess risk by asking the following questions:

A) Do you have pain (*emotional and/or physical*) that at times seems unbearable?

B) On a scale of one to 10, how would you rate your pain?

C) Do you have a plan? How do you intend to do it? (*Is there means available, and has time been decided?*)
Note: The more lethal the means, the more available the means, and the more definite the time frame, the greater the risk.

D) Have you tried to kill yourself before? When? How many times? What did you do?

E) Do you know anyone else who has attempted suicide or have taken their life?

F) Do you have family and friends you can go to for help? Would you go to them if you needed to?

G) Has anyone close to you suggested that you need help?

H) Have you experienced challenges with your mental health and/or addictions?

I) Have you ever been prescribed medication for your moods or your nerves?

J) Have you ever used alcohol and/or drugs to make you feel better?

WHAT to do

The following is a list of contacts for supports:

- Child and Youth Crisis Service (*for clients under the age of 18*) – 1-866-327-3224
- CAST – Crisis Assessment and Support Team (*for age 16 and over*) – Crisis line – 1-866-487-2278
- Emergency Psychiatric Team – St. Joseph's Hospital Hamilton – after 4:30 p.m. 905-522-4941
- Children's Hospital of Western Ontario – Child and Adolescent Mental Health Care 519-667-6640
- London Mental Health Crisis Service – 519-433-2023
- COAST Hamilton Crisis line – 905-972-8338
- Brantford General Hospital – for 16 years and older 519-752-CARE
- Ontario Provincial Police – 1-888-310-1122
- Brantford Crisis Response Service - 519-209-6788

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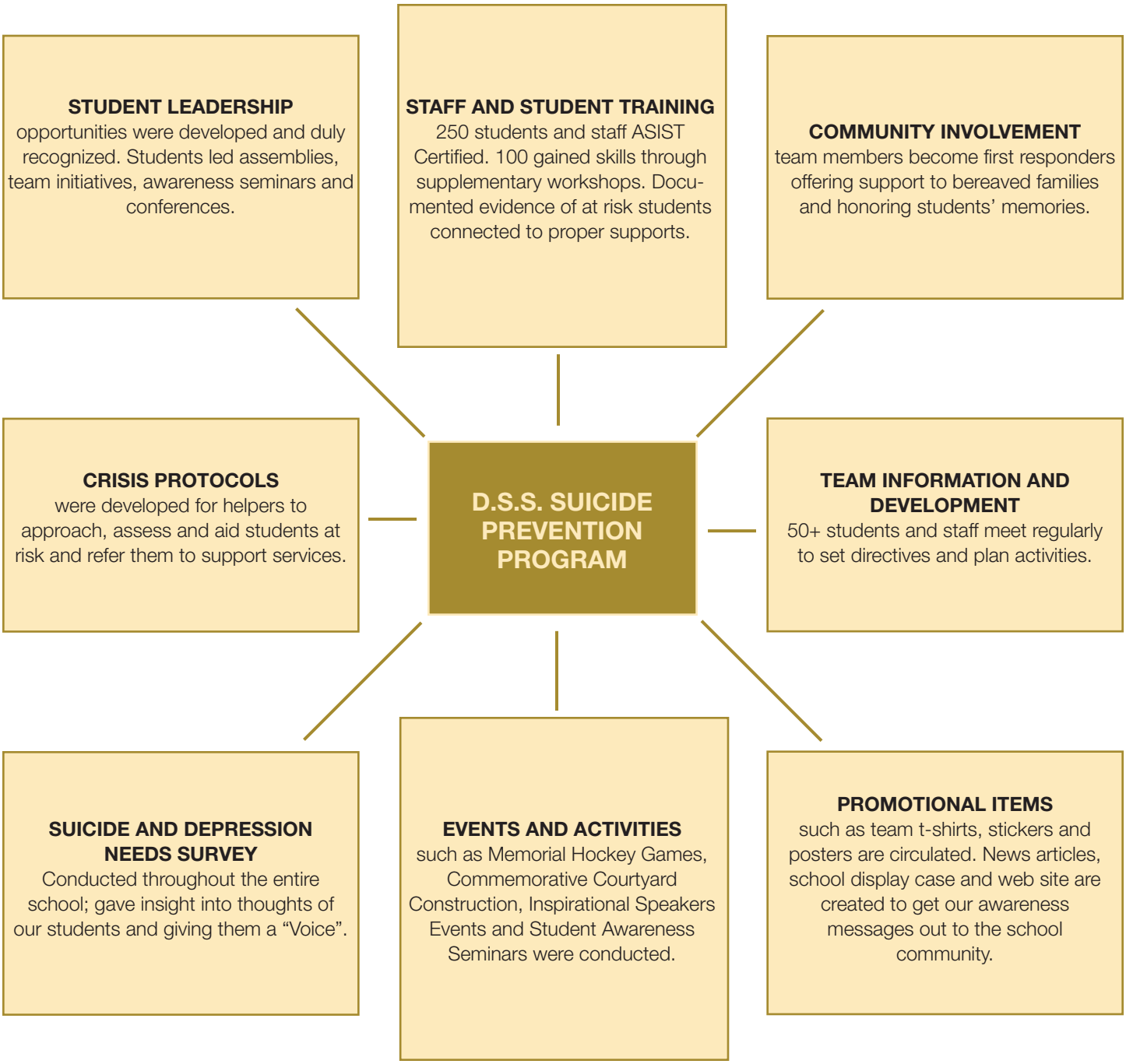
■ DUNNVILLE SECONDARY SCHOOL SUICIDE INTERVENTION TEAM

The Dunnville Secondary School Suicide Intervention Team is a rural health initiative that promoted positive mental health outreach among students through suicide awareness and prevention. The team fostered a collaborative approach that utilized a multifaceted mental health promotion approach that utilized eight components: 1. Team Formation and Development, 2. Student Leadership, 3. Student and Staff Training, 4. Community Involvement, 5. Crisis Protocol, 6. Suicide and Depression Needs Survey, 7. Events and Activities and 8. and Promotional Items (see Figure 7).

Figure 7: Dunnville Secondary School Suicide Intervention



Where to go for Help in Haldimand and Norfolk

Child and Youth Crisis Services	(for clients under the age of 18) 1-866-327-3224
Crisis Assessment and Support Team (CAST)	(for age 16 and older) 1-866-487-2278
London Mental Health Crisis Service	519-433-2023
COAST Hamilton Crisis	905-972-8338
Brantford General Hospital	(for people age 16 and over) 519-752-2273
Ontario Provincial Police	1-888-310-1122
Crisis Response Service, Brantford	519-209-6788
Haldimand-Norfolk Health Unit	519-426-6170
Haldimand-Norfolk REACH	519-587-2441 or toll-free at 1-800-265-8087

Case Study: The Story of Sam

The case study below is a story about the horrific effects of abuse over time. It is a story of a teenager who was victim of physical and emotional abuse and his journey to regain his life through the help of community members who were trained in ASIST.

Sam is a high school student in his senior year who excels in school and sports and has many friends. He has a girlfriend named Tanya, who he cares for deeply and spends a lot of time with. When he is not with his girlfriend, doing homework or playing sports, he spends time with his sister, who has special needs. Although Sam has many close relationships and appears to do well in all aspects of his life, Sam has a secret. He is a victim of domestic violence and is physically and emotionally abused by his mother and stepfather. The constant beatings and put-downs have caused deep emotional and physical scarring throughout the years.

In the summer of 2008, Sam was physically abused by his stepfather and mother. After they beat him one evening, Sam was kicked out of the home and found himself alone and scared. He walked the streets and had nowhere to go. After a few days on the streets, Sam decided to go to a friend's house. His friend convinced him to report the abuse to the police. With much reluctance, he reported the abuse to the police, hoping the abuse would stop and he would have a better life at home. The police advised him to stay away from the home and to live independently. He then decided to obtain financial assistance from the government. Shortly after, Sam found a place of his own, where he was free from emotional and physical abuse. Although he was removed from the home, the effects of abuse diminished Sam's confidence and self-esteem. He felt hopeless and worthless and thought that people would be better off if he were no longer here. The pain of his childhood was overwhelming, and he often found himself crying every evening as thoughts of suicide consumed him. He felt he had no one to turn to for help. He stopped doing things that brought him pleasure and slowly started to withdraw from his friends. He felt truly alone. To escape from the overwhelming pain, Sam decided to take his own life. At home one evening, he was lying in bed and felt that life was no longer worth living. He took a bottle of pills from the bathroom cabinet and as he looked himself in the mirror, he put 10 to 20 pills in his hand and walked over to the bed. As he stared at the photograph of his girlfriend on the dresser, he picked it up, kissed it, said goodbye and swallowed the pills. As he lay on the bed, the room was quiet and he could hear himself breathing heavily. He could hear the cars drive by, but after a few minutes, he could only hear his hoarse and shallow breathing. His cousin, who spoke to Sam every evening, did not hear from Sam that night, so with much concern decided to visit Sam. When he arrived at Sam's house, he found Sam lying on the bed. He called 911, and the ambulance took Sam to the hospital. Sam was revived at the hospital and later discharged.

In the fall of that same year, Sam's personality began to change. He was no longer depressed. Instead, his depression turned to anger. He was angry at his mom and stepdad for the way they treated him over the years. Sam began to lash out at Tanya and his friends. One afternoon at school, he felt an outburst of rage and put his fist through a window. At that time, Sam was referred to a Public Health Nurse who was an ASIST trainer. Sam confided to the nurse about his emotional and physical abuse and told the nurse he felt guilty about the way he was treating Tanya. Sam told the nurse he was also a runner for his parents' drug deals and was feeling guilt and remorse for "having caused somebody's drug addiction." The nurse comforted Sam and told him the abuse wasn't his fault and that she understood why he would have a lot of anger. After their discussion, Sam informed the nurse that he was willing to work on his anger

issues. Sam and the nurse agreed to see each other the following week.

Unfortunately, Sam did not return to school after that initial meeting with the nurse. Sam became more depressed, and his inability to cope with the abuse became more apparent. By the end of the month, Sam was out of money, had no food, was sleep deprived and was using drugs and alcohol. His relationships were deteriorating, he withdrew from sports and his grades were poor.

After speaking with his friend Ian, Sam decided to return to school. When Sam was walking down the hallway, the ASIST-trained guidance counsellor, who had been informed of Sam's situation, approached him and asked if she could talk to him and invite the school nurse. Sam reluctantly agreed and walked with the guidance counsellor to her office. He looked pale and thin, and his eyes looked dark and heavy as though he had been crying. He appeared lifeless.

As Sam began to confide in the guidance counsellor and the nurse, he told them that nobody cared about him and that people would be better off if he were not around. It was apparent that Sam was in a lot of pain. When asked on a scale of zero to 10 how he would describe his pain, he responded with 10. Then, the nurse looked at Sam and reassured him that he was surrounded by people who loved and cared for him. She spoke of Tanya and his friend Ian. Sam looked at the nurse with heavy eyes and said, "but I hurt them, I hurt everyone." The nurse told him, "they love you and they understand the pain that you are going through." He then broke down and started crying. The nurse and guidance counsellor reassured Sam that everything was going to be all right. Sam replied, "But I am in so much pain, please take it away." The nurse told Sam "it will take some time, but we can help you through your pain, and your friends and Tanya will help you as well."

Drying his eyes, Sam then asked if he could see Tanya and Ian, and the guidance counsellor quickly went to find them. When Tanya saw Sam crying, she immediately took his hand and gave him a hug and said, "I love you, and I will always be here no matter what." Ian then said, "We can get through this together." Sam's mood lifted and he started to raise his head, looked at them and realized at that moment that everything was going to be all right. Sam then promised the guidance counsellor that he would go for counselling.

Over the next several months, Sam went for counselling and felt "alive again." Sam decided to move to the city to live with his brother and go to school. The nurse asked to see Sam before he left. He looked healthy and his eyes were sparking. Sam thanked the nurse for her help and said that without her support and the support from the school, he would not be where he is today: "happy."

Through this experience, the guidance counsellor and the nurse recognized the value of ASIST. They also realized the importance of training more students and teachers, especially the principal and the vice-principal. The more people trained the more suicide-safe our community will be.

REFLECTION OF SAM'S STORY

Sam's Story provides illustrates several key points including

1. It's okay to talk about suicidal thoughts and tendencies because there is help available.
2. To know that confidentiality is respected and maintained.
3. For schools and community agencies to promote suicide safer communities by becoming ASIST certified.

Suicide Bereavement Support Group

Suicide
BEREAVEMENT
Support Group

A support group for people who have lost friends and relatives to suicide has formed in Haldimand - Norfolk.

If you are interested in attending contact Marilyn Antkiw, PHN at 519 426-6170 ext. 3252 or 905 318-6623 ext. 3252 to find out when the next meeting is scheduled.

This is an opportunity for survivors (people who have lost a loved one to suicide) to connect with other survivors and to talk openly about suicide with people who really understand.

An important part of the healing process is the support and sense of connection a survivor feels by sharing his/her grief with other survivors.

If you are interested in attending contact Marilyn Antkiw PHN at 519 426-6170 ext. 3252 or 905 318-6623 ext. 3252 to find out when the next meeting is scheduled.

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Conclusion

Rural populations are understood to have different health status compared to urban counterparts.[1, 2] The variations in economics, environmental characteristics, demography and culture in rural areas affect health status.[3] On average, rural populations have a larger populations of seniors and children, higher unemployment, higher poverty, higher disability rates, shorter life expectancy, higher infant mortality rates and higher death rates than their urban counterparts, particularly with respect to deaths due to injuries, circulatory diseases, respiratory diseases, diabetes and suicide.[4] All of these health disparities contribute to rural Canadians being at risk of poorer quality of life and poorer health compared to their urban counterparts.[3, 4] Of particular interest, higher suicide rates in rural areas, particularly among men and youth age 15 to 19, compared to their urban counterparts may be attributed to socio-economic factors such as poverty and unemployment as well as the lack of access to mental health services due to the enduring shortage of mental health professionals and the distance and travel required to access mental health services.[3] Moreover, maladaptive lifestyle behaviour, including high-risk drinking, stress and weak social capital, may be attributed to accessibility barriers to health promotion programs and services associated with living in a rural community. Increased investments in mental health programs and services and health promotion programs with a rural focus are essential to decrease suicidal thoughts and attempts and improve the mental health of the residents of Haldimand and Norfolk.

Recommendations

1. To support primary care physicians by improving their capacity to identify suicide ideation and provide suicide prevention and/or intervention.
2. To promote ASIST training to health professionals in an effort to decrease the prevalence of suicide in Haldimand and Norfolk.
3. To promote suicide awareness to health professionals, physicians, media, schools the community and other key stakeholders within the community to promote a suicide-safe community.
4. To conduct further research on mental health with a focus on suicide from a rural health perspective.
5. To develop an inventory of suicide prevention strategies in Haldimand and Norfolk.
6. To further conduct student health research into the area of mental health with a focus on suicide.

Data Sources

PROVINCIAL HEALTH PLANNING DATABASE (PHPDB)
Data was extracted by the Health Unit from the Provincial Health Planning Database (PHPDB) and statistical calculations were performed in Excel. Only Ontario residents and persons with valid health cards were included in the analysis.

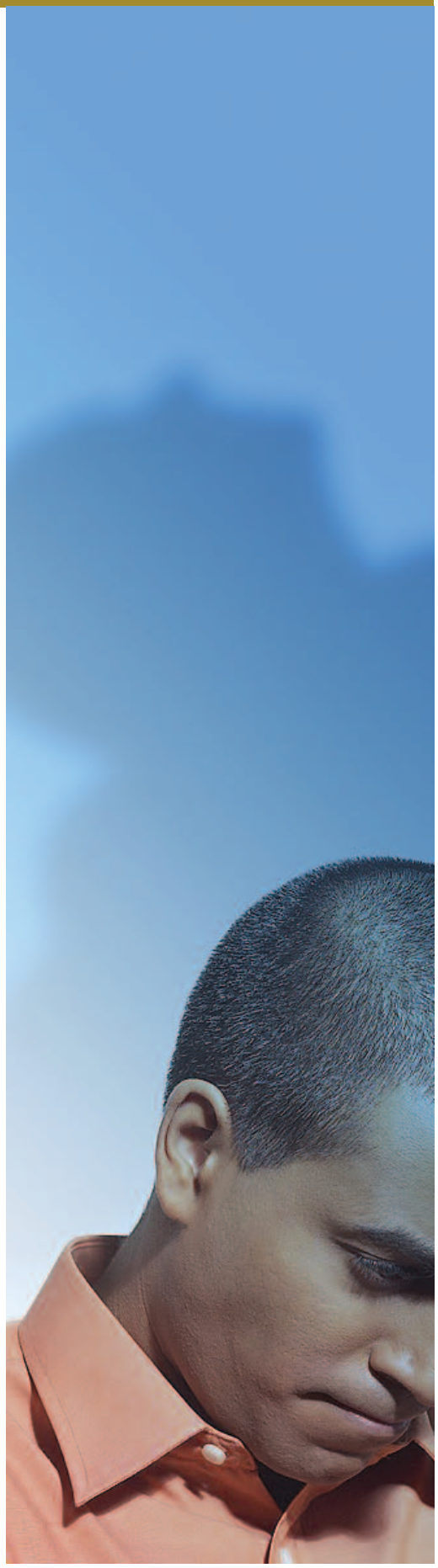
THE CANADIAN COMMUNITY HEALTH SURVEY (CCHS)
The Canadian Community Health Survey (2005) (CCHS) data source was used to extract data on lifestyle behaviours and cancer screening methods. The CCHS is a national population household survey conducted by Statistics Canada that provides timely, regular, cross-sectional estimates of health status, health determinants and health system utilization across Canada. The CCHS excludes populations on Indian Reserves, Canadian Forces Bases and some remote areas. Bootstrap weights were used to estimate precision. Bootstrap is a method used to create a mean value for a point estimate, calculate the point estimate using 500 different weights and calculate the variance and 95% confidence interval for that estimate. A confidence interval is an interval within the true value of the variable in which the proportion, rate and mean are contained. In this report, this is calculated as a 95% probability. If the confidence bounds between point estimates do not overlap, then the difference between the estimates being compared are most likely statistically significant. The bootstrapping method also produces the coefficient of variation (CV), which is used to determine if the point estimate is releasable. Data with a CV between 16.6% and 33.3% should be determined with caution. Data with a CV greater than 33.3% are not reportable due to extreme sampling variability and are therefore suppressed. Missing variables (not stated, refuse and don't know) were collapsed to mean not stated. Based on the principles of proportion, non-applicable responses were removed from the data set.

Data Interpretation

Some figures in this report contain age-standardized rates (SRATE). The age-standardized rate is a single, summary rate that allows a comparison rates among populations or within populations over time. SRATE represents a rate if the age structure and sex distributions were the same as that of the selected standard population. The standard population used in injury surveillance is the 1991 Adjusted Canadian population. Sex- and age-standardized rates are based on sex- and age-specific rates in the population studied and the age distribution of the standard population.

Limitations

Attempted suicide and suicide rates are often underreported.[5] Suicide attempts are difficult to measure because a generally acceptable reporting procedure does not exists and non-lethal suicides are not reported.[5] According the World Health Organization, there are approximately 20 suicide attempts for each suicide death.[6] For suicide mortality, the Officer of the Registrar General obtains information from death certificates, which are completed by physicians. If the physician deems the cause of death "uncertain," then the coroner may code the death as "undetermined." After further investigation, the coroner may reclassify the death and code as a more specific cause. The actual number of deaths from suicide may also be greater because the nature of the death may only become available after the death certificate is completed. Also, a suicide death can only be reported if the victim's intent was clear.[6]



Resources

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CARING FOR THE SUICIDAL PATIENT

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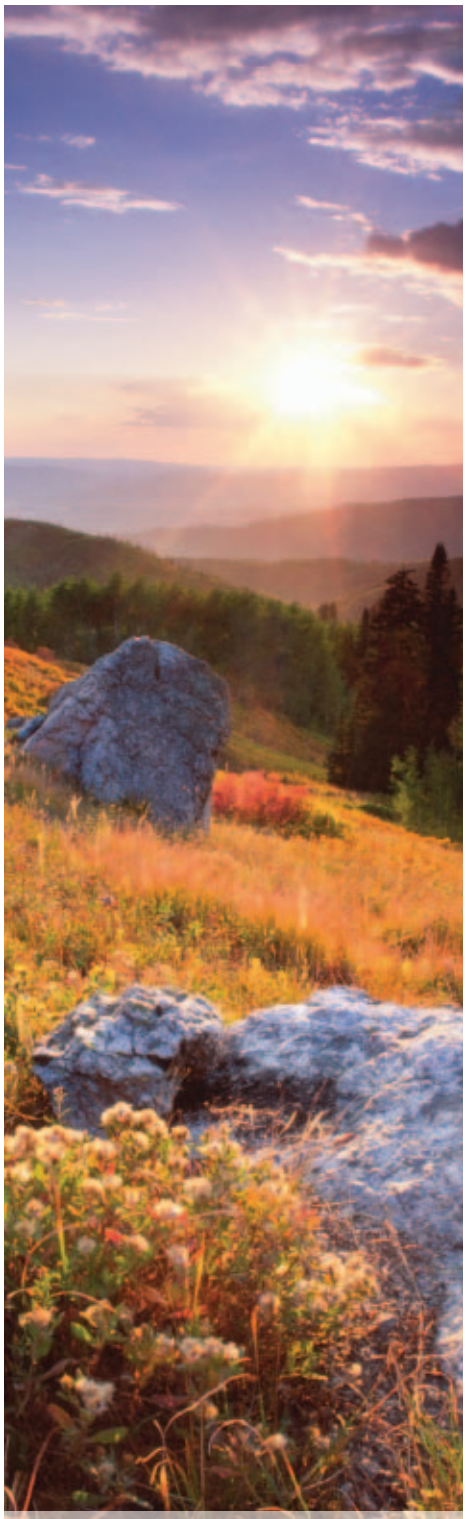

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