QUÉBEC'S STRATEGY FOR PREVENTING SUICIDE

Help FOR life

Québec

Coordination and text
Guy Mercier
Danielle Saint-Laurent

Secretarial work
Georgianne Bélanger
Hélène Piché

Design and production of cover page
Larochelle et Associés

English version
Service de la traduction
Ministère des Relations avec les citoyens et de l'Immigration
Translation: Gillian M. Baird
Revision: Elly Mialon

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as well as the members of the task force, for their contribution to this publication.

Jeannine Auger, Ministère de la Santé et des Services sociaux
Sylvie-Chantal Corbeil, Centres jeunesse de l'Estrie
Lorraine Deschênes, Centre de prévention du suicide de la Haute-Yamaska
Jean Désy, Régie régionale de la santé et des services sociaux des Laurentides
Marie-Chantale Forget, Cité de la santé de Laval
André Gagnon, Centre hospitalier Pierre-Janet
Marie Julien, Régie régionale de la santé et des services sociaux de la Montérégie
Richard Labelle, École Curé Antoine-Labelle
Brian Mishara, Université du Québec à Montréal
Lynda Pomerleau, CLSC Basse-Ville-Limoilou
Robert Simon, president, Centre de prévention du suicide 02
Serge Turmel, Bureau du coroner

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Telephone: (418) 643-3380
1 800 707-3380 (toll free)
Fax: (418) 644-4574

In the interests of simplicity, the masculine form is used in this text to indicate either gender.

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MESSAGE FROM THE MINISTER

The ministère de la Santé et des Services sociaux believes in the importance of enhancing the meaning of life through a sense of community and responsibility. Concerned by the suicide rate in Québec, we have sought the advice of specialists to guide us in our actions.

The Strategy we are submitting today is the result of a broad consensus. It stems from one of our priorities in public health and from our guidelines for transforming mental health services. We had choices to make, and we made them. We will now do everything we can to see that this strategy is acted upon, with a view to stabilizing and eventually reducing the suicide rate in Québec.

The department is not the only government authority involved in this initiative, but it is the one that must guide by example and provide leadership. It will be responsible for coordinating action, and the cooperation required for effective preventive action will be obtained through partners in the health and social services network. Once the network has stipulated how it plans to see to its responsibilities at the local and regional level, which it should be doing shortly, we will be in a better position to determine the support required from our partners in this area.

This is the first time the government has proposed an overall strategy for suicide prevention. This is not a policy paper, but a strategy based on a series of specific measures designed to involve us in practical, cooperative action with all our partners. In proposing this strategy, we were also inspired by a desire to ensure that the steps we take will be evaluated, that the goals we set will be acted upon, and that any improvement or suggestion on which our partners agree will be taken into consideration.

The people of Québec must mobilize their resources and refuse to see suicide trivialized and treated as if it were one solution among many. Together we must develop the skills required to provide life choices for the members of our community.

Jean Rochon
***M**inister*

FOREWORD

Since suicide has reached troubling proportions in Québec, suicide prevention is a priority of the ministère de la Santé et des Services sociaux. Suicide is a problem with which many groups are grappling, as we were able to note during the consultations we held last spring as a preliminary step to the preparation of this strategy.

The object of the consultations was to glean opinions and comments on the document we had been given by the task force created to draw up guidelines for our offensive against suicide. These consultations enabled us to hear the points of view of close to 40 organizations, institutions and speakers, as well as of the members of the Association québécoise de suicidologie. As a result of this exercise, we were able to finalize our priorities and publish Québec's Strategy for Preventing Suicide.

Suicide is a problem that concerns everyone. Even if we do not fully understand the causes, we certainly know enough to act, both to prevent suicide and to help those who engage in suicidal behaviour and the people around them. It is to this end that we must all work together to implement this Strategy.

The Strategy covers a five-year period, from 1997 to 2002. This is the same time frame as was established for carrying out Québec's priorities in public health.

I would like to sincerely thank all those who contributed to this publication through their expert knowledge and opinions. It is our hope that all our partners will join with us to work for suicide prevention.

Christine Colin
Assistant Deputy Minister
for Public Health

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INTRODUCTION

Suicide is a social phenomenon of concern to Quebecers. It is a major public health problem and both an individual and a family tragedy. The constant increase in the number of suicides in Québec and the large amount of suffering associated with this problem have mobilized social forces and created a determination to deal with the problem.

This publication is the product of the work and cooperation of a group of experts from various milieus, and of consultation with many other people interested in suicide prevention in Québec. The department favoured an approach based on solutions that require a consensus by partners in the health and social services network and other interested networks if they are to be successfully carried out. The Strategy provides for a five-year period during which to reach its goals.

The guidelines put forth in this publication are intended for all the people of Québec. They depend on the creation of a community spirit that will respond to the aspirations of the general public. The Strategy does not deal specifically with the suicide problem among the Native peoples of Québec, although those communities that have taken or will be taking steps to reduce suicidal behaviour in their midst will find it useful. The Native communities will judge for themselves whether the guidelines and strategies best suited to their needs are appropriate. It is hoped that this publication will provide them with the support they need. Some of their communities have expressed interest in our work and a number of them have already taken steps to reduce suicidal behaviour among their people.

The success of this plan of action depends on existing resources in Québec. This is why the department wishes to stress the exceptional devotion of numerous volunteers, some of whom have been working in suicide prevention in Québec for many, many years. Community organizations have developed tools, provided high-quality training for thousands of volunteers and helped awaken the public to the problem of suicide. Their expertise will be a major asset in implementing Québec's suicide prevention strategy. Researchers and social workers in various networks have also made a noteworthy contribution to our understanding of the phenomenon. Improved education, coupled with more effective mobilization and greater cooperation among community organizations, health and social services and the general public should serve to reduce suicidal behaviour in Québec and help ease the suffering associated with this problem.

The suicide rate has been climbing steadily in Québec in recent decades, making this cause of death a major public health problem. In 1995, there were 1 442 completed suicides in Québec: 1 144 by men and 298 by women. Suicide is a social phenomenon, the instances and effects of which call for appropriate action to reduce the impact and alleviate the consequences.

The phenomenon of suicide must be properly defined, both in terms of epidemiological data and of the main factors associated with it. The associated factors are described by age group (children, young people, adults, the elderly), an approach suggested by existing research and by the question of access to and organization of services. These factors were analyzed using a number of descriptors including personal predisposition, membership in a social group, and life events.

For each death by suicide, there are many attempted suicides. Generally, there are more attempted suicides among women and girls than among men and boys. The prevention of suicide attempts and follow-up for those who made the attempt is an integral part of *Québec's Strategy for Preventing Suicide*. The Association québécoise de suicidologie (AQS) gives the following definitions of suicidal behaviours:

- **Suicide** means death through a deliberate self-destructive act.

- **Attempted suicide** occurs when a person exhibits a behaviour that puts his life in danger, with the real or seeming intention of taking his life or making people believe he means to take his life, but does not die.

- **Suicidal ideation** includes behaviours that may be directly observed or heard and that imply that a person may plan to commit suicide, or behaviours that suggest such an intention, but that have not resulted in the fatal act.

It is not possible to predict the growth of suicide rates with any certainty. Our grasp of the psychosocial and environmental factors is incomplete and changes in attitudes are often unclear and occur over the long term. Given the current trend in suicide rates, the department believes it is unlikely to reach the objective set in the *Policy on Health and Well-Being* (1992) of a 15% reduction in the number of suicides by the year 2002. We do believe, however, that creating an essential range of services and better coordinating these services will help slow down the growth in the suicide rate among certain groups at risk and eventually contribute to a reduction in the suicide rate.

The consultations we held last spring resulted in a consensus on a number of proposed actions, as well as on the measures that should be implemented. Briefly, the main points that surfaced from the opinions expressed are as follows:

- Suicide among young people, as well as attempted suicide among girls, is of great concern to all those we heard. We therefore contacted the Conseil permanent de la jeunesse and took into consideration the recommendations it made. The consultations also clarified the extent of the problem of suicide among men.

- Our work proved of interest to a number of people in the education and public security networks. It is clear that the commitments made by the health and social services network should rapidly be placed in tandem with those of other partners concerned by the phenomenon of suicide. The action taken initially by the ministère de la Santé et des Services sociaux will thus become part of a government action plan for the prevention of suicide.

- Most of the groups consulted believe that we must look at the values that prevail in our society and their effect on suicide in Québec. They believe that there is not enough discussion of subjects like poverty, individualism, intolerance of hardship, the consumer society and so forth. According to the scientific literature, it would be risky, to say the least, to try to establish a link between various points of view and the growth of the suicide rate in Québec. The risk factors identified are well documented and do not contradict an interpretation based on broader cultural and social values.

- There is no theoretical model for suicide prevention, since suicide cannot be considered a specific physical or mental health problem, or even a problem of social behaviour, which is the definition generally given to it. Suicide is a combination of all of the above. We have developed a strategy whose main objectives are the subject of a consensus and we have tried to clarify the relation between our classification of the risk factors (personal characteristics, social group and life events) and the objectives sought.

EPIDEMIOLOGICAL DATA

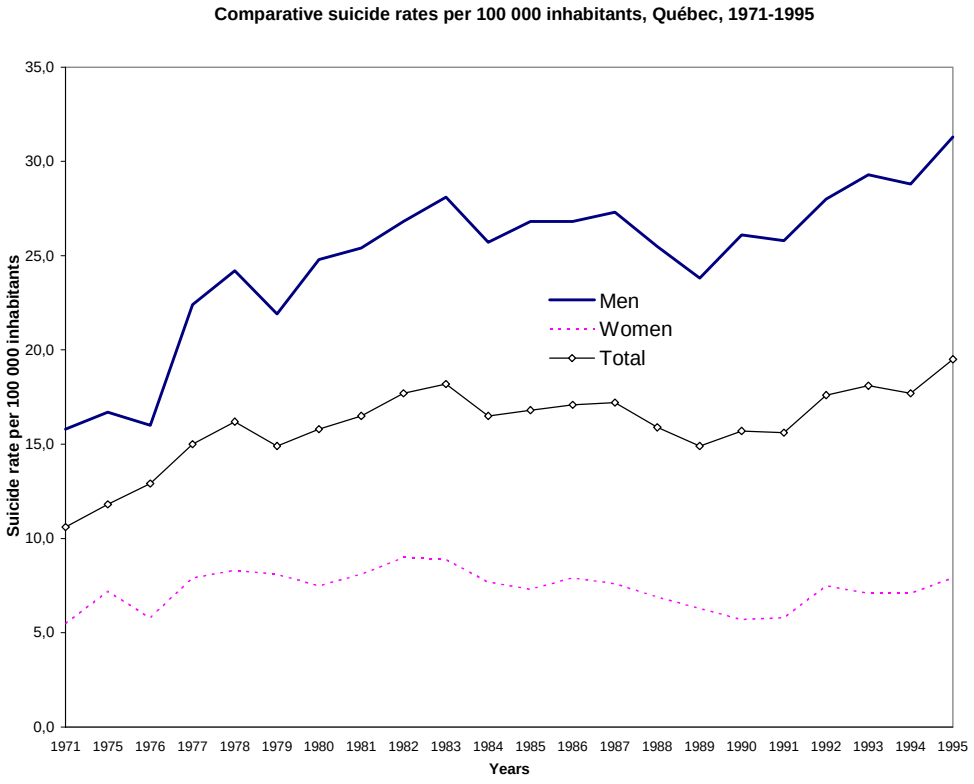
There are two sources of official data on suicidal behaviour: the mortality figures entered on the Registre de la population and hospital data compiled in MED-ÉCHO records. An analysis of these data leads to significant observations. For example, contrary to what is suggested by the media, adult men have as high a rate of death by suicide as young people. Young people, however, especially girls, are more often hospitalized following attempted suicides than are other groups.

New upward trend in death by suicide since 1990

In 1995, 1 442 Quebecers took their lives, that is, 19.5 per 100 000 people.[1]

Beginning in the early 1970s, the suicide rate grew steadily to reach a peak in 1982 and 1983. It remained stable for several years and then began to climb once again in the early 1990s.

Figure 1



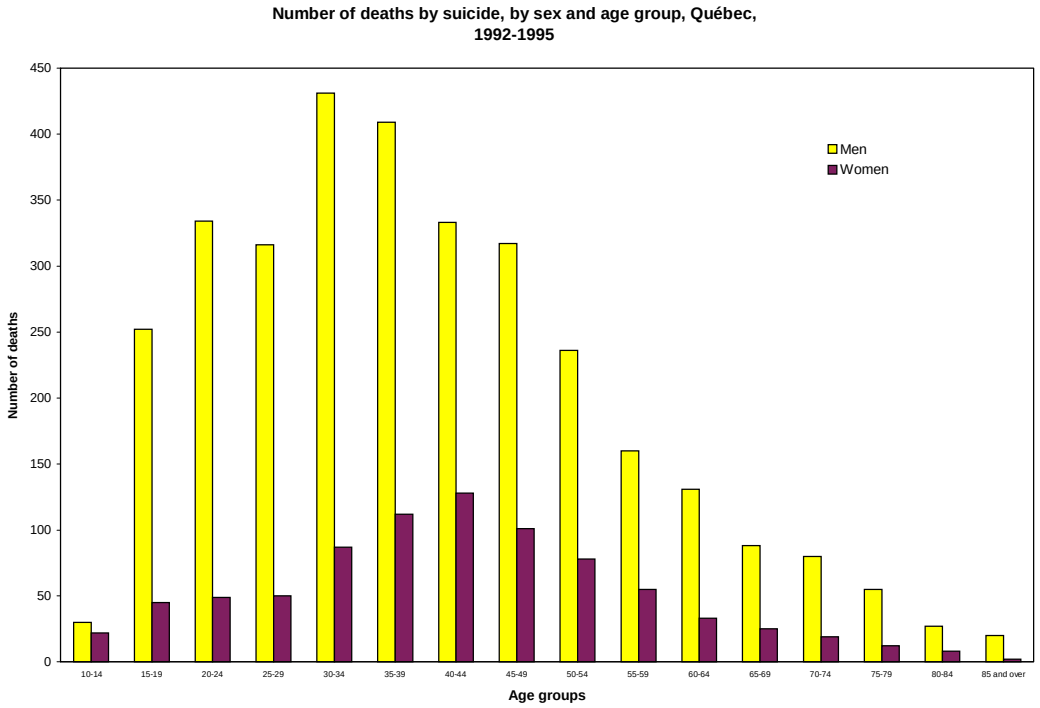
Source: MSSS, Direction générale de la santé publique.

1 Bureau de la statistique du Québec, *Registre de la population 1995.*

Four times more men than women commit suicide

In 1995, 80% of suicides were men, that is, 1 144 cases out of 1 442. The rate observed among men in 1995 was 31.3 per 100 000, compared with 7.9 per 100 000 for women (298 deaths).[2] Suicide occurs among all age groups and both sexes in Québec. However, men commit 3 suicides out of 4 before the age of 50, while most suicides among women are committed between the ages of 40 and 54.

Figure 2



Source: MSSS, Direction générale de la santé publique.

More women attempt suicide

It is possible to estimate suicidal behaviour among Quebecers thanks to the data on suicidal ideation and suicide attempts provided by the Enquête sociale et de santé 1992-1993 carried out on a representative sample of the population in the 15-and-over age group.

According to the results of the survey, more women try to end their lives. In fact, close to 5 women out of 100 attempted suicide (parasuicide) at some time during their life, while only 3 men out of 100 say they have done so.

2 Bureau de la statistique du Québec. *Fichier des décès 1995.* Calculations by the ministère de la Santé et des Services sociaux, 1996.

Age is also a significant variable. Prevalence decreases with age, dropping from 6% in the 15-24 age group to about 1% in the over-65 age group.

According to the same survey, reports for the year preceding the survey suggest that the ratio of attempted suicides among both men and women is an estimated 6 per 1000.

However, records kept by short-term-care hospitals confirm that suicide attempts are much more common than suicides among women and that many more women than men are hospitalized for attempted suicide. The highest rate of hospitalization is among women between the ages of 15 and 19.

Figure 3

Life-time and 12-month prevalence of parasuicidal behaviour,[3] reported in the Enquête sociale et de santé 1992-1993, by sex and by age, Québec, 15-and-over age group

	Life-time	12-month
	%	%
Men		
15-24	4.5*	1.9**
25-44	3.5	0.6**
45-64	1.8*	0.2**
65 and over	0.4**	0.0
Total	2.8	0.6*
Women		
15-24	7.6	1.7*
25-44	5.2	0.5**
45-64	3.7**	0.3**
65 and over	1.0**	0.1**
Total	4.5	0.6*
Men and Women		
15-24	6.0	1.8*
25-44	4.3	0.6*
45-64	2.7	0.2**
65 and over	0.7**	0.1**
Total	3.7	0.6

Source: Enquête sociale et de santé 1992-1993, Québec.

* Coefficient of variation between 15% and 25%; interpret with care.

**Coefficient of variation of 25%; imprecise estimate, provided simply as an indication.

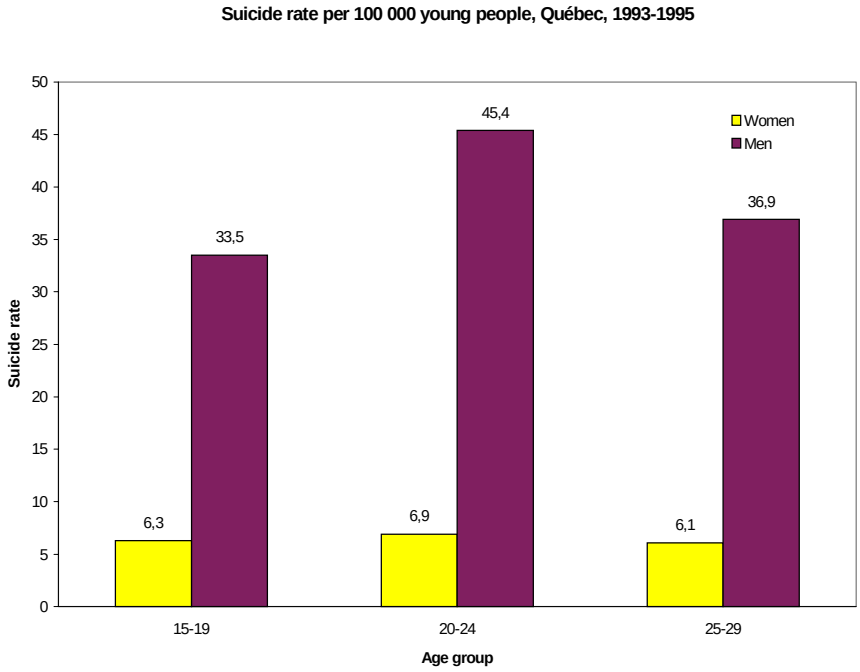
3 In the text of the general survey on health, the use of the expression "suicide attempts" is not considered appropriate since the real intention of dying and the state of mind essential for suicide are difficult to estab lish. This is why the term parasuicidal behaviour has been used in the figure.

Suicide: the main cause of death among young men between the ages of 15 and 29

Suicide is the main cause of death among young men under 30. Among young women, the rate is relatively low. Death by suicide among young men and among slightly older men has risen significantly since the early 1990s.

At the same time as this rate was rising, suicide among young people between the ages of 10 and 14 was becoming more and more common. In 1994, 22 deaths were recorded in this age group, the highest ever seen in suicide statistics. In 1995, there were 15. Because the figures are not large, it is difficult to identify a trend. The phenomenon is nevertheless worrisome, especially since, during the same period, hospitalization for attempted suicide increased for the same age group.

Figure 4



Source: MSSS, Direction générale de la santé publique.

Men use more violent means to commit suicide than women

An analysis of the means used to commit suicide shows that over one third of deaths are caused by hanging. Among men, close to 3 deaths out of 10 are achieved using firearms, while less than 10% of women resort to the same means. Close to 3 out of 10 suicides by women, however, are caused by poisoning or swallowing solid or liquid medication. Although carbon monoxide is responsible for only 13% of deaths, its use is much more common than in the past.

Figure 5

Breakdown of deaths by suicide by means taken, Québec, 1992-1994

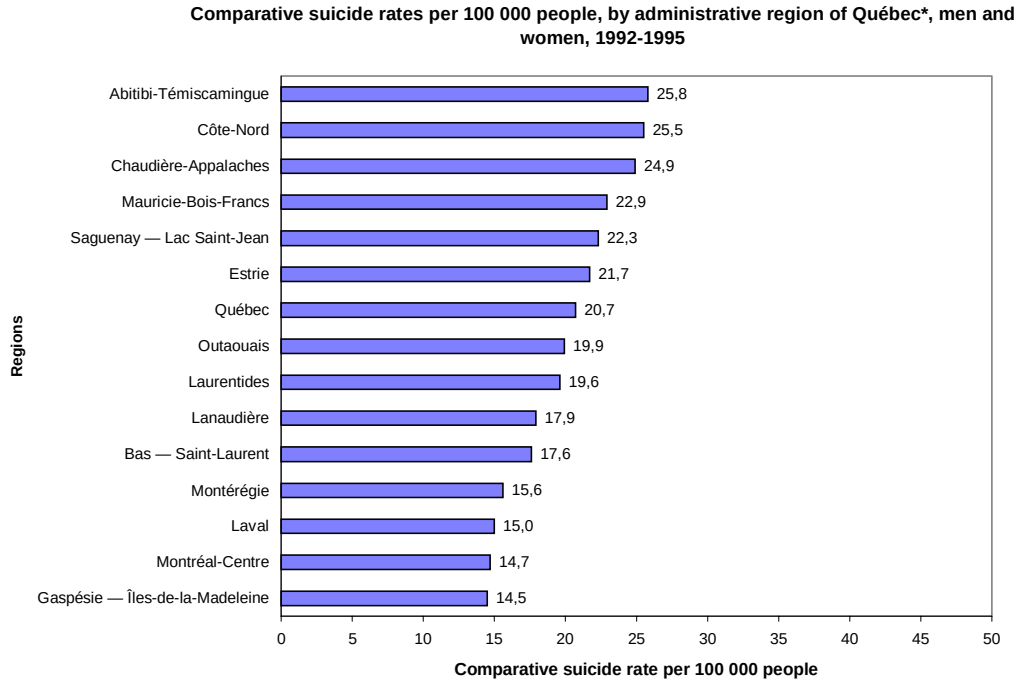
	%			Number		
	MEN	WOMEN	TOTAL	MEN	WOMEN	TOTAL
Hanging, strangling, asphyxiation	40.6	34.2	39.3	1 229	268	1 497
Firearms or explosives	26.7	7.3	22.7	807	57	864
Poisoning (gas or vapour)	12.8	11.5	12.5	388	90	478
Poisoning (solids or liquids)	7.6	26.7	11.5	230	209	439
Drowning	4.6	8.7	5.4	138	68	206
Jumping from a height	3.7	5.0	4.0	112	39	151
Other	2.5	5.7	3.2	77	45	122
Sharp or pointed instruments	1.5	1.0	1.4	46	8	54
Total	100	100	100	3 027	784	3 811

Source: MSSS, Direction générale de la santé publique.

Suicide rates are higher in outlying regions

Half of all deaths by suicide between 1992 and 1995 were recorded in the Montréal metropolitan region. However, even if, in absolute terms, there are a large number of deaths by suicide in Montréal-Centre, Laval and Montérégie, these are the regions of Québec in which the suicide rate is lowest. On the contrary, the highest suicide rates are recorded in isolated, low-population areas. The only exception to this general rule is the Gaspésie-Îles-de-la-Madeleine region.

Figure 6



Source: MSSS, Direction générale de la santé publique.
*Rates in Nunavik and the Cree James Bay Lands are not included because of their high variations and the small number of deaths observed.

Calculations based not on region but on number of inhabitants per census area confirms this discrepancy between urban and rural areas. In fact, an analysis[4] by geographic environment (Montréal, regional capital, small town, rural area) for the 1992-1994 period reveals major differences. Among men, the death rate per 100 000 inhabitants was 25.0 in Montréal, 31.0 in the regional capitals and 38.0 in small towns and rural areas. Among women, there was no statistical difference between the rates observed in different geographical areas.

Québec compared to Canada and other countries

The suicide rate has increased significantly in most industrial countries, as in Québec, in recent decades. Québec is on a par with Switzerland, France, Belgium and Scandinavia, right behind Finland and Hungary, for the highest suicide rates for men. Québec also has a very high premature death rate among men[5] as a result of this phenomenon. When the potential years of life lost are calculated on the principle that the average life expectancy of a man is 75 years, Québec ranks very high, above France, Belgium, Switzerland and Scandinavia.

4 These calculations were made at the Direction de la santé publique of the ministère de la Santé et des Services sociaux du Québec.
5 Premature death refers to death before the age of 75.

Québec has one of the highest suicide rates in Canada, along with Alberta. While suicide rates grew in Québec over recent years, they stabilized or dropped elsewhere in Canada.

The significance of premature death due to suicide may be explained in part by the high suicide rates in the general population and the high rates among young people. This last aspect is characteristic of Québec, when it is compared with other industrialized societies. In industrialized countries as a whole, including the United States, suicide rates among men increase with age. Only Norway's situation is similar to Québec's.

In the industrialized countries as a whole, suicide rates among women are much lower than those observed among men. Moreover, in a good many countries, the suicide rate among women is less than half the rate among men. Québec again stands out, with a much greater gap between the rates for men and those for women.

Figure 7

Comparative suicide rates per 100 000 people in 1993 and potential years of life lost (PYLL) per 1 000 people in 1993, by industrialized country and by region of Canada

	SUICIDE RATE			PYLL		
	MEN	WOMEN	TOTAL	MEN	WOMEN	TOTAL
Québec	29.4	7.1	18.1	10.7	2.5	6.6
Australia	18.7	4.3	11.4	6.4	1.4	3.9
Austria	32.0	9.6	19.7	8.5	2.6	5.6
Belgium (1989)	27.4	10.5	18.3	7.4	2.8	5.1
Denmark	27.7	13.3	20.3	7.5	3.0	5.3
Finland	44.8	11.0	27.3	14.6	3.5	9.1
France (1992)	30.2	10.0	19.4	8.3	2.7	5.5
Germany	21.8	7.1	13.9	5.7	1.7	3.8
Hungary	56.4	15.8	34.5	14.9	3.7	9.2
Iceland	15.2	6.1	10.7	5.6	1.7	3.7
Israel (1992)	13.3	4.6	8.9	5.3	4.6	1.0
Japan	20.8	9.3	14.9	5.6	2.2	3.9
Netherlands	13.4	6.5	9.9	4.1	1.9	3.0
Norway (1993)	20.9	7.6	14.1	7.0	2.3	4.7
Spain (1992)	10.9	3.0	6.7	2.7	0.7	1.7
Sweden (1992)	20.8	8.9	14.7	5.9	2.6	4.3
United Kingdom	12.8	3.4	8.0	4.3	1.0	2.7
United States	20.8	4.7	12.3	6.6	1.5	4.0
Maritimes	20.1	4.1	12.0	*	*	*
Ontario	15.7	4.6	10.0	5.0	1.5	3.2
Prairie Provinces	23.6	5.8	14.7	*	*	*
Alberta	26.4	5.9	16.1	9.0	1.8	5.5
British Columbia	18.5	4.6	11.5	6.4	1.6	4.0
Canada	20.8	5.3	12.9	7.4	1.9	4.7

Source: World Health Organization, MSSS, Danielle Saint-Laurent, 1997.
* Data not computed.

FACTORS ASSOCIATED WITH SUICIDE AND SUICIDAL BEHAVIOUR

Suicide is a complex phenomenon

Suicide is a complex phenomenon determined by the interaction of various factors. The individual, his history, his immediate environment, his social setting all make up a web almost impossible to untangle.

Suicide is a universally recognized phenomenon, references to which are found in the oldest historical documents. However, suicide has been studied from different perspectives only over the past 100 years, following the publication of Émile Durkheim's S*uicide*. At one time, sociological theories of suicide dominated scientific literature; at other periods, psychoanalytical, behaviourist or biological theories prevailed. Despite thousands of articles on suicide published in scientific journals, there is no one theory accepted by a majority of researchers and caseworkers. One might even say that the complexity of the issues involved in suicide and the very nature of the fact of taking one's own life preclude any explanation relying on a single point of view. Most researchers agree, however, that we are able to identify a number of important factors associated with the risk of suicide and suicidal behaviour. These factors are neither independent of one another nor exclusive.

The factors associated with suicide can be divided into three main groups: personal predisposition, social environment and life events. In the following section, we will briefly discuss the factors most commonly identified in the scientific literature.

The main personal factors or predispositions associated with suicide are: mental disorders, including substance dependence and abuse, physical illness, interpersonal psychopathology and adjustment problems.

Social factors involve the family, the extended social environment and the cultural values and attitudes transmitted by those milieus. The main risk factors include a dysfunctional family, difficult economic circumstances, previous suicidal behaviour in the family, social isolation and a value system that views suicide as an acceptable solution to certain problems.

Immediate environmental factors and life events can take different forms. They may be common circumstances of life, such as a death, loss of employment, separation, failure at school, hospitalization or simply access to the means of self-destruction (firearms, medication, etc.). Alcohol and drug abuse may also lead to suicidal behaviour.

Scientific studies show that a multitude of factors can be associated with suicide and suicidal behaviour. Despite all that has been accomplished to date, however, we are still a long way from understanding the nature of the relation between the various factors. Although mental disorders and psychoactive drug abuse are the factors most often pinpointed by researchers and the ones with the strongest association with suicide and suicidal behaviour, they do not in themselves explain the appearance of the phenomenon. Most people who present with mental disorders or who take psychoactive drugs do not commit suicide or exhibit suicidal behaviour. Various environmental factors and life events also play a major role in this area.

While the factors associated with suicide can be divided into three main groups, their relative importance also varies with age group. A distinction must therefore be made between the factors that play on children, those that play on young people, those that affect adults and those that influence the elderly. Appendix 1 gives a summary of the research on the main factors associated with suicide and suicidal behaviour by age group.

OBSERVATIONS ON SERVICES OFFERED

Observations on services offered provide a basis for our perception of the various levels of action associated with suicide prevention.[6]

Prevention comprises measures designed to avoid a suicidal crisis by acting on certain risks (particularly critical situations) and improving unfavourable social conditions. This definition includes the notion of health promotion, the goal of which is to create conditions and life skills that will enhance the health and well-being of the people.

Intervention refers to initiatives that make it possible to deal immediately with a crisis situation and to provide longer-term follow-up of at-risk subjects, namely, care, treatment and support.

Postvention comprises support measures offered individuals, families, communities and caseworkers following a suicide.

General observations

We will begin by identifying the general context in which initiatives and cooperation designed to prevent suicide were fostered in Québec. Without providing an exhaustive picture, this exercise will serve to better define the issues involved in the development of strategies to deal with suicide.

In most regions of Québec, prevention, promotion and postvention are primarily the work of communities, which have managed to acquire the necessary skills. This is due in part to the fact that, for close to 20 years, suicide prevention centres have been dealing with the problem. An unequal and ad hoc distribution of financial resources by region did nothing to help develop a structured network that would give to caseworkers involved in suicide prevention access to information and a forum for discussion. Despite criticism of the involvement of institutions in the management of suicide, the outstanding commitment of many psychiatrists, psychologists, social workers, police officers and researchers deserves mention. (Appendix 2 provides a few examples of the contribution made by these people).

6 Health Canada. *Suicide in Canada, Update of the Report of the Task Force on Suicide in Canada*, 1994.

From a historical perspective, the problem of suicide has taken a backseat in the strategies and policies developed in the fields of public and mental health. Institutions and their main stakeholders have never really risen to the challenge of dealing with suicidal individuals or suicidal crises. For example, a telephone survey on the organization of health and social services conducted in the regional boards in the spring of 1996 confirmed that suicide was not a priority, except in a few regions and for a few exceptional cases. Some mental health crisis centres and a number of other organizations actually refuse to work with suicidal people.

Skills in dealing with the problems surrounding suicide have been developed mainly by and for volunteers and caseworkers in community organizations, particularly with respect to telephone hot lines and awareness campaigns in schools.

Cooperation between suicide prevention centres (SPCs) and other organizations in the health and social services network is intermittent, although there are agreements with the CLSCs for providing some or all services in most regions. It is generally more difficult to link up with the hospital network, which in turn looks for little support from the community. Protocols have been drawn up, however, for taking charge of and referring suicidal individuals. A noteworthy example of an integrated service model may be found in the Gaspésie-Îles-de-la-Madeleine region. Studies on suicide have been carried out in some regions and action taken to tighten control over firearms and restrict access to certain areas (Appendix 2).

Observations on prevention

The public attitude to suicide varies. While people in the general population hesitate to broach the subject, 25% of those questioned in a CROP survey (1996) think that it takes courage to commit suicide. Half of the respondents believe someone has to have a psychological problem to commit suicide. The public is not familiar with the main risk factors for suicide. Moreover, suicide is being trivialized and the media provide very uneven coverage of the subject.

We have to face the fact that, generally speaking, we would be well advised to better direct and coordinate our efforts to promote well-being and prevent suicide. A notable exception to this observation is Québec's Suicide Prevention Week, organized by the Association québécoise de suicidologie. During one week every February, suicide prevention centres and other local organizations in each region hold a large number of activities, in cooperation with the AQS. Activities to promote well-being and suicide prevention activities are rarely evaluated, however, and there is some question as to how effective they are in preventing suicide. Moreover, there are not enough such activities aimed at adult males, the highest-risk group.

Efforts made in recent years, particularly to train volunteers and caseworkers, have given rise to expertise in the understanding of the suicidal process, in the evaluation of risk and urgency, and in the identification of the highest-risk groups and individuals and of available resources. In some regions, suicide prevention centres offer training and consciousness-raising activities for various professionals, such as police officers, community organization employees and teachers. Most of the gatekeepers, that is, the people best placed to have meaningful contact with suicidal individuals, particularly medical personnel and psychosocial caseworkers, do not take part in training or consciousness-raising activities. Training should include a module on screening techniques for the highest-risk groups.

Observations on intervention

Suicidal individuals can receive services from many community organizations and the health and social services network, but intervention seems to be hampered by a lack of coordination. In addition to the lack of commitment from institutional resources and even from certain community organizations, there are no clearly identified mechanisms for taking charge of and following up on a person during and after a suicidal crisis.

Roles and responsibilities are not clearly defined in terms of different users, who may already be in the charge of the network (drug abuse, mental health) or who may be turning to front-line services for the first time. The knowledge required to evaluate, take charge of and follow up on a person is not sufficiently wide-spread or integrated.

Lack of leadership hampers the implementation of essential services. There are very few inter-establishment agreements designed to facilitate recourse to various services (clarifying who does what) and prevent the patient from being given the runaround, and resource banks organized to match the patient to the professional are rare. In many cases, the police, who are the first to intervene in crisis situations, are unable to direct the individual toward the appropriate resource.

Most of the regions of Québec have a telephone hot line. However, this service is not available 24 hours a day or seven days a week in all regions. Moreover, in several regions, the telephone hot lines are not connected to intervention services, case management services or follow-up services. A full telephone hot line service should provide follow-up, case management and referrals where necessary, as well as a sympathetic ear, an assessment and ad hoc crisis management.

Suicide is perceived as a problem to be handled by specialists, whether they be professionals or community-trained. A much larger number of stakeholders must be given access to the clinical support and training required to help suicidal individuals in order to ensure a complete and detailed assessment, case management and follow-up. The contribution of users, families, friends and the community is not sufficiently encouraged or supported.

Observations on postvention

Postvention comprises the measures to take following a suicide. The effect on individuals or a family of a death resulting from suicide is not the same as the impact of other types of mourning, particularly for more vulnerable persons. The death becomes an additional risk factor for the community or individuals involved. Unfortunately, the friends and family, colleagues and classmates do not always receive the support they require, either individually or as a group.

Although postvention is the area in which the most service agreements exist, between suicide prevention centres and schools, for instance, it is nevertheless underdeveloped in Québec, as are the mechanisms for cooperation and referral between various partners and organizations. Clinical intervention, for individuals or groups, is offered in some suicide prevention centres and CLSCs. There are not enough protocols, however, explaining what to do when a suicide occurs in a given environment (workplace, school, etc.).

There also seems to be major weaknesses in the follow-up offered after a suicide attempt. Services vary from one resource or institution to another, and follow-up mechanisms in the person's natural environment are too often deficient or non-existent.

Observations on research

A record of the budgets allocated to research on suicide indicates underinvestment in this area. Moreover, research guidelines and priorities are scant. As a result, basic research from the standpoint of the many factors involved in the problem is underdeveloped, particularly with reference to risk. There is also very little diversity in the research projects under way. Much of the research being done focusses on young people, while very little effort is devoted to suicide among adults.

Another observation made in this area is the lack of evaluative research, whether aimed at promotion, prevention, intervention or postvention. A number of programs have been set up and used widely without any evaluation whatever.

In light of current research on suicide and suicidal behaviour, various data would be useful in planning prevention and postvention programs. Unfortunately, there are very few instances where our knowledge is applied to the implementation of prevention and postvention activities. This is the result, in concrete terms, of a lack of communication between researchers and caseworkers.

THE PRINCIPLES UNDERLYING ACTION

The debates and points of view heard in discussions on individual and collective rights, especially on questions of life and death, cannot leave anyone indifferent.

It is essential to identify the principles and values that must guide the choice of objectives and strategies at all times. Three principles were chosen to provide a framework for the measures adopted.

Enhance the meaning of life through a sense of community and responsibility

Unfortunately, the most vulnerable people and those faced with multiple problems often see suicide as a way to end their suffering. Reality is often perceived in terms of social problems rather than in terms of support strategies based on individual potential and the good things that happen in life.

Life can be given new meaning by looking at individual potential and proactive measures for the social integration of people faced with persistent problems. The role of parents, friends, relatives and institutions in the local community must be enhanced to this end.

People feel particularly isolated when they are dealing with multiple problems. This is often the case of suicidal individuals. The legal obligation to intervene in cases of real and immediate physical danger should be extended, in principle at least, to encourage mutual aid and oblige people to provide moral and preventive assistance to anyone experiencing a suicidal crisis and, particularly, anyone who makes known his intention of committing suicide.

The behaviour of most people can be positively influenced by enhancing the value of life, promoting mutual assistance and emphasizing the importance for everyone of a sense of belonging to a group. For instance, certain violent actions that were once tolerated are no longer socially acceptable.

While the work and commitment of volunteers is widespread in Québec, more help would be forthcoming if suicide were demystified and the interrelation of the various support systems was encouraged so that the burden of taking action in this area did not rest entirely on the shoulders of one person or of no more than a few. A proactive approach must be fostered in front-line services so that help and mutual assistance are more available and more readily used.

In a society that grants a great deal of importance to individual rights, the manifest intention of ending one's life demands a commitment on the part of everyone.

Acknowledge that the individual and society have certain skills for dealing with suicide, and the potential to develop new ones

Suicide is often described as a multiple-factor phenomenon over which we have little control, yet there is a suicidal process that can usually be identified. The risk inherent in a given situation can be evaluated, as can the urgency of intervening immediately. Some people present a higher risk and some stakeholders, primary care clinicians, for instance, are more likely to be consulted by people in need.

There is a problem in coordinating services for suicidal people. Many workers are also afraid of having to deal with such people.

Measures to arouse awareness and a sense of responsibility in the public and among gatekeepers people likely to be in contact with suicidal individuals must be increased.

Referral and counselling tools must be developed at the same time as protocols for intervention and agreements between institutions (CLSCs, hospitals, etc.) are set up. Suicide must not be turned into a problem to be handled by specialists alone. On the contrary, many more people are needed who are able to intervene with suicidal individuals.

Everyone should be concerned by the suffering of others. Life is sometimes difficult, and this is universally true. In many respects we all have what it takes to understand and help our peers. The quality of our intervention is the product of our own experience and springs from the sincerity of our intentions. It is up to each and every one of us to make use of the abilities we possess as human beings, never forgetting the professional and community resources to which we can turn for support.

Counting on existing caseworkers and services

The expertise and skills required to help suicidal individuals and their relatives are available. But we must encourage linkage among the various partners in the community and institutional sectors and promote avenues and agreements that foster greater complementarity in our actions and interventions. We must also work to reinforce the abilities and skills required for intervention through a standard further training program for caseworkers in all the networks involved. This training could deal with the characteristics of different groups, the roles and responsibilities of the various caseworkers, the most appropriate local resources, etc.

OBJECTIVES SOUGHT

Scientific studies reveal that, even if it is difficult to categorically state that the suicide rate can be reduced, it is possible at least to stabilize it. The many reasons for which people commit suicidal acts and the various environments in which such events occur have convinced us to join forces with the greatest possible number of caseworkers and to support them in their work. The importance of crisis intervention services and follow-up must be recognized, and the roles of the participants must be better defined.

Although very different in nature, suicide prevention must be seen as complementary to crisis intervention and follow-up.

While it is difficult to define a theoretical framework to characterize suicide, it is important to emphasize the relation between the objectives and the various **risk factors.**

Knowledge of **the factors associated with personal predispositions** enables us, for example, to set up screening programs and programs for treating depression and personality disorders, and consciousness-raising programs for "gatekeepers"[7].

The **factors** associated with the social environment tell us, among other things, to work first on the people who shape public opinion in general, to direct intervention to areas where the suicide rate is highest, or to provide follow-up in any family environment affected by suicide.

Lastly, **life events** require the implementation of strategies suited to effective crisis intervention, the development of hot lines and peer support, and increased control over the available means of action.

The goal of the proposed policies is to define common objectives in order to attack the problem effectively. These objectives and actions are based both on scientific knowledge and on experiments and evaluations considered worthwhile.

It is essential to mobilize the health and social services network, and its partners, to achieve common objectives so that together they may develop a solution better adapted to the problem of suicide.

7 These are people who, because of their role, are more likely to identify individuals presenting predispositions associated with suicide.

In keeping with the results of our consultations, it is important to give priority to the objectives identified to facilitate the implementation of *Québec's Strategy for Preventing Suicide*:

- Provide and consolidate essential services and put an end to the isolation of caseworkers.
- Increase professional skills.
- Intervene with groups at risk.
- Foster promotion-prevention programs among young people.
- Reduce access to and minimize risks associated with the means of suicide.
- Counteract the trivialization and the sensationalization of suicide by developing a sense of community and responsibility.
- Intensify and diversify research.

PROVIDE AND CONSOLIDATE ESSENTIAL SERVICES AND PUT AN END TO THE ISOLATION OF CASEWORKERS

One of the main observations associated with the question of suicide in Québec is the unequal development of services from one region to another and the lack of cooperation and coordination among these services. Furthermore, it is not clear what services must be provided.

This situation creates confusion in a number of regions with respect to the sharing of responsibility for suicidal individuals. Moreover, the connection between resources, community and support system is often very weak, which means that each one is alone in its effort to intervene and provide follow-up for individuals struggling with the problem of suicide. We propose that a range of essential services be offered as well as a few additional tools to ensure the coordination and continuity of intervention.

Essential services

In each region, essential services should be available for suicidal individuals, their support system (friends, relatives) and people who have lost someone close to them through suicide. The resources of the community should be sufficient to meet the needs of these people or to direct them elsewhere, if necessary. The following is a list of such services.

Access by telephone

Access by telephone means 24-hour-a-day, 7-day-a-week service. Telephone service includes assessment, crisis intervention and, if need be, referral for case management and follow-up. Telephone intervention should serve suicidal individuals and their support system, as well as people who have lost someone through suicide.

Intervention

The risk of suicide should never be used as a reason for not providing the services required. On the contrary, it should increase the priority given the intervention. For at-risk groups already receiving care in one network or another (drug abuse, mental health, violence, etc.), suicide crisis intervention should be provided by the same network. Caseworkers in these networks should be trained to deal with the problem of suicide. For groups that are not already in the system, evaluation and referral services, support services and information services for third parties should be set up, preferably where help is likely to be sought.

Evaluating the risk of suicide and the urgent nature of the situation is not the private preserve of specialists. Intervention can rely on regular professional services without depending on them entirely. These services may be available in any number of local organizations or institutions (reception centres, CLSCs, SPCs, private clinics, etc.).

Intervention includes:

- a full, detailed assessment;
- the required assistance;
- follow-up and monitoring.

These forms of intervention must be carried out with the help of the suicidal individual's support system (family, friends, community), to the extent of its abilities, in order to promote, maintain and stimulate its commitment. This cooperation enables the support system to play a role in protecting and following up on suicidal individuals whenever possible. However, it must not be forgotten that the support system itself also requires support.

Even if the caseworkers feel capable of helping someone experiencing a suicidal crisis, they should still be able to count on the support of more highly trained resources if they think the case is becoming too demanding.

Postvention

Postvention includes:

- the availability of individual and group debriefing services for friends, relatives and caseworkers within 48 hours of the event (suicide or attempted suicide) and follow-up, if necessary;

- the availability of individual or group debriefing services for people in mourning as the result of a suicide, suited to the situation and offered in cooperation with their community resources. Particular attention should be given children, who should be assessed and supported systematically;

- protocols for cases of suicide or attempted suicide outside the home (at work, at school) in order to determine responsibility for taking appropriate action.

Tools for intervention

Protocols for intervention in each institution, service agreements between institutions, reference guides and clinical support for caseworkers are the cornerstones on which the smooth operation of essential services rests.

Protocols for intervention

If it does not have a crisis intervention plan, each community organization or resource likely to provide services for individuals who are experiencing a suicidal crisis or who have attempted suicide, their friends and relatives, or people in mourning as a result of a suicide should adopt protocols for intervention. These protocols enable stakeholders to better define their responsibilities and to provide services more efficiently. Institutions, as well as community organizations and resources, could refer to the proposed models for intervention.

Service agreements

The coordination of services is essential if people struggling with the problem of suicide are to receive adequate support. Coordination means clear roles for each service or resource and mechanisms for referral and cooperation. This is why the coordination of services should be confirmed by agreements binding all the partners (CLSCs, hospitals, SPCs, police, schools, reception centres, etc.). These agreements will reinforce the application of established protocols by facilitating recourse to services deemed essential. All caseworkers should be familiar with these mechanisms for coordination.

Reference guides

To facilitate intervention, all the partners must have in their possession counselling guides and reference tools that clearly describe the roles and responsibilities of the resources in a position to intervene with groups grappling with the problem of suicide. Consequently, counselling guides and intervention tools must be developed in each region and territory.

Clinical support

All caseworkers and professionals should have access to people and resources that will provide clinical support whenever necessary. Each region should also have a team of experts or people able to provide clinical support in suicide-related cases.

Provide and consolidate essential services and put an end to the isolation of caseworkers		
ACTION	**TIME FRAME**	**LEVEL OF RESPONSIBILITY**
• Identify the person or organization responsible for leadership.	1998	Regional
• Draw up a list of services (telephone access, intervention and postvention), available locally and regionally.	1998	Regional
• See that essential services are available and specify the respective mandates and roles of all the local and regional partners.	1999	Regional and local
• Design models for intervention protocols and service agreements.	1998	Central, with regional cooperation
• Identify the team of experts who will provide clinical support in each region for caseworkers and professionals.	1998	Regional
• Make counselling guides and reference tools that clearly describe all the roles and responsibilities of the resources in a position to intervene with suicidal individuals available to all caseworkers and professionals in the health and social services network.	1999-2000	Regional

Implementation indicators

– Existence of a regional plan for the organization of integrated suicide prevention services (stipulating who does what).

– Existence of coordination mechanisms (protocols and agreements).

– Percentage of the population with access to a hot line.

– Support given caseworkers and effectiveness of action taken.

– Every region should be able to assess, from time to time, whether users and those close to them received the follow-up they required.

INCREASE PROFESSIONAL SKILLS

Mental disorders are cited in scientific literature as a predisposing factor in many persons who commit suicide. Professional skill in screening for suicide risk and treating mental disorders is an essential element of suicide prevention. It is important, then, to see that professionals receive the training required to diagnose and treat mental disorders as soon as they appear. Increased professional skills must be accompanied by a change in attitudes and by an understanding of how to react to suicidal persons and their needs.

Ensure the identification and treatment of people suffering from mental disorders

The first step is to better train and equip general practitioners so that they can more reliably diagnose and treat people suffering from mental disorders, particularly depression, adjustment problems, associated problems and their signs. The scientific literature reports that most people who commit suicide consulted a physician during the weeks preceding the event. During their training, general practitioners must be given a good understanding of the phenomenon of suicide.

Other front-line practitioners (psychologists, social workers, police officers psychoeducators, teachers, etc.) must acquire the skill necessary to detect depressive states, the disorders associated with them, and their signs, both among adults and among young people in difficulty.

Ensure that front-line practitioners receive adequate training in intervening with suicidal individuals, the people around them and people in mourning as a result of a suicide

In an effort to cover all that must be done to increase professional skills, two main elements must be developed in any training program:

– identification of suicidal individuals, risk assessment, evaluation of urgency, crisis intervention with suicidal persons and the people close to them, and postvention;

– greater understanding of the referral mechanisms and resources for suicidal individuals, for those close to them and for people in mourning as the result of a suicide.

Workers will be trained to optimize their skills in suicide risk assessment, crisis intervention and case management, including treatment and follow-up.

Training programs for caseworkers likely to intervene with suicidal individuals must be the subject of on-going evaluation and adaptation. While increased knowledge is important, it is essential that caseworkers be made more aware of and given more instruction in certain human qualities (compassion, lending a sympathetic ear, tolerance, etc.) needed in dealing with people who suffer grievously and who are particularly vulnerable in the face of adversity.

Training should also be continuous in order to ensure that new knowledge is fully integrated and that practices are updated.

Along with these strategies geared toward the delivery of services and the means of maximizing their implementation at the regional level, two other strategies should be carried out on a Québec-wide scale in order to reinforce the training given caseworkers:

– making representations to professional corporations and orders interested in human relations so that they design programs on suicide risk and intervention;

– working with professional orders to find a way to deal in codes of ethics with the problem of confidentiality and the right to life, with a view to protecting individuals by establishing contact with family and friends. This initiative requires a scrupulous examination of the ethical, legal and professional issues at stake.

Increase professional skills		
ACTION	**TIME FRAME**	**LEVEL OF RESPONSIBILITY**
• Train all general practitioners in the diagnosis of depression, in adjustment problems and in treatment strategies.	1999	Regional, with central support and the cooperation of the Fédération des médecins omnipraticiens du Québec
• Train caseworkers in the identification of depression, disorders associated with depression and their signs.	1999	Regional, with central support
• See that caseworkers receive adequate training in working with suicidal persons, the people around them and people in mourning as the result of a suicide.	1998-1999	Regional

Implementation indicators

– Percentage of general practitioners by region who receive training in the diagnosis of depression and its signs.

– Percentage of caseworkers who receive training in the identification of depression, associated disorders and their signs.

– Percentage of caseworkers who receive training, depending on their place of work, in dealing with suicidal individuals, the people around them and people in mourning as the result of a suicide.

INTERVENE WITH GROUPS AT RISK

We know that some groups are at greater risk of committing suicide than others, for instance, people who have manifested suicidal behaviour in the past, men between the age of 20 and 55, substance abusers and people with mental disorders.

We believe that if we target groups at risk of suicide or suicide attempts, we should be able to prevent suicidal acts. However, since proof of the effectiveness of preventive measures is rather weak, and the means of intervening with certain groups are not very advanced, we must proceed with caution in developing and validating intervention and prevention models for groups at risk.

It is proposed that projects to develop and evaluate effective prevention programs and intervention activities be encouraged and supported in one or more interested regions among groups with the greatest risk of suicide or attempted suicide. These projects should be carried out in cooperation with the main stakeholders in the health and social services network and the other departments and organizations concerned. They would also be the subject of a rigorous and systematic evaluation and, if necessary, an adjustment, before being implanted in other territories.

These projects should target as priorities:

Men at risk of suicide

- Men with problems of substance abuse or dependency (drugs, alcohol or other);
- Men and young people with mental disorders;
- Men in prison;[8]
- Men presenting a number of risk factors.

People at risk of attempting suicide or who have already attempted suicide

- Young women between the ages of 14 and 19 presenting a number of risk factors;[8]
- People who have made previous suicide attempts.

Gatekeepers can identify, guide and counsel people in the throes of a suicidal crisis and those close to them. They also have a role to play with people who are difficult to contact or people, such as the elderly, who do not use the services offered. Because of their duties, their responsibilities or their involvement in the community, a number of these gatekeepers are called upon to play a meaningful role with people at risk of suicide. The gatekeeper is asked to be vigilant, attentive and receptive. Arousing the awareness of gatekeepers and mobilizing

8 The MSSS believes that intervention with these groups should be carried out with the departments concerned.

them is one of the goals of a process designed to involve as many people aspossible in suicide prevention.

A plan to encourage gatekeepers to become involved with groups of people at risk of suicide should also be set up. This plan should begin by targeting gatekeepers in contact with:

– adult men (union representatives, workers in employment centres, barmaids, hairdressers, etc.);

– older men (family helpers, golden age associations, other associations that work with the elderly);

– young people with unhealthy lifestyles and no sense of belonging to a life environment, workplace or school.

These plans must be evaluated to determine the conditions under which they can best be implemented.

Before this step is taken, however, a list of essential services must be drawn up.

Intervene with groups at risk		
ACTION	**TIME FRAME**	**LEVEL OF RESPONSIBILITY**
• Target and financially support prevention and intervention programs for groups at higher risk of suicide and attempted suicide, and evaluate the projects.	1998-2000	Central
• Introduce suicide prevention programs for the groups at greatest risk.	1998-2002	Regional
• Target and support a plan to involve gatekeepers with groups at risk and evaluate the feasibility of such a step with a view to implementing the plan.	1998	Central

Implementation indicators

– Number of plans accepted and implemented.

– Type of people the projects reached.

FOSTER PROMOTION-PREVENTION PROGRAMS AMONG YOUNG PEOPLE

On the one hand, it is important to distinguish between activities associated with the prevention of suicidal behaviour and actions designed to improve personal and social skills likely to stop the growth of various social problems. On the other hand, it is important to act before problems arise, as clearly stated in *Québec Priorities in Public Health.* In cooperation with the ministère de l'Éducation, the MSSS has adopted the recommendations of the Conseil permanent de la jeunesse that are most likely to lead to our objective.

Increase the personal and social skills of children and young people

Priority should be given to the development and social adjustment of children and young people. This priority must be carried out in an on-going manner beginning in the pre-school years. Action geared to support must be promoted, in cooperation with parents and other family members, since more and more importance is being given to the participation of a person's natural environment in the management of health and social problems. We agree with the proposal by the Conseil permanent de la jeunesse recommending that the ministère de l'Éducation include the development of personal and social skills, such as problem solving, conflict management and self-esteem, in school curricula and in all primary and secondary school activities.

School principals, professional support staff and teachers, as well as orientation committees, should be made aware of the need to encourage the development of strategies for peer counselling and peer support.

This proposal is based on the recommendation of the Conseil permanent de la jeunesse which reads as follows: "since adolescents who experience serious problems confide mainly in other young people, the Conseil recommends that the Minister of Education and school commissioners promote among school principals the idea of developing peer counselling by and for young people, by supporting peer helper initiatives in secondary and post-secondary institutions."[9] This could be achieved with the support of community resources.

9 Conseil permanent de la jeunesse, *Le suicide chez les jeunes* : *S.O.S. Jeunes en détresse* ! Opinion, 1997, p. 86.

Develop suicide prevention expertise among young people

There is no consensus on the pros and cons of introducing adapted suicide prevention programs in schools. Before thinking of proposing comprehensive suicide prevention programs in schools, it would be preferable, in keeping with the comments made by the Conseil permanent de la jeunesse, the Centers for Disease Control and other organizations concerned with suicide prevention among young people, to test one or more projects in schools to determine the exact conditions under which such measures to prevent suicide would be effective or even desirable.

Provide postvention services

These questions must be dealt with directly, however, when a suicide or a suicide attempt takes place. At that point, each regional board must ensure that postvention services are rapidly made available.

Foster promotion-prevention programs among young people		
ACTION	**TIME FRAME**	**LEVEL OF RESPONSIBILITY**
• Create a school program to reinforce the personal and social skills of young people and promote a favourable environment for the adoption of healthy lifestyles.	1998-2002	Central
• Test and evaluate one or more suicide prevention projects in schools.	1998-2000	Central
• Ensure the presence in each region of a response team trained to work in and with schools in cases of suicide and attempted suicide.	1998	Regional

Implementation indicators

– Existence of a regional response team able to work in schools in cases of suicide and attempted suicide.

REDUCE ACCESS TO AND MINIMIZE RISKS ASSOCIATED WITH THE MEANS OF SUICIDE

Measures associated with means of suicide have proven to be effective means of suicide prevention. They have been known to impact on suicide and to reduce the consequences of suicidal acts. In England, for instance, a reduction in the toxicity of gas for home use has affected the suicide rate. When access to the means is limited, there is a greater chance that the suicidal person will postpone taking action. Furthermore, when another, less lethal instrument is substituted, suicide attempts result in fewer deaths and less serious injuries. Initiatives to restrict access to certain means must therefore be encouraged and acted upon.

Promote initiatives designed to restrict access to or minimize the risks inherent in certain means that facilitate suicide and see to their implementation in all regions of Québec

– Firearms

Enable health professionals to verify whether there are any firearms in the home of persons at risk of suicide and, if necessary, to have them seized.

Encourage police officers to seize firearms in case of danger, as provided for in the Criminal Code,[10] and invite caseworkers to call upon them to do so. Relatives should also be made aware of the need to remove firearms from the vicinity of individuals at risk of suicide.

In cooperation with regional partners, see that legislation on the storing and registration of firearms is respected. These measures will be backed by lobbying among decision-makers and people responsible for administering the law. Storage arrangements should be inspected by municipal authorities, firemen for instance, when they inspect homes for fire hazards. The recommendation of the Conseil permanent de la jeunesse that anyone who purchases a firearm be obliged to buy a trigger lock at the same time should be implemented.

10 *Criminal Code*, paragraphs 101(1), 103(1) and 103(2).

– Bridges and other dangerous sites

In the interests of safety, certain structures or sites where suicide could be committed (the Jacques Cartier bridge, for example) should be closely inspected by the regional boards. The people in charge of the suicide dossier at the ministère de la Santé et des Services sociaux will make representations to governments and landowners, if need be, to see that access to these sites is restricted.

– Medication

To restrict access to stocks of medication, representations should be made with the Association québécoise des pharmaciens propriétaires and the people responsible in the CLSCs for home care, so that they make the public aware of the importance of getting rid of unused medication.

Corporations and associations of physicians and pharmacists should be encouraged to prescribe limited quantities of any strong medication (powerful painkillers, narcotics, etc.).

– Carbon monoxide

Representations should be made with Transport Canada so that it induce manufacturers of motor vehicles to equip them with devices that would switch off the motor whenever the level of carbon monoxide in the vehicle climbs. This device is already available in certain models.

Reduce access to and minimize risks associated with the means of suicide		
ACTION	**TIME FRAME**	**LEVEL OF RESPONSIBILITY**
• Inform caseworkers in the health and social services network of the procedures to follow when there is a firearm in the home of a suicidal person.	1998-1999	Regional
• Sensitize the police to the legislative provisions allowing them to seize a firearm in the home of a suicidal person.	1998-1999	Regional
• Make representations to the ministère de la Sécurité publique and the police departments with respect to legislation on the storing and registration of firearms, to ensure it is enforced.	1998-2000	Central and regional
• Make a list of high-risk places for suicide and assess the pertinence of taking action with respect to them.	1999	Regional
• Meet the people responsible in each region for home care to sensitive them to the importance of getting rid of unused medication, and draw up a strategy with them for recuperating it.	1999	Regional
• Ask Transport Canada to make changes to automobile manufacturing standards in order to reduce the number of deaths caused by carbon monoxide.	1998	Québec government, in cooperation with the ministère de la Santé et des Services sociaux

Implementation indicators

– Percentage of police officers aware of the legislative provisions that allow them to seize firearms.

– Percentage of caseworkers in the health and social services network aware of the procedures to follow when there is a firearm in the home of a suicidal person.

– Regional evaluation of the implementation of a strategy for recuperating strong medications left in the home after a death or a disease.

COUNTERACT THE TRIVIALIZATION AND THE SENSATIONALIZATION OF SUICIDE BY DEVELOPING A SENSE OF COMMUNITY AND RESPONSIBILITY

The messages transmitted with respect to suicide trivialize it, making it socially acceptable, something about which nothing can be done. Suicide is trivialized in all types of media, from cartoons for children to documentaries, television serials and CD-ROM games.

Sometimes, witness the recent events at Coaticook, improper media treatment of suicidal acts can have dramatic effects.

Each individual can act responsibly with respect to suicide and suicidal individuals, However, for everyone to shoulder his responsibilities, access to more accurate information on suicide, the risk factors and the warning signs must be more readily available. The resources at hand (support groups, hot lines, CLSCs, etc.) must also be made known. The information conveyed to the public must provide real and practical means for everyone to help deal with the problem of suicide.

It is proposed that a communication plan be developed to support *Québec's Strategy for Preventing Suicide.*

All relevant news and information must be part of a coherent communication plan. It is not enough to simply remove the sensationalism from the media coverage of suicide.

The preparation of this plan must take into account the pertinence of the proposed action and make it possible to inform the groups concerned of the activities recommended for the entire implementation phase of *Québec's Strategy for Preventing Suicide*. The communication plan should foster the transfer of knowledge in terms of the issues, current practices and new developments.

When the communication plan is drawn up, an evaluation should be made of the pertinence of certain activities, such as:

– a multifaceted information campaign on suicide, comprising the production of a wallet-sized card for each region, describing the main warning signs, the action to take, the resources available in the region and where they can be obtained.

– an awareness week that would deal with a variety of themes (the will to live, mental illness, suicide, etc.).

– the creation of an Internet site on suicide.

In addition to this communication plan, less general action could be taken to support the suicide prevention:

– make representations to the Press Council and various media in order to draw up codes of ethics for dealing with information on suicide, based in particular on the work of the Canadian Association for Suicide Prevention and the Société de transport de la communauté urbaine de Montréal for suicides in the subway system.

– make representations to authors, television and radio producers, the Union des artistes, advertisers and other artistic milieus to raise their awareness of the impact they can have, either negative or positive, when they deal with suicide.

– make sure that each region has a guide to facilitate the intervention of the media when handling information on cases of suicide and homicide/suicide (statistics, risk factors and proposals for covering the event in a constructive manner).

Counteract the trivialization and the sensationalization of suicide by developing a sense of community and responsibility		
ACTION	**TIME FRAME**	**LEVEL OF RESPONSIBILITY**
• Prepare a communication plan to support *Québec's Strategy for Preventing Suicide.*	1998	Central
• See that a code of ethics is adopted and disseminated by the media.	1998	Central
• Give the people responsible for suicide prevention in the regions access to a guide for handling information on cases of suicide.	1998	Regional, with central support
• Meet with associations and organizations of authors, artists, playwrights, advertisers and other artistic milieus to sensitize their members to suicide prevention.	1998	Central

INTENSIFY AND DIVERSIFY RESEARCH

From 1991 to 1995, about $500 000 was invested in suicide research in Québec.[11] Given the impact of the problem on mortality and morbidity rates, as well as its complexity, research must be stepped up.

Research should support the strategies laid out in the department's action plan. It should help to better target groups at risk and effectively prevent suicidal behaviour. For example, in the past, research on suicide has been almost exclusively directed toward young people, even though adult men were also at risk. Furthermore, research should make it possible to determine, identify and develop methods of intervention adapted to the various groups faced with the problem of suicide, and their support systems. This perspective should make it easier to implement efficient action. The thrust of the research should be to increase our understanding in order to increase our ability to take action.

11 Source : Banque sur la recherche sociale et en santé, Service de la recherche DGPE, ministère de la Santé et des Services sociaux, April 1996.

Intensify and diversify research by emphasizing three facets in the following order:

- evaluative research in the areas of promotion, prevention, intervention and postvention;
- development of methods of intervention better adapted to the different target groups and the different aspects of the problem;
- basic research on suicide (etiology, genesis, social epidemiology).

Create within the Conseil québécois de la recherche sociale and the Fonds de recherche en santé du Québec a specific program on suicide, making sure that there is communication between the two organizations so that research projects can be submitted to one or the other for financial assistance without danger of duplication.

The funding agencies should invest a total of $2 million in research on suicide over the next five years.

Ensure within the ministère de la Santé et des Services sociaux and the regional boards that a fair share of the funds available for studies and analyses is devoted to research on suicide (for example, the financial assistance program for public health projects).

Intensify and diversify research		
ACTION	**TIME FRAME**	**LEVEL OF RESPONSIBILITY**
• Make representations to funding agencies and regional boards to obtain financing for research on suicide and for the priorities identified.	1998-2002	Central

Implementation indicators

- Annual budget for research on suicide set aside by funding agencies.

RESPONSIBILITIES AND DUTIES

Clearly identified leadership

In view of the complexity of the suicide question and the multiple factors involved, as well as the apprehension felt in dealing with suicidal persons, the structures and persons responsible for assuming leadership and achieving results must be clearly identified. At the local, regional and central levels, an organization or person will be made responsible for the file.

The implementation of *Québec's Strategy for Preventing Suicide* will encounter obstacles and resistance from some people, just as it will arouse enthusiasm and commitment in others. In the same way as the MSSS believed the problem of suicide should be treated as a separate issue in its priorities for public health and its guidelines for transforming mental health services, experiments in Québec (in Gaspésie, for instance) and abroad lead us to conclude that leadership must be provided by a distinct entity.

To achieve the desired results, the structures and people responsible for dealing with suicide at the local, regional and central levels must be identified so that efforts made in the short and medium terms to prevent suicidal acts and meet the needs of suicidal people and the people around them receive the support they require.

The example of Gaspésie and its regional coordinator is proof of the importance and relevance of leadership in implementing a process designed to deal with suicide in a given region. For several years already, that region has been in a position to offer coordinated, coherent services to people faced with the problem of suicide. In Alberta, local and provincial leadership has played a fundamental role in the implementation of a suicide prevention program. In New Brunswick, too, the application of a suicide prevention program is in the hands of a person responsible at the provincial level and clearly identified regional leaders.

Responsibilities of the ministère de la Santé et des Services sociaux

The round of consultations held established a consensus on central and regional responsibilities. For the local level, a few basic actions were identified and other initiatives could be carried out in different communities and regions.

Support for implementing suicide prevention strategies

The department must act as a facilitator. This means it must offer the regional boards the support they require for prevention and intervention, by promoting the sharing of experiences, providing information on the programs available and offering advice where necessary.

Moreover, by means of periodic meetings of those responsible in the regions for suicide prevention and intervention (individuals or organizations), the department must foster the dissemination of information in the regions and the coordination of activities held throughout Québec.

Creation of tools

In cooperation with the regional boards, the department will propose standard protocols, service agreements and reference tools.

Support for training for caseworkers and professionals

The department will promote the identification of guidelines for training programs for caseworkers and professionals and provide support for the regional boards, if necessary. The boards will be responsible for training.

Support mechanisms

The department is responsible for creating mechanisms to help the boards deal with specific problems (suicide contagion, for example), especially by setting up a bank of experts who can advise regional and local stakeholders. These resource people could also work at the regional level and serve as consultants, where needed, on various points related to the implementation of the Strategy.

Guidelines and criteria for evaluations

The department should establish the guidelines and criteria required for evaluating existing prevention and intervention programs.

R*epresentations*

A number of the strategies proposed call for representations to corporations, orders, national organizations and other departments. The MSSS is responsible for promoting cooperation in areas requiring action throughout Québec as well as in areas under the jurisdiction of other departments (education, public security, relations with citizens and immigration). The department will also support the regional boards, where requested, in their interaction with partners in other sectors.

Follow-up and monitoring of the Strategy

In cooperation with the regional boards, the ministère de la Santé et des Services sociaux will be responsible for follow-up on the strategies. The department will create a monitoring system to study the implementation of *Québec's Strategy for Preventing Suicide* and will use indicators to determine whether the objectives proposed have been reached.

Evaluation of projects for the highest-risk groups

The ministère de la Santé et des Services sociaux will provide support for regional boards in the evaluation of suicide prevention programs developed for groups known to be at risk. These programs could eventually be implemented in all the regions of Québec.

Transfer of knowledge

The transfer of knowledge is a major challenge. The department, in cooperation with the funding agencies, will promote the introduction of mechanisms to facilitate the transfer of knowledge to the health and social services network, the community network and their partners.

Responsibilities of the regional boards

Essential services and coordination

The mandate of the regional boards is to organize services and ensure coordination and the sharing of responsibilities between the various partners on their territory (community organizations, police officers, teachers, CLSCs, youth centres, hospitals, etc.). They are also responsible for implementing agreements on cooperation between partners specifying their responsibilities toward the clientele. The sharing of responsibilities and the introduction of essential services should be based on existing regional resources (community organizations, CLSCs, youth centres, hospitals, etc.).

Suicide is of concern to a number of sectors, such as mental health and public health. It is essential that there be a single authority in charge, whether it be an institution, an organization or a committee.

Clinical support

The regional boards are mandated to form regional teams responsible for providing clinical support for caseworkers and professionals who do not have access to such a service locally.

Regional media

The struggle against the trivialization of suicide relies to a large extent on the way in which suicide-related news is handled. The boards are responsible for proposing strategies to the regional media for dealing with reports on suicide, using information prepared by the Association québécoise de suicidologie and the Canadian Association for Suicide Prevention.

Training

Since each region has its own resources and methods of intervention, the training and tools required for caseworkers and professionals must be adapted whenever the regional leaders consider it necessary. This is why it is up to the regional boards, supported by the ministère de la Santé et des Services sociaux, to see that caseworkers and professionals receive the training and tools dictated by regional needs.

Action to deal with instruments of suicide

The regional boards are responsible for identifying high-risk sites on their territory and evaluating the possibility of taking preventive action. They are also responsible for doing what must be done to restrict access to firearms by suicidal persons.

Responsibilities of local organizations and institutions

We cannot underestimate the importance of the contribution of local partners to action against suicide. The success of any plan of action, no matter what the goals sought, depends on the participation of the people, institutions and organizations the most closely involved. Although it is difficult to determine the exact boundaries of a local territory, each region will adopt a method of organization that takes into account its own nature in this respect (sub-regions, territories, CLSCs, RCMs, etc.).

The main actions to be taken are:

provide access to crisis intervention and follow-up services in the local community, while keeping the door open between local and regional responsibilities;

foster local agreements for cooperation, using existing models (between community organizations, CLSCs, schools, hospitals, police, etc.);

mobilize caseworkers and see that action is coordinated and evaluated at the local level;

in cooperation with the regional board, inform the public of the services available and make referrals in consequence. Once the whole array of essential services is in place, see that the public is aware of and can use the tools at its disposal for obtaining references when needed;

provide the clinical support required by caseworkers and professionals.

INVESTING IN SOLUTIONS

The current context is not particularly favourable to new investments. One of the principles underlying the identification of objectives for *Québec's Strategy for Preventing Suicide* emphasizes the fact that we must rely on existing workers and services.

At present, it is impossible to obtain an exact idea of the budgets devoted to preventing suicide in Québec. The only specifically identified activity is funding for suicide prevention centres. All other activities are integrated into a larger field of intervention, such as mental health, emergency services and psychosocial services.

A list of the services available to deal with suicide shows that accessibility varies widely and that there are obvious deficiencies in some regions. This is why specific sums must be set aside if we are to carry out the proposed activities.

Although the organization of suicide prevention services is strongly tied to the organization of mental health services, all sectors involved in suicide prevention should contribute according to their budget and in keeping with the priorities announced in the 1997-1998 departmental guidelines. Not all regions, however, can be expected to allocate the financial resources required for intraregional reallocation at the same time.

The approach to financing *Québec's Strategy for Preventing Suicide* is double-barreled:

1. **Departmental funding** for projects designed to provide effective intervention for groups at risk.

2. **Regional funding** to ensure the implementation of *Québec's Strategy for Preventing Suicide* at the local and regional levels.

It will be up to the ministère de la Santé et des Services sociaux to choose the projects geared to groups at risk. The department will also be responsible, in cooperation with the people dealing with suicide in the regional boards, for setting the parameters for project funding and evaluation. A non-recurrent total of $700 000 will be provided over the next three years.

It is also recommended that an amount be allocated, as a priority, to implementing *Québec's Strategy for Preventing Suicide*. This amount, which could vary from region to region, depending on existing resources devoted to direct services for the public, should also be used to train caseworkers, provide continuous training, prepare protocols and reference tools, support caseworkers and professionals and provide clinical support in the regions over the next few years.

EVALUATION

Evaluation is an important element in a process designed to focus all efforts on common objectives. It must be an integral part of the Strategy, analysing the effect of implementation and the extent to which the objectives sought have been reached.

There are two ways of evaluating objectives and actions. One is implementation indicators, which reveal specifically whether the proposed actions were carried out. The chapter on objectives gives implementation indicators for the actions associated with each objective. However, these indicators cannot be used to evaluate the effect of the action taken on suicidal behaviour, or to determine whether the objectives have been reached. This is achieved by other measures used to determine the impact of the action on suicide rates and attempted suicide rates.

These measures are:

- mortality rates for death by suicide, by sex and by age;
- breakdown of the suicide rate by instrument used;
- attempted suicide rate estimated by the Enquête Santé Québec;
- hospitalization rate following attempted suicide, by sex and by age;

These statistics are generally compiled as part of the traditional monitoring and information activities of the department. Once their quality has been verified, it is simply a matter of working with the Coroner's office to collect additional data. Greater efforts must be made to obtain information on suicide attempts. These data are still incomplete and must be interpreted with a great deal of care.

One or more evaluative research projects is also required, in order to determine the effect of the Strategy on suicidal behaviour. Additional efforts must be made to provide a qualitative evaluation of the services offered suicidal individuals and their families.

CONCLUSION

The proposed Strategy is intended to give anyone faced with the problem of suicide the help he and his family need. It is also meant to serve as a means of implementing action to prevent suicidal behaviour. Above and beyond the actions proposed to reach the objectives sought, the mobilization and the cooperation of all the partners concerned are essential if the Strategy is to be implemented.

In light of the consultations carried out last spring, the commitment apparent in both the words and the intent of various partners promises success for the Strategy. The actions proposed will promote cooperation among the partners and greater involvement of those already in contact with suicidal persons. With the media and the public more aware of the issues, there will be increased consciousness among Quebecers of the risks of suicide and a greater concern on the part of each and every one for the welfare of those close to them.

Major efforts will be made to ensure follow-up for the implementation of the Strategy and support will be provided for all those concerned by the problem of suicide, whether at the central, regional or local level. Cooperation and coordination will benefit from the mobilization of all the partners involved.

And the expression "Help for Life" will take on its full meaning.

APPENDICES

APPENDIX 1

FACTORS ASSOCIATED WITH SUICIDE AND SUICIDAL BEHAVIOUR[12]

Factors associated with suicide among children (under 12)

Suicide and suicidal gestures are rare among children, but a number of risk factors have nevertheless been identified in the scientific literature. Among the personal predispositions mentioned are psychiatric disorders (Breton *et al.*, 1994) and a lack of problem-solving skills (Asarnow *et al.*, 1987; Orbach *et al.*, 1987; Levenson and Neuringer, 1971). A more or less mature understanding of death may also lead to acting-out on the part of a suicidal child (Melear, 1973; Koocher, 1973; Orbach *et al.*, 1985; Grenier, 1986).

A dysfunctional family is another recognized risk factor. There appears to be a strong link between parental violence and sexual abuse on one hand, and suicidal and self-destructive behaviour on the part of children on the other (Adams-Tucker, 1982; Green, 1978). Other risk factors for suicide among children frequently mentioned in the literature are alcohol and drug abuse, psychopathologies and suicide or attempted suicide by the parents (Garfinkel *et al.*, 1982; Pfeffer, 1986).

The trivialization of suicide by the media is also referred to in recent publications as a factor to be taken into account among children (Mishara, 1995).

12 This section is based on the text on suicide published by the National Forum on Health, *Methods to Prevent Suicide in Children, Youth and the Elderly*, written by R. Dyck, B. Mishara and J. White.

Factors associated with suicide and suicidal behaviour among young people (12 to 24 years old)

The personal predispositions reported are psychiatric disorders associated with depression, antisocial behaviour and substance abuse (Brent *et al*., 1988; Lesage *et al*., 1994; Pfeffer *et al*., 1991; Runeson et Beskow, 1991; Spirito *et al*., 1989). Learning difficulties and impulsivity are also risk factors (Hoberman et Garfinkel, 1988; Kienhorst *et al*., 1992; Rourke *et al*., 1989). A young person with chronic peer difficulties or a pathological attachment to his parents is also considered at risk (Marttunen *et al*., 1992; Shafii *et al*., 1985; Adam, 1986; Richman, 1986; Van der Kolk *et al*., 1991). As with children, a lack of problem-solving skills is another risk factor associated with suicidal behaviour (Clum *et al*., 1979; Asarnow *et al*., 1987; Spirito *et al*., 1989; Curry *et al*., 1992; Fremouw *et al*., 1993; Orbach *et al*., 1987; Levenson and Neuringer, 1971). Loss of a parent early in life is also recognized as a factor capable of causing suicidal behaviour (Adam *et al*., 1982; Pfeffer, 1990; Spirito *et al*., 1989).

The social environment, that is, the family, the living environment and the social context in which the young person develops plays a significant role in his well-being. This is why social isolation and poor social integration are related to a high suicide risk (Trovato, 1992; Sakinofsky and Roberts, 1985). A family in which a child is abused or neglected, in which one of the parents suffers from mental illness or where there is a history of suicide is a recognized risk factor (Brent *et al*., 1988; Pfeffer, 1990; Spirito *et al*., 1989; Lester, 1992; Garfinkel *et al*., 1982).

Economic factors may also present a risk (Platt, 1984). One study has shown that the suicide rate among young Canadians is higher when the unemployment rate rises in that age group (Leenaars and Lester, 1995). There also appears to be a correlation between the suicide rate among young people and the percentage of young people living in poverty (McCall, 1991).

A comparative study of suicide among young Canadians and young Americans revealed that suicide was a possible solution for Canadians when they were confronted with a problem. Cultural attitudes toward suicide constitute another factor. Young people are growing up in cultures where suicide is acceptable behaviour. (Kienhorst *et al*., 1992).

Among the immediate environmental factors that may increase the risk of suicidal behaviour among young people are the death of a parent, the separation of the parents, a serious conflict with a family member and perceived rejection by the family (Brent *et al*., 1988; Graham and Burvill, 1992; Hoberman and Garfinkel, 1988). Peer rejection or the break-up of a relationship are also factors reported by some authors (Brent *et al*., 1988; Davidson *et al*., 1989; Hoberman and Garfinkel, 1988).

Imitation or suicide contagion, following suicide or attempted suicide by other young people, is a recognized factor. There is a high suicide risk for a young person when one of his friends puts an end to his life (Brent *et al*., 1988; Gould *et al*., 1990; Hazell, 1993).

The other more commonly discussed factors in the scientific literature are the threat of academic failure or expulsion from school, pressure to succeed and the threat of disciplinary or legal sanctions (Brent *et al*., 1988; Hoberman and Garfinkel, 1988). Easy access to the means of self-destruction is an added incentive (Health Canada, 1994).

Alcohol and drug abuse is a frequently cited risk factor for suicide and suicidal behavior (Adcock *et al*., 1991; Berman and Schwartz, 1990; Pfeffer *et al*., 1991; Brent *et al*., 1988). A large number of the young people who commit suicide do so in a state of intoxication (Brent *et al*., 1988).

Factors associated with suicide among adults (25 to 64 years old)

Adults, like young people, have a higher risk of suicide when they are suffering from psychiatric disorders such as depression, schizophrenia, anxiety disorder and personality disorders (Appehy, 1992; King and Barraclough, 1990; Henriksson *et al*., 1993; Lesage, 1994; Lesage *et al*. ; 1994; Paris, 1994; Strakowski *et al*., 1996; Tanney, 1992). Drug and alcohol abuse is a further factor (Murphy and Wetzel, 1982; Health Canada, 1994; Dorpat and Ripley, 1960; Barraclough *et al*., 1974). It has been proven that the risk of suicide increases when substance abuse coexists with psychiatric problems (Maris *et al*., 1992). Some personality traits are also linked to suicide. The traits the most frequently reported are a high anxiety level, neuroses, low self-esteem and a lack of skill in solving certain problems (Lester, 1992). Prior suicide attempts are another major risk factor (Health Canada, 1994; Motto and Tanney, 1990; Lonnqvist, 1983; Sakinofsky and Roberts, 1985; Leon *et al*., 1990).

More recent studies suggest that genetic and biological factors could also be associated with the risk of suicide (Roy *et al*., 1991; Roy, 1993).

Among the factors associated with social environment are the absence of a solid social network and isolation due to separation, divorce or a death (Petronis *et al*., 1990; Maris, 1981). Sexual and physical abuse are often factors among women hospitalized for attempted suicide (Egmond and Jonker, 1988).

More broadly, a number of experts acknowledge that high unemployment rates cause suicide rates to climb (Platt, 1984; Leenaars and Lester, 1995; Cormier and Klerman, 1985).

The immediate environmental factors associated with suicide most commonly mentioned in the literature on suicide among adults are life events that are considered humiliating, such as major interpersonal problems, loss of employment and the threat of imprisonment (Blumenthal, 1984; Blumenthal and Kupfer, 1986, 1988; Cohen-Sandler *et al*., 1982; Hirschfeld *et al.*, 1986; Murphy *et al*., 1979; Paykel, 1989; Shaffer, 1974).

The literature also notes that a serious illness requiring hospitalization and an absence from work lasting over one month increase the risk of suicide (Paykel *et al*., 1975; Kizer *et al*., 1988; Marzuk *et al*., 1988; Plott *et al*., 1989; Barraclough *et al*., 1974; Dorpat *et al*., 1968; Mackenzie and Popkin, 1987; Whitlock, 1986). The suicide rate is reportedly higher, for instance, among AIDS victims.

Added to these immediate environmental factors are drug and alcohol use and access to firearms (Health Canada, 1994; Centers for Disease Control, 1984; Haberman and Baden, 1978; Crompton, 1985; Dorpat and Ripley, 1960).

Factors associated with suicide and suicidal behaviour among the elderly (65 and over)

One of the personal predispositions associated with suicide in the literature on elderly persons is the presence of a psychiatric disorder. According to the research, 60% to 80% of older people who commit suicide are suffering from depression (Cattell and Jolley, 1995; Dyck and White, 1990; Gurland and Cross, 1983; Jarvis and Boldt, 1980). This is often related to physical or social loss (Wasylenki, 1980). Chronic illness, physical handicaps and the dependency associated with certain problems, as well as chronic pain, are also related to depression and suicide (Conwell and Caine, 1990; Draper, 1995; Frierson, 1991; Jarvis and Boldt, 1980; McCartney, 1978; Shulman, 1978).

In addition to the mental and physical health problems reported in the literature, alcohol use and abuse are also major suicide risk factors among the elderly (Conwell and Caine, 1990; Lester and Beck, 1974; Mishara and Kastenbaum, 1974; Mishara and McKim, 1987).

The factors in the social environment associated with suicide and suicidal gestures include an inadequate social network. Suicide is linked with elderly people who live alone and do not have anyone to confide in (Abrahams and Patterson, 1978-1979; Barraclough, 1971; Bock and Webber, 1972; Cattell and Jolley, 1995; Draper, 1995; Haight, 1995; Jarvis and Boldt, 1980; Lonnqvist, 1977; Miller, 1978). The accommodations of the elderly are also cited in the literature as a factor associated with suicide.

Another recognized social factor identified is cultural attitude. Our society tends to accept suicide among the elderly, while it is horrified by the suicide of a young person (Evans *et al*., 1987; Mishara and Riedel, 1994; Osgood, 1985). Even the elderly share this point of view, which fact may increase the risk of suicide among older people.

The most common immediate environmental factor documented and the one considered most significant is widowerhood (Benson and Brodie, 1975; Berardo, 1968; Bock and Webber, 1972 b; Lalonde and Grunberg, 1988; MacMahon and Pugh, 1965; Miller, 1978; Stroeber and Stroeber, 1983). It is deemed to be one of the main suicide risk factors. The use and abuse of medication is also a significant risk factor (Mishara and McKim, 1987). The elderly are given more prescriptions for tranquillizers and sleeping pills than for any other type of medication. The fear of being put into an old people's home may also be a precipitating factor (Loebel *et al*., 1991). For some old people, however, accommodation in a long-term residence may actually protect them from suicide (Conwell, 1994).

CHILDREN		
Personal predisposition	**Social environment**	**Life event**
More or less mature understanding of death	Trivialization of suicide by the media	Separation, divorce or death of a parent
Lack of problem-solving ability	Family history of alcohol and drug abuse	
Psychiatric disorders	Psychopathological parents	
	Suicide or suicide attempt by parent	
	Parental violence or sexual abuse	

YOUNG PEOPLE		
Personal predisposition	**Social environment**	**Life event**
Poor adaptation mechanisms	Social isolation and lack of social integration	Parental death or divorce
Prior suicide attempt	Family's inability to help suicidal young people	Easy access to means of suicide
Learning difficulties and impulsivity	Psychopathological parents	Alcohol or drug use
Psychiatric disorders associated with depression, antisocial conduct or substance abuse	History of suicide in the family	Serious conflict with a family member
Chronic difficulty with peer relations	High unemployment rate and poverty among children and young people	Imitation or suicide contagion
Pathological attachment to parents	Sensational coverage of suicide by the media	Perceived rejection by the family
Loss of a parent early in life	Perception of suicide as acceptable or "private" behaviour	Rejection by peers or break-up of a relationship
Difficulty recognizing or accepting sexual orientation	Abuse and neglect	Academic failure, expulsion from school and pressure to succeed

ADULTS		
Personal predisposition	**Social environment**	**Life event**
Poor problem-solving skills	Absence of a social network and isolation associated with divorce, widowerhood or separation	Access to firearms
Prior suicide attempt	High unemployment rate	Alcohol and drug use
Imprisonment or threat of imprisonment	Suicide perceived as acceptable behaviour	Serious illness (AIDS, HIV-positive)
Psychiatric disorders, such as depression (particularly unipolar), schizophrenia, anxiety disorder and personality disorders		
Genetic and biological factors	Physical or sexual abuse, in the case if a woman	Humiliating events, end of a relationship or serious interpersonal problems
Personality traits (anxiety, feeling of loss of control, low self-esteem, neurotic traits)		
Substance abuse (alcohol and drugs)		
Difficulty recognizing or accepting sexual orientation		

THE ELDERLY		
Personal predisposition	**Social environment**	**Life event**
Psychiatric disorders associated with physical illness	Social isolation	Abuse or improper use of medication
Chronic illness (dependence, pain)	Poverty	Widowerhood
Alcohol abuse	Portrayal in the media of suicidal behaviour among the elderly	Placement in a home for the aged
	Social acceptance of suicide among the elderly	

APPENDIX 2

EXAMPLES

We have focussed on three types of intervention :

- one example of regional planning;
- two examples of action to deal with means of suicide;
- one example of an approach to the problem of suicide among adolescents.

Although not typical of the services usually offered by traditional partners such as the CLSCs, the community and the schools, these examples illustrate the cooperation achieved with other stakeholders.

AN EXAMPLE OF REGIONAL PLANNING

In 1992, the Direction de la santé publique of the Gaspésie–Îles-de-la-Madeleine region introduced a suicide prevention program in cooperation with its local partners (the hospital, CLSC, youth centres, community organizations, school boards, private firms, etc.). This program was set up following a regional study that showed, among other things, that the suicide rate had practically tripled in the region between 1975 and 1989. The ultimate goal of the program is to reduce the rate of suicidal behaviour by 15% (suicide ideation, suicide attempts and suicide) in Gaspésie and the Îles-de-la-Madeleine by 2002.

Briefly, the four steps required to set up the program introduced in the eight CLSC territories of the region were as follows :

- Understanding the problem of suicide and identifying suicide prevention initiatives and services.
- Proposing a regional frame of reference.
- Preparing an annual action plan for each CLSC territory.
- Carrying out and evaluating each of the initiatives provided for in the action plans of the various participating territories.

(1) Understanding the problem of suicide and identifying suicide prevention initiatives and services

A review of the problem, prevention initiatives and services was prepared in the eight CLSC territories of the region in 1992, during consultations of its local partners by the Direction de la santé publique. This resulted in quite a precise profile of the people affected by the problem of suicide (suicidal persons, people close to a suicidal individual and people in mourning following a suicide) and the groups at risk in the region. The consultation also gave a general idea of existing initiatives and services in the areas of promotion, prevention, intervention and postvention in all the territories of the region.

(2) Proposing a regional frame of reference

Using the information gathered and the insight gleaned from the literature, the Direction de la santé publique was able to prepare a regional frame of reference for suicide prevention which it proposed and submitted to its partners in each of the eight CLSC territories, in the shape of a framework program. The suggestions the Direction de la santé publique made for its partners in this program may be expressed in terms of operational objectives that are presented briefly here.

Operations objectives

- See that an essential range of services is introduced in each CLSC territory.
- Implement and consolidate initiatives and services at all levels (promotion, prevention, intervention, postvention).
- Implement and consolidate initiatives and services for all age groups.
- Organize services with a view to accessibility, availability, proximity, rapidity, mobility, continuity, complementarity, coordination and evaluation.

To reach these objectives, the Direction de la santé publique and its partners in each CLSC territory agreed to prepare, implement and evaluate an annual action plan for each territory.

Certain conditions were set beforehand to ensure this agenda could be carried out:

- creation of a working group composed of representatives of the various organizations and designation, in each territory, of an agent[13] responsible for preparing and carrying out the local action plan.
- identification of a regional leader[14] to plan and coordinate the preparation, implementation and evaluation of the annual action plans in the participating territories and support for the organizations involved.

13 Local agent : in most participating territoires, the CLSC has been designated as the agent.
14 Regional leader : the Direction de la santé publique is the regional leader in this case.

(3) Preparing an annual action plan for each CLSC territory

Once these conditions had been accepted and approved by all the partners, it was time to prepare an action plan that would meet the objectives set. To this end, the Direction de la santé publique and the working groups agreed to proceed in the following manner :

- Identify the strong points and the weak points in the areas of promotion, prevention, intervention and postvention.
- Give priority to the areas of activity to be developed (promotion, prevention and postvention).
- Do a critical analysis of existing initiatives and services, given the preferred area or areas of activity.
- Determine the needs of the community with respect to the initiatives and services to be introduced and consolidated.
- Identify the objectives sought for the area or areas of activity to be consolidated and developed.
- Determine the means to be introduced and consolidated for the preferred area or areas of activity.
- Identify the roles and responsibilities of the partners involved and set timetables for carrying out the means provided for in the action plan.
- Prepare methods of evaluating the implementation and impact of initiatives and services.
- Define the terms and conditions of cooperation and coordination for the initiative to be introduced, implemented and evaluated.
- Make the local suicide prevention action plan known to all the organizations on the territory of the CLSC.

(4) Carrying out and evaluating each of the initiatives provided for in the action plans of the various participating territories

After five years of work, a number of initiatives and services were introduced, consolidated and evaluated in response to the operational objectives of the program. Specific training, general training, consciousness-raising, manuals and referral guides, action kits for schools, protocols and so forth are examples of initiatives and tools designed and implemented within the framework of the approach to suicide prevention adopted in this region.

A report on the program (1991-1997) will be distributed by the Direction de la santé publique by winter 1998, which will enable the Gaspésie–Îles-de-la-Madeleine regional board and its partners to determine the extent to which the objectives set were reached, what adjustments should be made, and what suicide prevention strategies should be stressed in the region in the coming years.

TWO EXAMPLES OF ACTION TO DEAL WITH INSTRUMENTS OF SUICIDE

The trestle railroad bridge in Cap-Rouge

We often assume that measures taken to increase control over the instruments used to commit suicide will have little effect on the number of attempts, in the belief that their determination will simply lead attempters to choose another mean. This is not necessarily true.

We wish to describe here the efforts made to better control access to the CN railroad bridge in Cap-Rouge, a municipality located in the suburbs of Québec City. Nine people, eight of them under 21, jumped off the bridge to their death between 1991 and 1996.

A report by Coroner Louise Nolet highlighted the steps that had to be taken to improve surveillance of this site, which had acquired almost symbolic status. These steps were particularly important since a high school and a youth centre were located nearby.

A surveillance system was set up including :

– a lighting system providing the equivalent of full daylight;

– surveillance cameras at both ends of the bridge;

– mass detectors;

– loudspeakers making two-way communication possible in real time with anyone on the bridge.

This surveillance system was installed through a cooperative effort involving the City of Cap-Rouge, Canadian National and Entreprises Microtec. The Sainte-Foy police department also works with Canadian National as a primary resource in a crisis situation.

The Québec SPC, the Laurentien and Sainte-Foy–Sillery CLSCs and the Découvreurs school board also participated in the organization of meetings held to set up suicide prevention / postvention committees in the elementary and secondary schools on the territory.

Firearms

Men use more violent means than women to commit suicide. Firearms are used in almost three suicides out of ten committed by men. The Centre de prévention du suicide de Québec conducted an awareness-raising campaign focussing on the proper storage of firearms as a means of suicide prevention. It chose the hunters who shop at Latulippe in Québec City as its target and provided information on the safe storage of firearms to the customers in the store every Thursday and Friday evening throughout the hunting season. The hunters cooperated in this initiative.

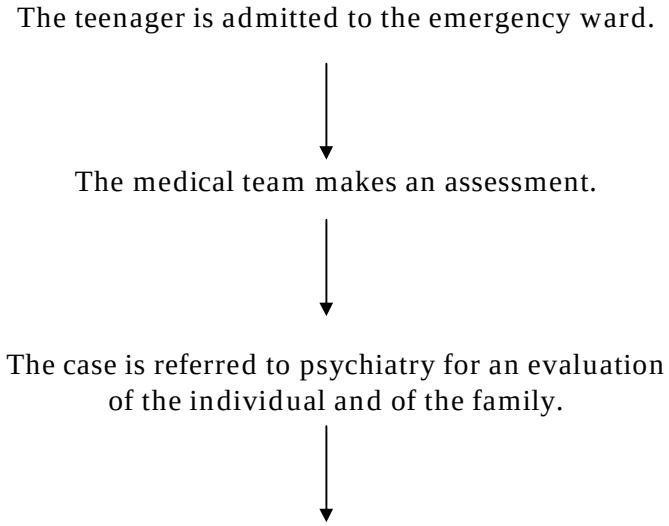
Neither of these examples of action dealing with the instruments of suicide has been evaluated.

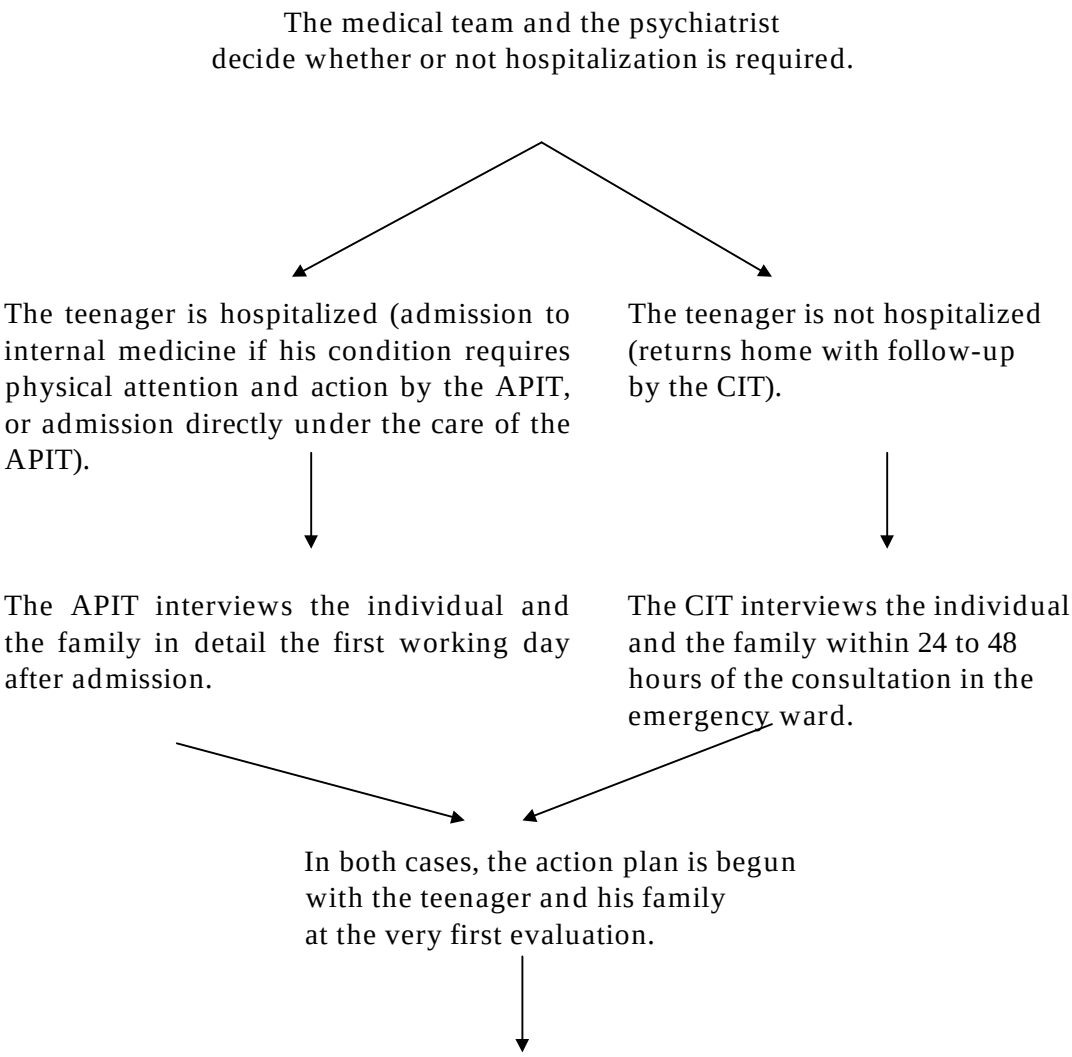
STEPS TAKEN BY THE MONTRÉAL CHILDREN'S HOSPITAL TO HELP ADOLESCENTS IN CRISIS

The Montréal Children's Hospital (MCH) has a special approach to the problem of suicide among adolescents. Two teams work with teenagers between the ages of 14 and 18, the crisis intervention team (CIT) and the acute phase intervention team (APIT). The APIT is a multidisciplinary team made up of a number of health care professionals, including a psychiatrist (half-time), a specialized clinical nurse (full-time), a social worker (half-time), a therapist (psychologist, half-time), an occupational therapist (one day per week) and an art therapist (four hours a week). The CIT is made up of a psychiatrist and a nurse, both full time.

Both teams work with teenagers who present with mental health problems such as manic depression, depression or psychosis, but they are also referred young people who have attempted suicide or who entertain suicidal ideas.

The port of entry to the services of these two teams is the emergency ward of the Montréal Children's Hospital. The teenagers may go alone or be accompanied by a relative, a friend or a community worker such as a social worker, a family doctor, a school nurse, a school counsellor or psychologist or someone in private practice. The following diagram illustrates the entire process.




The medical team and the psychiatrist decide whether or not hospitalization is required.
The teenager is hospitalized (admission to internal medicine if his condition requires physical attention and action by the APIT, or admission directly under the care of the APIT).
The teenager is not hospitalized (returns home with follow-up by the CIT).
The APIT interviews the individual and the family in detail the first working day after admission.
The CIT interviews the individual and the family within 24 to 48 hours of the consultation in the emergency ward.
In both cases, the action plan is begun with the teenager and his family at the very first evaluation.

The teenager and his family are asked
for permission to contact the community workers
who had previously been called upon.

The APIT may invite these workers to a team meeting or consult them over the telephone.

The CIT contacts these workers by telephone.

The evaluation continues throughout the period of hospitalization. Suicidal potential is re-evaluated each day and therapy is begun. The intervention is more intensive when the team expects to participate in the follow-up. Two or more family interviews are carried out during the young person's hospitalization.

After the evaluation, the team decides whether to continue with the intervention or to direct the teenager and his family to an outside resource.

When the team believes a longer period of hospitalization is necessary, the patient and his family are consulted in order to arrange a transfer to a long-term care unit. The Montréal Children's Hospital does not offer this service, but there are two other hospitals that do.

When his condition does not require long-term hospitalization, we work with the patient and his family to determine the best way to help. Following an in-depth evaluation and recommendations by the team, the young person and his family may :

(1) return for a follow-up with caseworkers consulted earlier;
(2) receive short-term follow-up from the APIT members;
(3) be referred to the CLSC or school for follow-up by a counsellor, nurse, psychologist, social worker or educator;
(4) be referred to a caseworker in private practice;

(5) be referred to a recognized institution where the cost of therapy is lower and usually adjusted to the income of the patient or his family.

Once the kind of follow-up has been decided upon and appointments have been made, the patient is sent home. Most patients return home within one week. The two teams remain available for consultation by the community caseworkers, who thus feel supported, particularly when dealing with someone who has attempted suicide or talked about doing so. The young person and his family may be re-evaluated, if need be, by the hospital's teams when the community resource so requests and once the case has been discussed. An interview with the teenager or the family is then arranged directly, without going through the emergency ward. Recommendations are made for the caseworker, to help him with the follow-up. A caseworker who is given the right tools is often able to avert a crisis or re-hospitalization. Sometimes, however, the teenager must be re-hospitalized.

LIST OF ABBREVIATIONS

- APIT Acute phase intervention team
- AQS Association québécoise de suicidologie
- CIT Crisis intervention team
- CLSC Centre local de services communautaires
- CQRS Conseil québécois de la recherche sociale
- CROP Centre de recherche en opinion publique
- FMOQ Fédération des médecins omnipraticiens du Québec
- FRSQ Fonds de recherche en santé du Québec
- MCH Montréal Children's Hospital
- MSSS Ministère de la Santé et des Services sociaux
- RMC Regional county municipality
- SPC Suicide Prevention Centre

LIST OF ASSOCIATIONS, INSTITUTIONS, ORGANIZATIONS AND INDIVIDUALS CONTACTED DURING CONSULTATIONS ON THE DOCUMENT ENTITLED *S'ENTRAIDER POU LA VIE - PROPOSITION D'UNE STRATÉGIE QUÉBÉCOISE D'ACTION FACE AU SUICIDE*

Association des centres jeunesse

Association des chefs de police de la région 03

Association des coroners

Association des hôpitaux du Québec

Association des psychiatres

Association des praticiens de service social en milieu hospitalier

Association québécoise de suicidologie (on behalf of close to 50 community organizations)

Dr. Pierre Bégin, Laval

Dr. Jean-Jacques Breton, Hôpital Rivière-des-Prairies

Centre de prévention du suicide de Québec

Michel Clermont, Direction de la planification et de l'évaluation, MSSS.

Collège des médecins

Comité provincial des traumatismes

Comité de la santé mentale du Québec

Health and Social Services Board of the First Nations of Québec and of Labrador

Fédération québécoise des directeurs et directrices d'établissements d'enseignement

Conseil permanent de la jeunesse

Fédération des CLSC du Québec

Dr. Alain Lesage, Centre de recherche Fernand-Séguin

Robert Bisaillon, Ministère de l'Éducation du Québec

Ordre professionnel des travailleurs sociaux

Ordre des psychologues du Québec

Ordre des infirmières et infirmiers du Québec

Abitibi-Témiscamingue Regional Board

Bas-Saint-Laurent Regional Board

Québec City Regional Board

Mauricie–Bois-Francs Regional Board

Estrie Regional Board

Montréal-Centre Regional Board

Montérégie Regional Board

Laval Regional Board

Laurentides Regional Board

Lanaudière Regional Board

Outaouais Regional Board

Gaspésie–Îles-de-la Madeleine Regional Board

Côte-Nord Regional Board

Suicide Action Montréal (SAM)

Sûreté du Québec

Michel Tousignant, UQAM

Ville de Québec (police department)

BIBLIOGRAPHY

Abrahams, R.B., and R.D. Patterson. 1978-1979. "Psychological distress among the community elderly: Prevalence, characteristics and implications for service." *International Journal of Aging and Human Development*. 9(1): 1-17.

Adam, K.S. 1986. "Early family influences on suicidal behaviour." *Annals of the New York Academy of Sciences.* 487: 63-76.

Adam, K.S. J.G., Lohrenz and D. Harper. 1982. "Early parental loss and suicide ideation in university students." *Canadian Journal of Psychiatry*. 27: 275-281.

Adams-Tucker, C. 1982. "Proximate effect of sexual abuse in childhood: A report on 28 children." *American Journal of Psychiatry*. 139: 1252-1256.

Adcock, A.G., S., Simpson, J.A. 1991. "Selected risk factors in adolescent suicide attempts." *Adolescence*. 26(104): 817-828.

Appehy, L. 1992. "Suicide in psychiatric patients: Risk and prevention." *British Journal of Psychiatry*. 161: 749-758.

Asarnow, J.R., G.A. Carlson and D. Guthri. 1987. "Coping strategies, self-perceptions, hopelessness, and perceived family environments in depressed suicidal children." J*ournal of Consulting and Clinical Psychology*. 56: 361-366.

Association québécoise de suicidologie. 1996. *Position de l'Association québécoise de suicidologie sur une Stratégie provinciale en prévention du suicide*. Submitted to the Groupe de travail sur la prévention du suicide au Québec, MSSS.

Barraclough, B.M. 1971. "Suicide in the elderly." In *Recent Developments in Psycho Geriatrics*. Edited by D.W. Kay and A. Walk. Kent, England: Headly Brothers. 89-97.

Barraclough, B.M. 1974. "A hundred cases of suicide: Clinical aspects." *British Journal of Psychiatry*. 125: 355-373.

Benson, R.A and D.C. Brodie. 1975. "Suicide by overdose of medicines among the aged." *Journal of the American Geriatric Society*. 23: 304-308.

Berardo, F.M. 1968. "Widowhood status in the United States: Perspective on a neglected aspect of the family life-cycle." *The Family Coordinator*. 17: 191-203.

Berman, A., and R.H. Schwartz. 1990. "Suicide attempts among adolescent drug-users." *American Journal of Diseases of Children*. 144: 310-314.

Blumenthal, S.J. 1984. *An overview of suicide risk factor research*. Presented at the annual meeting of the American Psychiatric Association. Los Angeles. May 1984.

Blumenthal, S.J., and D.J., Kupfer 1986. "Generalizable treatment strategies for suicidal behavior." *Annals of the New York Academy of Sciences*. 487: 327-340.

Blumenthal, S.J., and D.J. Kupfer. 1988."Overview of early detection and treatment strategies for suicidal behavior in young people." *Journal of Youth and Adolescence*. 17: 1-24.

Bock, E.W., and I.L. Webber. 1972. "Suicide among the elderly: Isolation. Widowhood and mitigating alternatives." *Journal of Marriage and the Family*. 34: 24-31.

Boyer, R. 1995. *État de situation sur les expériences de prévention du suicide dans une approche intégrée de prévention des troubles mentaux*. Research report. Centre de recherche Fernand-Séguin. Hôpital Louis-H. Lafontaine.

Brent, D., and J. Perper. 1988. "Risk factors for adolescent suicide." *Archives of General Psychiatry*. 45: 581-588.

Brent, D., and J. Perper. 1995. "Research in adolescent suicide: Implications for training, service delivery, and public policy." *Suicide and Life-Threatening Behavior*. 25(2): 222-230.

Breton, J.J., *et al.* 1994. *Prévalence des troubles mentaux . Rapport synthèse. Enquête québécoise sur la santé mentale des jeunes de 6 à 14 ans 1992.* Montréal. Hôpital Rivière-des-Prairies. Santé Québec.

Cattell, H., and Jolley D.J. 1995. "One hundred cases of suicide in elderly people." *British Journal of Psychiatry*. 166: 451-457.

Centers for Disease Control. 1984. "Alcohol and violent death. Erie County New York 1973-1983." *Morbidity and Mortality Weekly Report*. 33: 226-227.

Charron, M-F. 1983. *Le suicide au Québec*. Service des études épidémiologiques, ministère des Affaires sociales.

Clum, G.A., A.T. Patsiokas and R.L. Luscomb. 1979. "Empirically based comprehensive treatment program for parasuicide." *Journal of Consulting and Clinical Psychology*. 47(5): 937-945.

Cohen-Sandler, R. 1982. "Life stress and symptomatology: Determinants of suicidal behavior in children." *Journal of the American Academy of Child Psychiatry*. 21: 178-186.

Conseil permanent de la jeunesse. 1995. *Le point sur la délinquance et le suicide chez les jeunes.* Report.

Conseil permanent de la jeunesse. 1996. *La prévention du suicide chez les jeunes: le point de vue des intervenants.* Report.

Conseil permanent de la jeunesse. 1997. *Le suicide chez les jeunes : S.O.S. Jeunes en détresse!* Opinion.

Conwell, Y. 1994. "Suicide and aging: Lessons from the nursing home." *Crisis.* 15(4): 153-158.

Conwell, Y., and E.D. Caine. 1990. "Completed suicide at age 50 and over." *Journal of the American Geriatric Society*. 38: 640-644.

Cormier, H.J., and G.L. Klerman. 1985. "Unemployment and male-female labor force participation as determinants of changing suicide rates of males and females in Quebec." *Social Psychiatry*. 20: 109-114.

Coroner en chef. 1995. *Rapport d'enquête du Coroner.* Report on the storage and transport of firearms, prepared by Anne-Marie David, Coroner.

Crompton, M.R. 1985. "Alcohol and violent accidental and suicidal death." *Medical Science and Law*. 25: 59-62.

CROP. 1996. *La prévention du suicide.* Opinion poll of Quebecers.

Curry, J.F., Y. Miller and W.B. Anderson. 1992. "Coping responses in depressed, socially maladjusted, and suicidal adolescents." *Psychological Reports.* 71: 80-82.

Davidson, L. 1989. "An epidemiologic study of risk factors in two teenage suicide clusters." *Journal of the American Medical Association*. 262(19): 2687-2692.

Dorpat, T.L., and H.S. Ripley. 1960. "A study of suicide in the Seattle area." *Comparative Psychiatry*. 1: 349-359.

Dorpat, T.L., W.F. Anderson and H.S. Ripley. 1968. "The relationship of physical illness to suicide." In*Suicidal Behaviors*. Edited by L.P. Resnick. Boston: Little Brown.

Draper, B. M. 1995. "Prevention in suicide in old age." *The Medical Journal of Australia* 162: 533-534.

Dyck, R.J., B.L. Mishara and J. White (in the press). *Methods to Prevent Suicide in Children, Youth and the Elderly*. Ottawa. National Forum on Health.

Dyck, R., and White. J. 1990. *A Ten Year Death File Review of Elderly Suicides in Alberta*. Unpublished manuscript.

Egmond, Van M., and Jonker, D. 1988. "Sexual and physical abuse: Suicide risk factors for women? The results of an empirical study among 158 female suicide attempters." *Psychiatry*. 30(1): 21-38.

Evans, Fogle, and McDonald. 1987. *Cultural attitude towards suicide of the aged*. Annual meeting of the American Association of Suicidology. San Francisco.

Fremouw, W., T. Callahan and J. Kashden. 1993. "Adolescent suicidal risk: Psychological, problem solving, and environmental factors." *Suicide and Life-Threatening Behavior*. 23(1): 45-54.

Frierson, R.L. 1991. "Suicide attempts by the old and the very old." *Archives of Internal Medicine*. 151: 141-144.

Garfinkel, B.D., A. Froese and J. Hood. 1982. "Suicide attempts in children and adolescents." *American Journal of Psychiatry*. 139: 1257-1261.

Gould, M. 1990. "Suicide clusters: An examination of age-specific effects." *American Journal of Public Health*. 80(2): 211-212.

Graham, C., and P. Burvill. 1992. "A study of coroner's records of suicide in young people, 1986-1988 in Western Australia." *Australian and New Zealand Journal of Psychiatry*. 26: 30-39.

Green, A.H. 1978. "Self-destructive behavior in battered children." *American Journal of Psychiatry*. 135: 579-582.

Grenier, G. 1986. *L'acquisition d'un concept de mort évolué chez l'enfant en fonction des expériences vécues d'une part et du développement des concepts de vie, d'inclusion et d'âge d'autre part*. Université du Québec à Montréal. Canada.

Gurland, B.J., and P.S. Cross. 1983. "Suicide among the elderly." 456-465. In*The Acting Out Elderly*. Edited by M.K. Aronson, R. Bennett and B.J. Gurland. New York: Haworth Press.

Haberman, P., and M.M. Baden. 1978. *Alcohol, Other Drugs and Violent Death*. New York: Oxford University Press.

Haight, B.K. 1995. "Suicide risk in frail elderly people relocated to nursing homes." *Geriatric Nursing*. 16(3): 104-107.

Hazell, P. 1993. "Adolescent suicide clusters: Evidence, mechanisms and prevention." *Australian and New Zealand Journal of Psychiatry*. 27: 653-665.

Health Canada. 1994. *Suicide in Canada: Update of the Report of the Task Force on Suicide in Canada.* Ottawa: Health Canada.

Henriksson, M.M., *et al*. 1993. "Mental disorders and comorbidity in suicide." *American Journal of Psychiatry*. 150(6): 935-940.

Hirschfeld, R., *et al*. 1986. "Personality, life events, and other psychosocial factors in adolescent de pression and suicide." In *Depression and Suicide among Adolescents and Young Adults*. Edited by G.L. Klerman. Washington (D.C.): American Psychiatric Press. 213-253.

Hoberman, H.M., and B.D. Garfinkel. 1988."Completed suicide in children and adolescents." *Journal of the American Academy of Child and Adolescent Psychiatry*. 27: 689-695.

Jarvis, G.K., and M. Boldt. 1980. "Suicide in the later years." *Essence.* 4(3): 145-158.

Julien, Marie. 1993. *La mortalité due à la violence* : *suicides et homicides en Montérégie en 1988 et 1989. Une analyse descriptive*. Unité de santé publique Charles-LeMoyne.

Kienhorst, C., E. de Wilde, R. Diekstra and W. Wolters. 1992. "Differences between adolescent suicide attempters and depressed adolescents." *Acta Psychiatrica Scandinavica*. 85: 222-228.

King, E., and B. Barraclough. 1990. "Violent death and mental illness: A study of a single catchment area over eight years." *British Journal of Psychiatry*. 156: 714-720.

Kizer, K.W., C.L. Green, M. Perking, *et al.* 1988. "AIDS and suicide in California." *Journal of the American Medical Association*. 260: 1881.

Koocher, G.P. 1973. "Childhood, death and cognitive development." *Developmental Psychology*. 9: 369-375.

Lalonde, P., and F. Grunberg. 1988. *Psychiatrie clinique : Approche contemporaine*. Ch. 27. Montréal: Gaëtan Morin éditeur.

Leenaars, A., and D. Lester. 1995. "The changing suicide pattern in Canadian adolescents and youth, compared to their American counterparts." *Adolescence*. 30(119): 539-547.

Leon, A.C., *et al.* 1990. "Statistical issues in the identification of risk factors for suicidal behavior: The application of survival analysis." *Psychiatry Research*. 31: 99-108.

Lesage, A. 1994. "Troubles mentaux et suicide" (editorial). *Santé mentale au Québec*. 19(2): 7-14.

Lesage, A., *et al.* 1994. "Suicide and mental disorders: A case control study of young men." *American Journal of Psychiatry*. 151(7): 1063-1068.

Lester, D. 1992. *Why People Kill Themselves: A 1990 Summary of Research Findings on Suicidal Behavior.* Springfield, IL: Charles C. Thomas.

Lester, D., and A.T. Beck 1974. "Age differences in patterns of attempted suicide." *Omega: Journal of Death and Dying*. 5: 317-322.

Levenson, M., and C. Neuringer. 1971. "Problem-solving behavior in suicidal adolescents." *Journal of Consulting and Clinical Psychology*. 37(3): 433-436.

Loebel, J.P., *et al.* 1991. "Anticipation of nursing home placement may be a precipitation of suicide among the elderly." *Journal of the American Geriatric Society*. 39: 407-408.

Lonnqvist, J. 1977. *Suicide in Helsinki*. (Monographs on Psychiatry). Helsinki: Fennica.

Lonnqvist, J. 1983. *Outcome of eight-year follow-up of attempted suicides (Finland).* Study presented at the 12th Congress of the International Association for Suicide Prevention. Caracas. Venezuela.

Mackenzie, T.B., and M.K. Popkin. 1987. "Suicide in the medical patient." *International Journal of Psychiatry and Medicine*. 17: 3-22.

MacMahon, B., and T.F Pugh. 1965. "Suicide in the widowed" *American Journal of Epidemiology*. 81: 23-31.

Maris, R.W. 1981. *Pathways to Suicide: A Survey of Self-Destructive Behaviors.* Baltimore: Johns Hopkins University Press.

Maris, R.W., *et al.* 1992. "Summary and conclusions: What have we learned about suicide assessment and prediction?" In *Assessment and Prediction of Suicide*. Edited by R.W. Maris, A.L. Berman, J.T. Maltsberger and R.I. Yufit. New York: The Guilford Press. 640-672.

Marttunen, M., H. Aro and J. Lonnqvist. 1992. "Adolescent suicide: Endpoint of long term difficulties." *Journal of the American Academy of Child and Adolescent Psychiatry*. 31(4): 649-654.

Marzuk, P.M., H. Tierney, K Tardiff *et al.* 1988. "Increased risk of suicide in persons with AIDS." *Journal of the American Medical Association*. 259: 1333-1337.

McCall, P.L. 1991. "Adolescent and elderly white male suicide trends: Evidence of changing well being." *Journal of Gerontology*. 46(1): 543-551.

McCartney, J.R. 1978. "Suicide vs right to refuse treatment in the chronically ill." *Psychosomatics*. 19(9): 548-551.

Melear, A. 1973. "Children's conception of death." *Journal of Genetic Psychology*. 123: 359-360.

Miller, M. 1978. "Geriatric suicide: The Arizona study." *The Gerontologist*. 18(5): 488-495.

Ministère des Affaires sociales. 1983. *Avis sur la prévention du suicide.* Québec. Comité de la santé mentale du Québec.

Ministère de la Santé et des Services sociaux. 1987. *Pour un partenariat élargi*. Proposed mental health policy for Québec. Québec. Comité de la politique de santé mentale.

Ministère de la Santé et des Services sociaux. 1992. *The Policy on Health and Well-Being.* Québec.

Ministère de la Santé et des Services sociaux. 1989. *Politique de santé mentale.* Québec.

Mishara, B.L. 1995. *An Empirical Investigation of Children's Understanding of Suicide and Death.* Unpublished manuscript.

Mishara, B.L., and R. Kastenbaum. 1974. "The use of wine and the treatment of the chronic institutionalized geriatric mental health patients." *Journal of Geriatric Society*. 22: 88-94.

Mishara, B.L., and W.A. McKim. 1987. *Drugs and Aging.* Toronto: Butterworths.

Mishara, B.L., and R. Riedel. 1994. *Le vieillissement.* Third revised edition. Paris: Presses Universitaires de France.

Mishara, B.L., and M. Tousignant. 1983. "Pour une véritable prévention primaire du suicide." *Revue québécoise de psychologie*. 4(1): 21-31.

Mishara, B.L. (in the press). "An empirical investigation of children's understanding of suicide and death." In *Suicide Prevention: A Holistic Approach*. Edited by D. De Leo and R.F.W. Diekstra. Boston / Dordrecht: Kluwer Academic Press.

Mishara, B.L. (in the press) "The right to die and the right to live: Perspectives on euthanasia and assisted suicide." In *Suicide in Canada*. Edited by A. Leenaars, M. Kral, R. Dyck and S. Wenckstern. Toronto: University of Toronto Press.

Motto, J., and B.Tanney. 1990. *Long-term follow-up of 1570 attempted suicides.* Paper presented at the 23rd Annual Meeting of the American Association of Suicidology. New Orleans, LA.

Murphy, G.E., and R.D., Wetzel. 1982. "Family history of suicidal behavior among suicide attempters." *Journal of Nervous and Mental Disease.* 170: 86-90.

Murphy, G.E., *et al*. 1979. "Suicide and alcoholism: Interpersonal loss confirmed as a predictor" *Archives of General Psychiatry*. 36: 65-69.

Murphy, G.E., *et al*,. 1990. "The lifetime risk of suicide in alcoholism." *Archives of General Psychiatry*. 47(4): 383-392.

Orbach, I., Y. Gross, H. Glaubman and D. Berman. 1985. "Children's perception of death in humans and animals as a function of age, anxiety and cognitive ability." *Journal of Child Psychology and Psychiatry*. 26: 453-463.

Orbach, I., E. Rosenheim and E. Hary. 1987. "Some aspects of cognitive functioning in suicidal, chronically ill, and normal children." *Journal of the American Academy of Child and Adolescent Psychiatry*. 26: 181-185.

Osgood, N.J. 1992. "Environmental factors in suicide in long-term care facilities." *Suicide and Life-Threatening Behavior*. 22: 98-106.

Osgood, N.J. 1985. *Suicide in the Elderly: A Practitioner's Guide to Diagnosis and Mental Health Intervention*. Rockville: Aspen Systems Corp.

Paris, J. 1994. "Le suicide chez les patients présentant des troubles de la personnalité limités." *Santé mentale au Québec*. 19(2): 117-130.

Paykel, E.S. 1989. *Stress and Life Events.* In *Alcohol, Drug Abuse, and Mental Health Administration. Report of the Secretary's Task Force on Youth Suicide, Vol. 2, Risk Factors for Youth Suicide* (DHHS, Publ. No. ADM-89-162). Washington (D.C.): U.S. Government Printing Office.

Paykel, E.S. 1975. "Suicide attempts and recent life events: A controlled comparison." *Archives of General Psychiatry*. 32(3): 327-333.

Petronis, K.R. 1990. "An epidemiologic investigation of potential risk factors for suicide attempts." *Society for Psychiatry and Psychiatrical Epidemiology*. 25: 193-199.

Pfeffer, C.R. 1986. *The Suicidal Child.* New York: The Guilford Press.

Pfeffer, C.R. 1990. "Suicidal behaviour in children and adolescents: A clinical and research perspective." *The Yale Journal of Biology and Medicine.* 63: 325-332.

Pfeffer, C.R. 1991. "Suicidal children grow up: Demographic and clinical risk factors for adolescent suicide attempts." *Journal of the American Academy of Child and Adolescent Psychiatry*. 30(4): 609-616.

Platt, S. 1984. "Unemployment and suicidal behaviour." *Social Science and Medicine*. 19: 93-115.

Plott, R.T., S.D. Benton and W.J. Winslade. 1989. "Suicide of AIDS patients in Texas: A preliminary report." *Texas Medicine*. 85(8): 40-43.

Régie régionale de la santé et des services sociaux de l'Abitibi-Témiscamingue. 1996. *La problématique du suicide en Abitibi-Témiscamingue.*

Richman, J. 1986. *Family Therapy for Suicidal People.* New York: Springer Publishing.

Rourke, B., G. Young and A. Leenaars. 1989. "A childhood learning disability that predisposes those afflicted to adolescent and adult depression and suicide risk." *Journal of Learning Disabilities*. 22: 169-175.

Roy, A. 1993. "Genetic and biologic risk factors for suicide in depressive disorders." *Psychiatric Quarterly*. 64(4): 345-358.

Roy, A. 1991. "Suicide in twins." *Archives of General Psychiatry*. 48: 29-32.

Runeson, B., and Beskow, J. 1991. "Borderline personality disorder in young Swedish suicides." *The Journal of Nervous and Mental Disease*. 179(3): 153-156.

Sakinofsky, I., and R. Roberts. 1985. *The ecology of suicide in Canada. 1971-1981*. Presentation to the Epidemiology and Community Psychiatry Section. Symposium on the Future of Psychiatric Epidemiology, Edinburgh.

Séguin, M. 1991. *Le suicide : comment prévenir, comment intervenir.* Montréal: Éditions Logiques.

Shaffer, D. 1974. "Suicide in childhood and early adolescence." *Journal of Child Psychology and Psychiatry*. 20: 545-565.

Shafii, M., S. Carrigan, J. Whittinghill and A. Derrick. 1985. "Psychological autopsy of completed suicide in children and adolescents." *American Journal of Psychiatry*. 142(9): 1061-1064.

Shulman, K. 1978. "Suicide and parasuicide in old age: A review." *Age and Ageing*. 7(4): 201-209.

Silverman, M., and R.D. Felner. 1996. "The place of suicide prevention in the spectrum of intervention: Definitions of critical terms and constructs." In *Suicide prevention toward the year 2000.* Edited by M. Silverman and R.W. Maris. New York: Guilford Press. 70-81.

Spirito, A. 1989. "Attempted suicide in adolescence: A review and critique of the literature." *Clinical Psychology Review*. 9: 335-363.

Strakowski, S. 1996. "Suicidality among patients with mixed and manic bipolar disorder." *American Journal of Psychiatry*. 153(5): 674-676.

Stroeber, M.S., and W. Stroeber. 1983. "Who suffers more? Sex differences in health risks of the widowed." *Psychological Bulletin*. 93: 279-301.

Tanney, B.L. 1992. "Mental disorders, psychiatric patients, and suicide." In R.W. Maris, *et al. Assessment and Prediction of Suicide.* New York: The Guildord Press. 277-320.

Tousignant, M. 1995. "Le suicide et les comportements suicidaires." In *Traité des problèmes sociaux*. Edited by F. Dumont *et al.* Québec, Institut québécois de recherche sur la culture. 765-776.

Trovato, F. 1992. "A Durkheimian analysis of youth suicide: Canada, 1971 and 1981." *Suicide and Life-Threatening Behavior*. 22(4): 413-427.

Van der Kolk, B., C. Perry and J. Herman. 1991. "Childhood origins of self-destructive behaviour." *American Journal of Psychiatry*. 148(12): 1665-1671.

Wasylenki, D. 1980. "Depression in the elderly." *Canadian Medical Association Journal*. 122: 525-532.

Whitlock, F.A. 1986."Suicide and physical illness." In *Suicide*. Edited by A. Roy. Baltimore: Williams & Wilkins. 151-170.

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