

**Embodied Injustice:
Policies to address self-injury among
low-income women, aged 35-49, in Alberta**

by

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Ethics Statement



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Abstract

In Alberta, low-income women, aged 35-49, engage in self-injury at rates second only to female youth. This demographic faces the stressors of living in poverty combined with gendered and mid-age challenges and expectations. Government strategies addressing self-injury have been ineffective. A literature review and interviews with frontline professionals reveal that self-injury is a survival-based coping mechanism. Interviews with academics and policy professionals, supported by research on policy alternatives, illuminate the need for a comprehensive, intersectionality-informed approach to preventing and reducing self-injury. Three policy options are analyzed: the provision of counselling benefits for low-income individuals, greater integration of mental health care into the primary health care system and increased capacity for community mental health outreach and services. Increasing access to gender and trauma-informed mental health supports through community outreach is recommended to reduce self-injury among this population. Reforming systems of power to reduce inequity is recommended to prevent self-injury.

Keywords: self-injury; intersectionality; social determinants of health; equity; public policy; women's health

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Table of Contents

Approval.....	ii
Ethics Statement.....	iii
Abstract.....	iv
Acknowledgements.....	v
Table of Contents.....	vi
List of Figures.....	x
List of Tables.....	x
List of Acronyms.....	xi
Glossary.....	xii
Executive Summary.....	xiii

Introduction	1
---------------------------	----------

Chapter 1. Background.....	4
-----------------------------------	----------

1.1. Self-injury is a public health issue.....	4
1.2. What is self-injury?.....	5
1.3. What motivates self-injury?.....	6
1.4. Gender inequity & self-injury.....	7
1.5. Income, inequity & self-injury.....	8
1.6. Mid-life crises, the sandwich generation & self-injury.....	10
1.7. The Alberta “advantage”.....	11
1.8. What is the current policy context?.....	12
1.8.1. Suicide (and self-injury) prevention.....	12
1.8.2. Alberta mental health review.....	13
1.9. Applying an intersectional framework.....	14

Chapter 2. Methodology.....	16
------------------------------------	-----------

2.1. Overview of Methodology.....	16
2.1.1. Objectives.....	16
2.2. Semi-Structure Interviews.....	16
2.2.1. Interviews with Frontline Professionals.....	17
Design.....	17
Recruitment.....	18
Details.....	18
2.2.2. Interviews with Academics and Policy Professionals.....	19
Design.....	19
Recruitment.....	20
Details.....	20
2.3. Thematic Data Analysis.....	21
2.4. Intersectional Framework.....	21
2.4.1. Reflexive Analysis.....	22
2.5. Methodological Limitations.....	23
2.5.1. Recruitment.....	23
2.5.2. Focus Groups.....	23

2.5.3.	Diverse Knowledges	24
2.5.4.	Supplementary Quantitative Data	24
Chapter 3.	Thematic Analysis Results	25
3.1.	Frontline Professionals.....	25
3.1.1.	Contextual Understandings.....	25
	Self-injury as a coping strategy or a means of survival	25
	Self-injury as a means of communication	26
	Defining self-injurious behaviours	26
3.1.2.	Intersecting Categories	27
	Interactions of multifaceted factors	27
	Internalizing emotions	28
	Trauma, mental illness & stigma.....	29
	Poverty exacerbates the ability to cope	30
	Women's multiple roles.....	31
	Canadian in the twenty-first century.....	31
	Access, equity & systems of power	32
3.1.3.	Reduction & Prevention of Self-Injury	33
	Accessible, integrated, holistic care.....	33
	Education & awareness	34
	Systemic change.....	34
3.2.	Academics and Policy Professionals.....	35
	Dismantling structural inequality	35
	Leadership prerequisite	36
	Training, education & awareness.....	37
	Integrated practice	38
	Distribution of funding	39
	Contextual considerations.....	39
3.3.	Cross Data Themes	40
	Appropriate and adequate access	40
	Mid-life vulnerabilities.....	40
	Gender and children	41
Chapter 4.	Policy Discussion	42
4.1.	Conclusions for Policy Responses.....	42
4.2.	Social Determinants Policy.....	43
4.2.1.	Increasing income	44
4.2.2.	Measure competency requirements.....	44
4.2.3.	Public awareness	44
4.3.	Governance Prerequisites.....	45
4.3.1.	Wellness institution	45
4.3.2.	Transdisciplinary advisory committee	45
Chapter 5.	Policy Alternatives	47
5.1.	Wellness Benefits.....	47
5.2.	Primary Care Plus	49
5.3.	Community Outreach	51

Chapter 6. Evaluation Framework.....	54
6.1. Objectives, Criteria & Measures.....	54
6.1.1. Effectiveness.....	54
6.1.2. Equity.....	55
6.1.3. Cost.....	55
6.1.4. Administrative Ease.....	56
6.1.5. Stakeholder Acceptance.....	56
6.1.6. Additional Benefits.....	56
6.2. Evaluative Framework Summary.....	57
Ranking and Weighting Considerations.....	58
Chapter 7. Evaluation of Policy Options	60
7.1. Wellness Benefits.....	60
7.1.1. Effectiveness: Reduction.....	60
7.1.2. Effectiveness: Prevention.....	61
7.1.3. Equity: Between.....	61
7.1.4. Equity: Within.....	62
7.1.5. Cost.....	63
7.1.6. Administrative Ease.....	63
7.1.7. Stakeholder Acceptance.....	64
7.1.8. Additional Benefits.....	64
7.1.9. Evaluation Summary.....	64
7.2. Primary Care Plus.....	65
7.2.1. Effectiveness: Reduction.....	65
7.2.2. Effectiveness: Prevention.....	65
7.2.3. Equity: Between.....	66
7.2.4. Equity: Within.....	66
7.2.5. Cost.....	66
7.2.6. Administrative Ease.....	67
7.2.7. Stakeholder Acceptance.....	67
7.2.8. Additional Benefits.....	67
7.2.9. Evaluation Summary.....	68
7.3. Community Outreach.....	68
7.3.1. Effectiveness: Reduction.....	68
7.3.2. Effectiveness: Prevention.....	68
7.3.3. Equity: Between.....	69
7.3.4. Equity: Within.....	69
7.3.5. Cost.....	70
7.3.6. Administrative Ease.....	70
7.3.7. Stakeholder Acceptance.....	71
7.3.8. Additional Benefits.....	71
7.3.9. Evaluation Summary.....	72
7.4. Summary of Policy Evaluation.....	72
Chapter 8. Recommendations and Implementation	73
8.1. Community Outreach.....	73
8.1.1. Considerations for Implementation.....	74

8.1.2. Limitations and Challenges	74
8.1.3. Supporting Recommendations.....	74
8.2. Areas for Further Research.....	75
8.3. Reflexive Analysis	76

References	77
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Appendix A. Semi-Structured Interview Schedule: Frontline Professionals	84
Objectives:	84
Section 1: Intro	84
Section 2: Semi-Structure topics with potential probes	84
Appendix B. Consent Form for Frontline Professionals.....	87
Appendix C. Consent Form for Academics and Policy Professionals	91

List of Figures

Figure 1:	Self-Injury Hospitalization Rates in Alberta, 2014.	9
Figure 2:	Self-Injury Hospitalization Rate, by Sex and Age Group, Canada, 2009-2010.	10

List of Tables

Table 1:	Academics and Policy Professional Participants.....	20
Table 2:	Qualifying Income for AAHB.....	49
Table 3:	Evaluative Criteria, Measures and Ranking.	57
Table 4:	Wellness Benefits Evaluation Summary.....	64
Table 5:	Primary Care Plus Evaluation Summary.	68
Table 6:	Community Outreach Evaluation Summary.	72
Table 7:	Policy Options Evaluation Summary.	72

List of Acronyms

AAHB	Alberta Adult Health Benefit
ACSW	Alberta College of Social Workers
AISH	Assured Income for the Severely Handicapped
AMHB	Alberta Mental Health Board
AMHRC	Alberta Mental Health Review Committee
BPD	Borderline Personality Disorder
CASW	Canadian Association of Social Workers
DSM-5	Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition
GOA	Government of Alberta
GOC	Government of Canada
HBC	Health Benefits Card
IBPA	Intersectionality-Based Policy Analysis
NSSI	Nonsuicidal Self-Injury
PAA	Psychologists Association of Alberta
PHAC	Public Health Agency of Canada
RSW	Registered Social Worker
TA	Thematic Analysis
TD	Target Demographic (Low-income women, aged 35-49, in Alberta)
WBC	Wellness Benefits Card

Glossary

Frontline Professional	Individuals privately or publicly employed in the social services sector in supportive and care based roles working directly with individuals, couples, families and groups.
Gender-Informed Practice	Frontline practice informed by knowledge of the effects of patriarchy and sexism.
Harm-Reduction Approach	Practice or policy aimed at reducing various harms associated with substance use and abuse (Karol, 2010).
Intersectionality-Based Policy Analysis	Method of analysis utilized to understand implications of multiple and intersecting social identities for the purposes of promoting equity and social justice based policy (Hankivsky, et al., 2012).
Non-Judgemental Practice	Practice void of judgement based on the practitioner's values and beliefs.
Self-Injury	Any behavior intentionally causing physical or emotional harm to oneself for the purposes of temporary emotional relief.
Target Demographic	Low-income women, aged 35-49, in Alberta.
Trauma-Informed Practice	Frontline practice that centres an individual's choice, control and safety and strives to create a service delivery culture based on nonviolence, learning and collaboration as informed by knowledge on how trauma impacts individuals and communities (Poole & Greaves, 2012).

Executive Summary

In Alberta, hospitalization data highlights gender, age, and income disparities in relation to self-injury. Women self-injure in greater numbers than men, there is a spike in women's self-injury between the ages of 35 and 49, and self-injury is negatively correlated with neighbourhood income level. Rates of self-injury among low-income women, aged 35-49, in Alberta (the target demographic), are too high. Particularly as compared to their male and high-income counterparts and other adult age cohorts.

Literature on self-injury reveals varied and conflicting definitions of the behaviour over time and points to misunderstandings of its causes and consequences. Contrary to prior thought, self-injury is only slightly correlated with borderline personality disorder, childhood sexual abuse, and suicide attempts. Further, rather than a call for attention, self-injury is more often a private act. Negative consequences of self-injury include physical injury, disability, and death. Each has human, societal, and economic impacts. However, government strategies to reduce and prevent self-injury have been ineffective. Self-injury is typically addressed insofar as it relates to suicide and without attention to root causes.

To understand why rates of self-injury are high among the target demographic and to investigate the policy landscape and potential solutions to prevent and reduce self-injury, I conducted two sets of interviews. First, I spoke with twelve social workers and community practitioners in Alberta, whom have direct experience working with members of the target demographic. Next, I consulted two academics in the fields of community health and intersectionality, and three policy professionals whom could speak to health inequities, mental health policy and injury prevention in Alberta.

I conducted a thematic analysis of the interview data, informed by intersectionality-based policy analysis. The following points highlight the results:

- Self-injury is survival-motivated coping strategy that provides temporary relief and is a means of externalizing emotional pain

- Self-injury manifests in various “typical” behaviors such as cutting and scratching, as well as “atypical” behaviours such as eating disorders, hoarding, shaming, and blaming oneself
- Systems of power and oppression that create and perpetuate inequity, such as sexism and racism, are at the root of the factors contributing to self-injurious behaviour
- Self-injury results from the interactions of multiple factors, including: conditions and stressors associated with poverty, gendered internalized emotion regulation, past and current experiences of violence, trauma and oppression, the presence of mental illness including depression and anxiety, pressures associated with multiple roles - particularly when they clash with contextual societal expectations, and inaccessible mental health supports and services

To adequately reduce and prevent self-injury among the target demographic:

- Systems and policies contributing to inequity must be dismantled or reformed including eradicating poverty, increasing access to affordable housing and child care, and ending violence and oppression based on social identities
- Greater access to appropriate, integrated, community-based, non-judgemental, gender and trauma-informed mental health care is essential to preventing and reducing self-injury among the target demographic
- Leadership and funding from Alberta Health are required to ensure investment in mental health care and prevention, informed by the social determinants of health
- Training, education, and awareness of self-injury and the social determinants of health, with respect to diverse populations, is necessary for the greater public and for helping professionals

To successfully prevent self-injury, systems and policies must be reformed to address inequities. While work is done to create this high level societal change, policies to address social determinants of health and provide immediate relief for the target demographic were assessed. Literature and interview data informed the selection of three policy options to increase access to mental health services for the target demographic. These three options consisted of; (1) Wellness Benefits: including coverage for counselling to the health benefits available to low-income Albertans; (2) Primary Care Plus: integrating mental health screening and care into primary health clinics; and (3) Community Outreach: the provision of community-based, multi-

disciplinary care teams, coupled with increased funding for appropriate social service agencies.

Six criteria were utilized to compare and contrast these policies. First, effectiveness was measured both by the degree to which each policy is expected to reduce hospitalizations for self-injury among the target demographic and by the level of prevention (primary, secondary or tertiary) utilized. Second, equity was measured by the degree to which each policy would increase access to mental health supports for the target demographic, as compared to wealthier Albertans, and how the option would benefit members of the target demographic equitably. Administrative ease, cost, stakeholder acceptability and additional benefits comprised the remainder of the criteria.

Based on the analysis, the policy I recommend to best reduce self-injury among the target demographic is Community Outreach. In this option, interdisciplinary teams include peer support workers, social workers, psychologists, and psychiatrists. Partnering agencies would be funded to provide space, peer support workers, and training. Priority for funding would be allotted to community-based agencies that meet the greatest level of criteria specific to the needs of the target demographic, i.e. the agency is in an accessible location, serves low-income individuals, has women's only hours, provides child minding, and employs non-judgemental, gender and trauma-informed practice.

Coupled with this recommendation, I propose to define self-injury as any behavior intentionally causing physical or emotional harm to oneself for the purposes of temporary emotional relief. Further, I recommend that institutions collecting data on self-injury disaggregate between self-injury and suicide.

Self-injury is a coping mechanism that enables many individuals to survive. As such, any further research or treatment must recognize this fact and focus on addressing the root causes of self-injury and not solely seek to prevent the behaviour itself.

Introduction

Self-injury is not a new phenomenon. The earliest documented accounts of self-injury date back to the eighteenth century (Whitlock & Selekman, 2014). Yet, the behaviour has garnered recent media attention in Canada due to increasing rates for subsets of the population. Most striking is the 110% increase in hospitalizations for self-injurious behaviour by females, aged 15-24, between 2009 and 2014 (CIHI, 2014). Less attention, however, has been granted to other sociodemographic cohorts. Sex, age and income patterns in the data suggest that low-income women, age 35-49, self-injure nearly as frequently as young women and girls.

According to the Canadian Institute for Health Information (CIHI, 2016) females are 1.6 times more likely to be hospitalized for self-injury than males. In Alberta, female hospitalizations for self-injury increased between 2011 and 2014, from a rate of 70 per 100,000 individuals to a rate of 75 per 100,000. During the same timeframe, the rate for males remained constant at 49 per 100,000¹ (CIHI, 2016). Further, females are hospitalized for self-injury at greater rates than males across most age groups. The highest rates of self-injury hospitalizations overall are associated with females, aged 15-24, ranging from 80 to 145 per 100,000, followed by females, aged 35-49, with rates ranging from 80 to 100 per 100,000 (CIHI, 2011).

Additionally, hospitalization rates for self-injury are negatively correlated with neighbourhood income quintiles. In 2014, the lowest neighbourhood income quintile in Alberta had a self-injury hospitalization rate of 101 individuals per 100,000. This rate was twice as high as the rate of the highest income quintile at 44 individuals per 100,000 (CIHI, 2016). Similar to gender, income disparity differences in self-injury hospitalization rates have intensified in recent years. Between 2011 and 2014, the rates associated with

¹ All rates cited from the CIHI are age-standardized rates, referring to individuals aged 15+

lowest three income quintiles in Alberta increased. In contrast, the rate of the fourth quintile decreased slightly and the highest income quintile rate remained unchanged (CIHI, 2016).

It is important to note that *hospitalizations* for self-injury are just the tip of the iceberg. Persons that have self-injured may not require medical attention, may visit the emergency department and not be hospitalized or may not seek treatment at a hospital. The CIHI (2011) estimates that overall rates of self-injury are approximately 50% higher than hospitalization rates alone. As such, sex, age and income disparities are greater than hospitalization data suggests.

Self-injury is believed to be preventable (Harpa, Hawort-Brockman & Schaefer, 2013; Eggertson, 2013). The CIHI (2013) state that hospitalizations and emergency department visits for self-injury could be reduced by 27% if all Canadians had the same rates as those in the wealthiest neighbourhoods. Strategies to reduce self-injury, however, have been ineffective.

The Alberta Suicide Prevention Strategy asserts secondary aims of reducing incidences of self-injury (Alberta Mental Health Board, 2006). Despite this objective, all elements of the strategy focus on suicide prevention. Inarguably action must be taken to prevent suicide, but the strategy fails to acknowledge that self-injury is a distinct issue.

Rates of self-injury for Albertan women, aged 35-49, with low-incomes are too high. Particularly as compared to their male and high-income counterparts and other adult age cohorts. In this study, I utilize literature and qualitative research methods informed by an intersectional framework to better understand and explain the factors contributing to these high rates. Further, I explore how self-injury can be prevented and reduced among low-income women, aged 35-49 in Alberta, whom I refer to as the “target demographic”. I conclude this study with an in-depth policy analysis and detailed recommendations.

In the following chapter I summarize important background considerations and context to justify the research objectives and methodology of this study, which are detailed in Chapter 2. Chapter 3 contains the results of my thematic analyses, completed

with interview data from frontline professionals, academics and policy professionals. In chapter 4, I discuss my research findings and concluding implications for the selection and development of policy options. I detail a slate of options in Chapter 5 and lay out the objectives, criteria and measures for policy evaluation in Chapter 6. Chapter 7 contains my analysis of three policy contenders to reduce and prevent self-injury among the target demographic and in Chapter 9 I specify recommended policy action, considerations for implementation and implications for future research.

Chapter 1. Background

In this chapter, I present information to justify self-injury as a public policy issue worthy of policy action. Additionally, I summarize relevant literature on self-injury and provide details regarding the current policy landscape impacting self-injury in Alberta. I conclude the chapter with a discussion of the utility of an intersectional lens to understanding self-injury.

1.1. Self-injury is a public health issue

Self-injury hospitalization data exposes social determinants impacting self-injury. Gender, age and income all influence the behaviour. Low-income women, aged 35-49 in Alberta, are more likely to self-injure than men and individuals in other income demographics and adult age cohorts. Social determinants that impact various ill health outcomes tend to reflect and exacerbate existing inequities in society and self-injury is no exception. Inequities harm everyone in a society, even high income earners (Wilkinson & Pickett, 2010; National Council of Welfare, 2011, Broadbent Institute, 2012). Research has revealed that the healthiest and happiest societies have the smallest income gaps between the rich and the poor (Wilkinson & Pickett, 2010; National Council of Welfare, 2011, Broadbent Institute, 2012). These societies have a lower prevalence of mental illness, physical health issues and violence (Wilkinson & Pickett, 2010).

Health inequities are of public concern because they conflict with Canadian values. Canadians value accessible and comprehensive health care that gives them access to a range of quality supports and services (Mendelsohn, 2002; Soroka, 2007). Further, the Public Health Agency of Canada (PHAC, 2014c) reports that Canadians feel that health inequities, small or great, are unacceptable. Disproportionate rates of self-

injury by different demographics are unacceptable health inequities. To align with Canadian values, this issue needs to be addressed.

There are also economic justifications for reducing and preventing self-injury. In 2010, suicide and self-injury cost Canadians 2.9 billion dollars (Parachute, 2015, p.6). Albertans were responsible for 447 million dollars of that total (Parachute, 2015, p. 56). Further, suicide and self-harm cost Albertans 111 million less in 2004 (SMARTRISK, 2009, p.39). Although a cost breakdown disaggregating between suicide and self-harm is unavailable, as the associated death rate decreased in the same period, part of the increase is likely attributable to increased self-injury (SMARTRISK, 2009, p.39). The economic consequences are substantial, but so are the human consequences.

Bresin and Schoenleber (2015) state that self-injury is a public health issue because of inequity but also because it increases the risk of long term physical injuries and suicidal behaviour (p.56). In Alberta, unsuccessful suicide attempts and self-harm resulted in over 400 permanent disabilities in 2010 (Parachute, 2015, p.55). The impacts of which extend to family members and friends whom may assume caregiving roles. Accidental deaths resultant from self-injury are another consequence. Preventable injuries are “the leading cause of death for Canadians aged one to [forty-four]” (Parachute, 2015, p.2). In summary, “[t]he frequency, severity and significant economic costs involved make injury an important public health issue. Injury is also a concern from a health equity perspective: the burden of injury is higher for vulnerable groups” (PHAC, 2013, para 3).

Overall, whether the greatest concern is equality, the economic burden or human consequences, self-injury meets the credentials for public concern. As the case for concern has been established, in the next section I explore what constitutes self-injury.

1.2. What is self-injury?

There are various terms used to describe and understand self-injurious behaviour. The CIHI (2013) defines self-injury as “deliberate bodily injury that may or may not result in death” that “is the result of either suicidal or self-harming behaviours, or

both” (p. 25). As their data provides the most relevant statistics to quantify and describe self-injury in Alberta, I utilize CIHI’s term, self-injury, throughout this study. However, as the behaviour is associated with conflicting definitions, in my research, I employed an open approach to understanding the behaviour. In particular, I took steps to understand what distinguishes self-injury without suicidal intent from suicidal behaviour.

An Alberta study on adolescent *self-harm*, defines this term as “non-fatal self-poisoning or self-injury irrespective of suicidal intent” (Newton, Tsang & Rosychuck, 2015, p.498). Other terms found in the literature, self-mutilation and parasuicide also specify that these behaviours are void of suicidal intent (Angelotta, 2015).

Another common term, nonsuicidal self-injury (NSSI), is defined as “the deliberate, self-inflicted destruction of body tissue without suicidal intent and for purposes not socially sanctioned” (Zetterqvist, 2015). In 2013, NSSI was added as a unique diagnostic classification in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) with a note stating that it is a condition requiring further research (Angelotta, 2015; Bresin & Schoenleber, 2015; DeAngelis, 2015a). Angelotta (2015) summarizes the challenge of defining self-injury;

“Self-harm occupies the fuzzy border between normal and abnormal behaviour, making it particularly difficult to categorize. The exact bounds of this border have shifted over time with changing cultural norms” (p.75).

Despite nuances between definitions, all of the terms described in this section refer to self-injurious acts such as cutting, hitting, burning and scratching oneself. They typically exclude socially sanctioned forms of self-injury such as getting tattoos and piercings (Girardi, Babul, Rajabali & Pike, 2013).

1.3. What motivates self-injury?

Individuals self-injure in search of temporary relief from negative emotions, to express anger towards themselves, to punish themselves, to experience disassociation or to mitigate suicidal thoughts (Bresin & Schoenleber, 2015; Harpa et al., 2013; Klonsky et al., 2014). “Pain offset relief” is a term used to describe the positive emotions humans

feel after experiencing painful stimuli, before returning to a pre-stimulus state (DeAngelis, 2015a, p.58). For individuals that self-injure, these emotions include short and intense states of euphoria and/or feelings of relief and calm (DeAngelis, 2015a; Klonsky et al., 2014).

The notion that individuals self-injure to get attention is a common misconception. Researchers have concluded that self-injury is predominately a private act (Klonsky, Victor & Saffer, 2014, p. 567). Another misconception is that childhood sexual abuse is a primary cause of self-injury. Conversely, there is only a minimal association (Klonsky et al., 2014, p.567). Finally, it was thought that self-injury was principally a symptom of borderline personality disorder (BPD). However, the extent to which self-injury occurs independently of BPD was one reason NSSI was included as a distinct entry in the DSM-5. (Klonsky et al, 2014, p.567).

A long list of other conditions have been found to be correlated with self-injury to varying degrees. These include the presence of depression, anxiety, feelings of hopelessness, stressful events, previous trauma and abuse, emotional distress, negative emotionality and emotion dysregulation (Bresin & Schoenleber, 2015; DeAnglelis, 2015b; Harpa et al., 2013; Klonsky et al, 2014; Whitlock & Selekman, 2014). Additionally, individuals that self-injure dislike themselves to a greater degree than those that do not engage in self-injury (DeAngelis, 2015a). Finally, as a result of internalizing societal pressures, those that self-injure are more prone to body objectification, dislike of one's body and eating disorders (DeAngelis, 2015b). Many of the conditions associated with self-injury impact women to a greater degree than men. In the next section I explore what a gender lens has uncovered about self-injury.

1.4. Gender inequity & self-injury

In this section I discuss how gendered experiences contribute to self-injury. A meta-analysis on gender differences in NSSI research conducted by Bresin and Schoenleber (2015) found that women were 1.5 times more likely to report a history of NSSI than men (p.58). Despite this evidence, some researchers state that gender

differences are misconceptions, noting that in contrast to clinical samples, general population samples find equal prevalence rates (Klonsky et al, 2014).

A number of other gender differences are uncontested. Women are statistically more likely to injure themselves by cutting, biting, scratching, pinching, hair pulling and preventing wounds from healing properly whereas men are more likely to engage in hitting or punching (Andover, Primack, Gibb & Pepper, 2010; Bresin & Schoenleber, 2015; Klonsky et al., 2014). Additionally, women first self-injure at younger ages than men with greater variability and levels of occurrence across their lifespans (Andover et al., 2010).

Finally, self-injury has been connected to gender-based violence, which impacts women to a greater degree than men (Harpa et al, 2013). Survivors of gender-based violence have utilized self-injury as a mechanism that provides them some agency over the pain they experience (Harpa et al, 2013, p.317). Although the literature has clarified some gender differences, more information is required to understand how gendered experiences contribute to higher rates of self-injury for women.

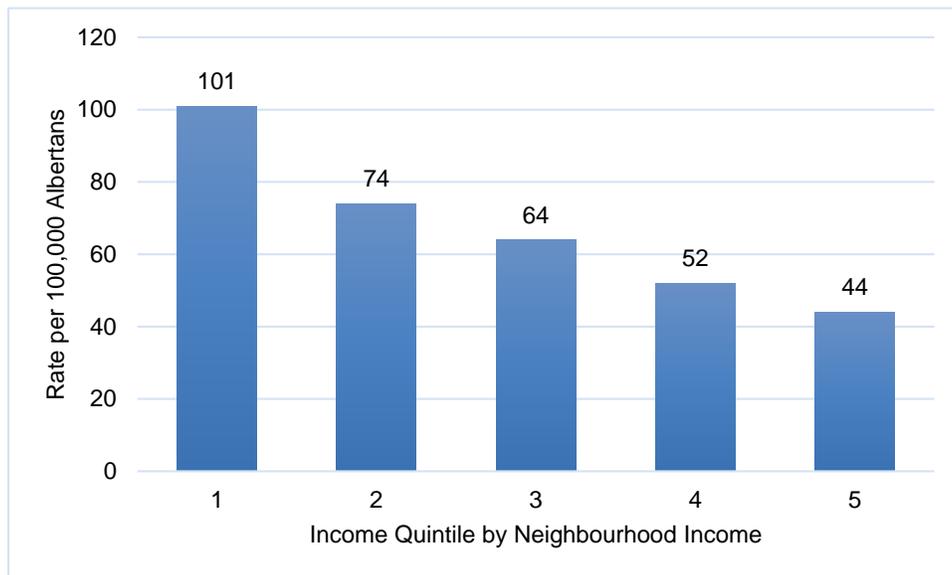
1.5. Income, inequity & self-injury

Research has established that various negative health outcomes can be explained in part by social determinants. These determinants include income level, income distribution, level of education, housing conditions, gender, ethnicity and disability status (Pathak, Low, Franzini & Swing, 2012; Wilkinson & Pickett, 2006; 2010; Mikkonen & Raphael, 2010; Tjepkema, Wilkins, & Long, 2013). Pathak, et al. (2012) state that, in Canada, “income is one of the most essential and well-documented social determinants of health; health increases at almost every higher income level” (p.10). Compared to the wealthy, individuals with low-incomes have decreased life expectancy and greater prevalence rates of various health issues including heart disease (Tjepkema et al., 2013) Income level impacts food security, nutrition, housing conditions and mental health which all contribute to overall health (Mikkonen & Raphael, 2010; Pathak et al, 2012).

The authors of *The Spirit Level* (2010), an oft cited book on the harms associated with unequal societies, conducted a literature review of peer-reviewed research papers that examined the correlation between income distribution and population health (Wilkinson & Pickett, 2006). Out of 168 analyses in societies ranging from nations to small parishes, 70% were supportive of a correlation expressed as follows; “health is less good in societies where income differences are bigger” (Wilkinson & Pickett, 2006, p.1768).

In the last forty years, income inequality has increased in Canada; the rich are getting richer and the poor are getting poorer (Pendakur, 2015). Further, income level and income distribution impact self-injury. As stated previously, and illustrated by Figure 1, hospitalizations due to self-injury are negatively correlated with neighbourhood income levels in Alberta and across Canada (CIHI, 2016; Eggertson, 2013).

Figure 1: Self-Injury Hospitalization Rates in Alberta, 2014.



Source: CIHI, Indicator Library, Hospitalizations for Self-injury, 2016

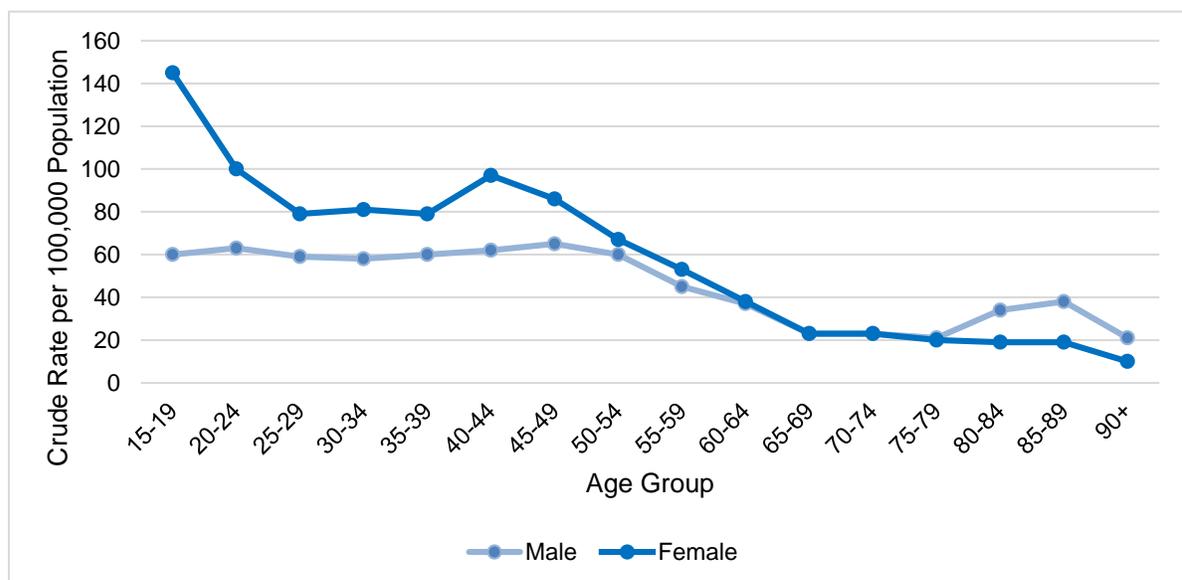
As compared to thirteen different health indicators, self-injury was found to be second only to ambulatory care sensitive conditions, such as diabetes, as the indicator with the greatest potential for rate reduction via greater income equality (CIHI, 2013).

Some evidence suggests income distribution is not a strong predictor of health outcomes. Latif (2015) states that correlations between income inequality and ill health vary depending on the method used to calculate inequality (p.946). However, he notes that there is no question regarding the effect of absolute income; positive health outcomes increase with income (Latif, 2015, p.946). This could be attributable to the fact that high-income households have much greater access to health care services than low-income ones (Slaunwhite, 2015). Although it is clear that income and income distribution impact self-injury, the literature does not clarify how or why. A greater understanding of these effects would contribute to a more effective policy response.

1.6. Mid-life crises, the sandwich generation & self-injury

Hospitalizations for self-injury are very rare for males and females under the age of 10 (Government of Alberta, 2015e). Rates are highest among teenagers and thereafter generally decline with age (CIHI, 2011). Figure 2 illustrates a noticeable exception; there is a significant peak in self-injury among females aged 35-49 (CIHI, 2011).

Figure 2: Self-Injury Hospitalization Rate, by Sex and Age Group, Canada, 2009-2010.



Source: CIHI, Health Indicators 2011, p.22

In a chapter on self-injury across the life span in the *Oxford Book of Suicide and Self-Injury*, Whitlock and Selekman (2014) state that limited research on adult self-injury has resulted in little empirical understanding of the issue in this large age group (Whitlock & Selekman, 2014). However, they do report statistical correlations between adult self-injury and childhood trauma, previous sexual abuse and suicide attempts. More, they note that anxiety is an important contributor to NSSI in adults (Whitlock & Selekman, 2014).

Increased life expectancy and the increasing average age at which children first leave the home is the cause of a phenomenon called “the sandwich generation”, a reality impacting many middle age adults (Mitchell, 2014, p.333). The term refers to the generation of individuals who are responsible for dually caring for their elderly parents and their children (Mitchell, 2014). Many of the target demographic are undoubtedly impacted by this situation. In a review of sandwich generation literature, Mitchell (2014) finds that the associated caregivers are predominately women and their roles involve multiple types of caregiving including financial support, housing and emotional labour. Further, those impacted by sandwich generation demands face increased stress (Mitchell, 2014). Better understanding the factors that contribute to the spike in self-injury for women aged 35-49 is essential for developing an appropriate policy response to the issue.

1.7. The Alberta “advantage”

In 2014, as compared to other Canadian provinces, Alberta had the fourth lowest overall rate of hospitalizations for self-injury at 62 per 100,000 (CIHI, 2016). Alberta’s lowest neighbourhood income quintile rate mirrored the Canadian average for lowest income quintile rate, while Alberta’s wealthiest neighborhoods had the lowest rates of self-injury as compared to the most affluent neighbourhoods in all other provinces (CIHI, 2016). Finally, Alberta had the third greatest disparity between rates of the least and most affluent neighbourhoods, next to New Brunswick and Saskatchewan (CIHI, 2016).

Additionally, Alberta is the province with the greatest overall income inequality. The difference between incomes in the top quintile and those in the bottom is much

greater than the differences found in other provinces (Stunden Bower, 2014). Further, studies have found that Alberta scores the lowest among the provinces in terms of gender pay equity (Lahey, 2014). Taken together, these factors and hospitalization rate disparities suggest that that the wealthy, and wealthy men in particular, are advantaged in Alberta in many ways.

Alberta's overall average rates of self-injury, coupled with the wealth advantage make it an ideal province for exploring the factors contributing to self-injury for the target demographic as compared to wealthier demographics. Further, a mental health policy window is currently open in Alberta.

1.8. What is the current policy context?

1.8.1. Suicide (and self-injury) prevention

An "Alberta Suicide Prevention Strategy" was published by the former Alberta Mental Health Board (AMHB) in 2006 (AMHB, 2006). Despite referring to self-injury statistics to help justify the importance of a suicide prevention policy, the stated purpose of the framework is to "prevent and reduce suicide, suicidal behaviour, and the effects of suicide in Alberta over the next 10 years" (AMHB, 2006, p.13). Of note, suicidal behavior is defined separately from self-harm and self-mutilation in the strategy's associated glossary (AMHB, 2006).

Information on self-injury is referred to throughout the strategy document including a statement acknowledging greater hospitalizations and emergency department visits for self-injury than suicide and a greater prevalence of self-injury for women (AMHB, 2006). Despite this, none of the final strategies acknowledge or address self-injury directly. Further, the use of the word prevention is inaccurate. The strategies consist of interventions after suicidal behaviours have presented and do not address the root causes of suicide or self-injury. Alberta's suicide prevention strategy has failed at addressing self-injury among the target demographic over the past ten years.

The policy context is very similar at a federal level. Self-injury is addressed insofar as it relates to suicide. Bill C-300, the Federal Framework on Suicide Prevention Act, received royal ascent in 2012. The passing of this act required the Government of Canada (GOC) to consult with relevant non-profit organizations as well as provincial and territorial governments on specific elements of a future framework for suicide prevention (GOC, 2015). The PHAC states that these public consultations were to be finalized in the spring of 2014 (PHAC, 2014a). A progress report is to be delivered by the end of 2016 (GOC, 2015).

Whether or not the framework will address self-injury is unclear. The PHAC has stated that they collect and distribute information on rates of both self-harm and suicide (PHAC, 2014a, para. 2). Further, on their website, they have specified their role in regards to prevention of “intentional injuries” by outlining their initiatives to combat family violence and prevent suicide (PHAC, 2013). However, they do not indicate a specific role with respect to preventing self-injury.

1.8.2. Alberta mental health review

In late February, 2016, the Government of Alberta (GOA) published a report by the Alberta Mental Health Review Committee (AMHRC) that summarizes the results of an engagement process with Albertans and stakeholders to set a new policy direction for mental health and addictions services in Alberta (GOA, 2016c). Overall the report asks the province to place a higher priority on mental health care by increasing access to a range of treatment and services for all citizens and outlines twenty-seven specific recommendations for improvement (AMHRC, 2015).

The report recommends the establishment of clear leadership on mental health care provision and prevention as well as integrated and coordinated services including access to mental health support through primary care providers (AMHRC, 2015). Further, it suggests that Alberta Health create and facilitate training and awareness for the public, educators and helping professionals regarding mental health and addictions to reduce stigma and increase understanding and compassion (AMHRC, 2015). In addition, the report recommends increasing culturally appropriate services and calls for

coordinated First Nations, Inuit and Metis mental health strategies (AMHRB, 2015). Further, it calls for greater funding for affordable housing and non-profits that support individuals with mental illness and addictions (AMHRC, 2015). Finally, while the report culminates with a section on suicide prevention, self-injury receives no mention (AMHRC, 2015).

The GOA (2016c) announced that it had accepted the report and would take immediate action on six recommendations. These actions primarily focus on addictions treatment but also include the establishment of “a leadership team to work with community and health partners to develop an action plan to implement the report” and “a performance monitoring and evaluation framework to track results on report recommendations and benefits to Albertans” (GOA, 2016c, para 3).

Self-injury falls into the realm of mental health policy and the climate is right in Alberta to advocate for and implement policies that will effectively prevent and reduce self-injury among the target demographic. As such, further understanding the unique needs of the target demographic is essential for developing effective policy responses.

1.9. Applying an intersectional framework

Examining self-injury across gender, age and income illuminates inequity with respect to each category of difference. However, what happens when many of these categories overlap and interact? In this section I make the case for utilizing an intersectional framework to inform my research and analysis of self-injury among the target demographic.

As stated by Hankivsky et al., (2012b), “policy analysis cannot assume the primary importance of any one social category for understanding people’s needs and experiences” (p.35). Intersectionality recognizes that human lives are complex and must be understood within the context of how individual identities interact together, with power structures and the situational contexts within which they reside (Hankivsky, Grace, Hunting & Ferlatte, 2012a, p.17). This form of analysis can support “the development of more equitable services because of its focus on multiple forms of oppression and

structural violence, which give rise to inequities” (Browne, Varcoe & Fridkin, 2011, p.295). As such, utilizing an intersectional analysis to better understand self-injury among the target demographic will result in a more in-depth analysis and inform a more effective policy response.

I must note that due to the limitations of this study many facets of identity were excluded from full analysis. These factors include, but are not limited to, ethnicity and sexual orientation. Some researchers report that ethnicity is not a significant factor in prevalence rates of self-injury (DeAngelis, 2015b). Others state that First Nations populations are disproportionately impacted (Harpa, et al., 2013; Newton et al., 2015) and some describe self-injury as a Caucasian issue (Klonsky, et al, 2014). Various studies have also found there to be higher rates of self-injury among lesbian, gay, bisexual and transgender individuals (DeAngelis, 2015b; Klonsky et al., 2014). However, due to the available data on incidences of self-injury in Alberta, my research focuses on understanding how the intersections of gender, age and income impact the behaviour. In the next chapter I outline the methodology I utilized to study self-injury through an intersectional lens.

Chapter 2. Methodology

Rates of self-injury among the target demographic are too high, particularly as compared other demographic cohorts. This is in part due to ineffective government policy. To address this policy problem, I designed data collection methods to enhance my understanding of the issue and identify potential policy solutions.

2.1. Overview of Methodology

The primary research for this study included qualitative, semi-structured interviews with two separate groups: (1) frontline social service professionals; and (2) academics and policy professionals. I analyzed data collected from interviews with both groups using Braun & Clark's thematic analysis (2006). Furthermore, my research was guided by an intersectional theoretical framework as defined by Hankivsky et al., (2012a; 2012b).

2.1.1. Objectives

I identified two research questions to answer in this study:

1. What factors contribute to high rates of self-injury among low-income women, aged 35-49, in Alberta?
2. What policies would prevent or reduce self-injury among low-income women, aged 35-49, in Alberta?

2.2. Semi-Structure Interviews

Semi-structured interviews were well suited to my study as they allowed for me to collect focused data and seek new ideas. According to Galletta and Cross (2013) semi-

structured interviews are utilized to collect data for a broad range of research goals. Open-ended questions, prompts and theory based questions are employed for the purposes of drawing out participant experiences and opinions on the research topic (Galletta & Cross, 2013). Further, the semi-structured style allows for participants to direct the researcher to new information and meaning (Galletta & Cross, 2013).

2.2.1. Interviews with Frontline Professionals

Design

Participants were asked to choose between completing interviews in-person, when possible, or via the telephone. I chose these methods over asynchronous communication methods as they allow for more spontaneous data from the participant and permit the researcher to interpret and interact with social cues in tone, and body language (Opdenakker, 2006). For in-person interviews, participants were given the option of conducting the interview at a location of their choosing or at a private office space provided by me.

Interview questions were designed based on recommendations by Galletta & Cross (2013). They state that semi-structured interviews should have three phases; an introduction acknowledging the purpose of the interview followed by open-ended questions designed to support the participant to reflect upon their experiences and ending with more specific questions guided by theory (Galletta & Cross, 2013, p.46). I began each interview by clarifying the purposes of my research, followed by questions pertaining to the participant's frontline experience and then asked questions related to the literature presented in Chapter 1. Topics addressed several themes including defining self-injury, motivations to engage in self-injury, gender, age and income impacts, available supports and service gaps².

² For a full interviewer's guide for the semi-structured interviews with frontline professionals, please see Appendix A

Recruitment

I recruited the interview participants using three methods. First, e-mail invitations were sent by the Alberta College of Social Workers, on my behalf, to all Registered Social Workers (RSWs) practicing in Alberta. Secondly, I spoke with personal contacts. Finally, e-mails, phone calls and visits to agencies serving low-income women and women with mental illness comprised the third recruitment method. Frontline professionals were invited to express interest in participating given professional experience, within the past two years, working with one or more members of the target demographic that had self-injured or continued to do so.

Details

Interviews were conducted with twelve frontline professionals between December 13, 2015, and January 13, 2016. Half of these interviews were conducted in-person at cafés and participant's homes. Five were conducted via telephone and one via video call³. Interviews averaged one hour in length and ranged from twenty-eight minutes to eighty minutes. All participants provided digital or paper copies of signed consent forms prior to participation in the study⁴.

Participant's work and volunteer experiences included crisis support, one-on-one counselling, case management and group therapy at more than eleven identified organizations as well as private practice in Alberta. The majority of these organizations were located in Calgary and the remainder in other towns and cities across the province. Populations served by these agencies include individuals that are homeless or in precarious housing, individuals with addictions, women escaping or navigating domestic violence, survivors of sexual abuse, women experiencing poverty, individuals with mental health concerns and individuals in crisis or with on-going counselling needs. Participant's frontline experience ranged from two years to over thirty years. One third of participants were RSWs.

³ The video call was offered once as an alternative to meeting in person when I was not able to travel.

⁴ To view the consent form for Frontline Professionals, see Appendix B

Participants were asked to draw on their experiences of working directly with members of the target demographic that had self-injured or continued to do so. Participant's direct experience in this regard ranged from one individual in the target demographic to numerous individuals over the course of several decades.

Participants were not asked to provide sociodemographic identifiers such as gender or income level. However, throughout the interviews many made disclosures which augmented their professional knowledge and opinions with lived experience. Many had experienced gendered oppression, some disclosed personal experiences of self-injury and some participants discussed the self-injurious behaviour of personal connections, both current and in the past. Some participants shared personal experiences of navigating low-income situations and others divulged Canadian cultural observations as self-identified immigrants.

2.2.2. Interviews with Academics and Policy Professionals

Design

Academics and policy professionals were selected based on their ability to offer information and analysis on factors associated with the topic such as injury policy, health policy, social determinants of health and intersectionality. Further, participants were selected for their ability to offer insight into the policy solutions and the current policy context.

Similar to the question design utilized for the interviews with frontline professionals, I included Galletta & Cross' (2013) three phases. I began by clarifying the purpose of my study. Participants were then given some information about the findings from the interviews with frontline professionals, which was followed by open-ended questions and enquiries regarding policy solutions. In general, participants were asked to discuss what policies they would recommend to reduce and prevent self-injury among the target demographic. When possible participants were given the option to participate via telephone or in-person at their place of employment.

Recruitment

Academics and policy professionals were contacted via e-mail and telephone using publicly accessible contact information from academic and public institutions, or by way of personal connections.

Details

Interviews were conducted with two academics and three policy professionals in Alberta and British Columbia, between December 18, 2015 and February 1, 2016. The interviews ranged in length from nineteen minutes to forty minutes and averaged thirty minutes. One interview was conducted in-person and the remainder via telephone. Each interviewee signed a digital or paper consent form prior to their participation in the study⁵. The following table is a list of participants, their title(s) and interview date.

Table 1: Academics and Policy Professional Participants.

	Name	Professional Role(s)	Interview Date
1	Dr. David Swann	Member of the Legislative Assembly for Calgary-Mountain View; Co-Chair of Alberta Mental Health Review Committee; Medical Doctor	18-Dec-15
2	Cathy Gladwin	Policy Analyst, Injury Prevention Centre, University of Alberta	14-Jan-16
3	Dr. W. E. (Billie) Thurston	Professor of Community Health Sciences, Ecosystem and Public Health, University of Calgary (Retired as of January 1, 2016)	11-Jan-16
4	Dr. Shannon Stunden Bower ⁶	Research Director of the Parkland Institute (2012-2014); Author of "Sick of Inequality", cited in Chapter 1	19-Jan-16
5	Dr. Olena Hankivsky	Professor, School of Public Policy, Simon Fraser University; Director of the Institute for Intersectionality Research and Policy; Canadian Institutes of Health Research Gender and Health Research Chair; Michael Smith Foundation for Health Research Senior Scholar	1-Feb-16

⁵ To view the consent form for Academics and Policy Professionals, see Appendix B

⁶ Dr. Stunden Bower is currently an Assistant Professor in the Department of History and Classics at the University of Alberta.

2.3. Thematic Data Analysis

To analyze data from both sets of interviews, I used Braun & Clark's (2006) thematic analysis; a "method for identifying, analyzing, and reporting patterns (themes) within data" (p.79). Thematic analysis consists of researchers familiarizing themselves with the data, generating initial codes and themes and then refining the themes to produce a final report (Braun & Clarke, 2006, p.87). To support this process I took field notes and fully transcribed the interviews with academics and policy professionals as well as six of the interviews with frontline professionals. I partially transcribed new and interesting data from the remaining six. Further, I reviewed field notes, audio recordings and transcripts several times and identified patterns. Braun & Clarke (2006) describe this as process of searching for latent themes rather than an inductive research process and state that this approach is best when informed by an explicit theoretical framework. As such, I utilized the guiding principles of an intersectional framework, as outlined in Section 2.4, to enlighten my thematic analyses.

2.4. Intersectional Framework

My analysis was informed by the guiding principles of Intersectionality-Based Policy Analysis (IBPA) as defined by Hankivsky et al. (2012a; 2012b). IBPA is a method of analysis utilized to obtain knowledge on inequities for the purposes of advancing socially just policy to address inequities (Hankivsky, et al., 2012b, p.33). IBPA's guiding principles are summarized below.

1. Intersecting categories: examination of the interaction between multiple categories of identity or social location;
2. Multi-level analysis: examination of micro and macro levels in society – including the individual, society, province and nation;
3. Systems of power: examination of power, privilege and oppression imbedded in systems and institutions;
4. Reflexivity: awareness and acknowledgement of researcher/analyst's role, positions of power and knowledge;

5. Time and space: examination of contextual influences such as geographic location, social norms, culture, etc.;
6. Diverse knowledges: examination of epistemologies and their relation to power and knowledge production;
7. Social justice: utilizing intersectionality to challenge inequity and promote equity in social processes and distribution of resources;
8. Equity: emphasis on equalizing outcomes between groups of different social locations (Hankivsky, et al., 2012b, p. 33-38).

In addition, I utilized the promotion of social justice and the pursuit of equity as overarching objectives to inform my selection and analysis of policy options. Finally, I conducted reflexive analyses prior to data collection and as a concluding step in this project. Summaries of these personal reflections are found in Sections 2.4.1 and 8.3.

2.4.1. Reflexive Analysis

Before commencing interviews, I conducted a reflexive analysis to acknowledge and examine my social location as a researcher. Hankivsky et al. (2012b) note that “critical self-awareness” and “role awareness” are integral components of transformative reflexive practice (p.36).

My interest in this policy issue and subsequent approach to the study were informed by my background as a RSW. Social work places a large emphasis on viewing individual issues within the context of their larger environments. In both addressing the cause of an issue and in searching for solutions, the social, economic and political climate all play important roles. As a RSW, I was bound by and upheld the Canadian Association of Social Worker’s (CASW) Code of Ethics (2005), which assigns high value to the pursuit of social justice and equity for all. These values are evident throughout this study from the topic selection and study design to the identification and analysis of policy options.

My position of power as a researcher must be noted. I approached this research with middle-class status and I am privileged by society for many other facets of my identity. I am white, able-bodied and university educated. Further, my status as an

academic policy researcher puts me in a position of power as a gatekeeper between data shared by participants and how I interpret, analyze and report it. Other aspects of my identity allow me to relate to less powerful positions. As a woman I can relate to gendered oppression. The concluding section of this capstone contains my final reflexive analysis. In the next section I discuss methodological limitations of this study.

2.5. Methodological Limitations

2.5.1. Recruitment

Despite e-mails to all RSWs in Alberta, only one-third of frontline interview participants were RSWs. There could be many explanations for a low response rate. Of note, however, is that many potential participants felt that they did not have enough experience with the topic to adequately participate. These sentiments were expressed similarly by a number of frontline professionals that did participate.

2.5.2. Focus Groups

Focus groups would have been particularly well suited to this research study. They allow for participants to build upon each other's ideas, creating the potential to produce data that could not be captured by one-on-one interviews (Barbour, 2010; Rabiee, 2004; Wilson, 2012). I made significant attempts to conduct a focus group with frontline professionals. However, recruitment was unsuccessful.

Some researchers believe that sensitive topics are best researched via one-on-one interviews, although focus groups have also proven to be safe spaces to discuss issues due to "safety in numbers" (Barbour, 2010, p.333). Potentially, the sensitive nature of self-injury resulted in a much greater interest in one-on-one interviews than focus groups. Concerns regarding qualifications to discuss self-injury may have been another deterrent to focus group participation.

2.5.3. Diverse Knowledges

An important component of an IBPA framework is privileging the voices and knowledge of those that are traditionally excluded from policy (Hankisky, et al., 2012). As such, it would have been desirable to speak to members of the target demographic themselves. However, due to time limits and ethical constraints on this project, this was not possible.

2.5.4. Supplementary Quantitative Data

An application to access supplementary data to inform background statistics via the Graduate Student Data Access Program of the CIHI was submitted at the beginning stages of this study. The data was to be received in time to be incorporated into the study. However, unexpected delays at CIHI made this impossible.

Chapter 3. Thematic Analysis Results

The results of thematic analyses I conducted with interview data from frontline professionals as well as academics and policy professionals are presented in sections 3.1 and 3.2 respectively. In section 3.3 I examine themes that emerged across data sets.

3.1. Frontline Professionals

I present the results in three parts. In the first part I discuss the contextual knowledge that framed the discussions. In the second part, I cover themes that answer the research question; what factors contribute to high rates of self-injury among the target demographic? In the final section I reveal considerations for policy options.

3.1.1. Contextual Understandings

Disagreement across the literature signified the need to establish how each participant characterized self-injury. Overall, self-injury was depicted as a coping mechanism motivated by survival and a method of communication. Further, it was understood to have typical and atypical behavioural manifestations.

Self-injury as a coping strategy or a means of survival

Participants described self-injury as an emotion regulating coping mechanism utilized to deal with life circumstances and trauma resulting from interpersonal or systemic abuse, violence and oppression. Self-injury assists individuals to feel one or a combination of the following: better, high, calm, in control. Additionally, participants clarified differences between self-injury and suicidal behaviour, some referring to a continuum of harm.

“I think that self-injury actually, sometimes prevents suicide. In terms of looking at those things on a spectrum of self-harm, with suicide being at one end of that and self-harm being before that. I think those two processes are separate but related. I would define suicide as the ultimate expression of that anger, not just at yourself, but about your relationship to the world and saying that, you don't think it's going to get any better. So to me, if someone is self-injuring, they are showing some kind of hope” (Participant 8⁷).

Intent was described as a key factor in differentiating suicide and self-injury. Unlike suicide, self-injury is enacted out of a will to survive.

Self-injury as a means of communication

Participants referred to some occurrences of self-injury as attention-seeking behaviour. However, these instances were qualified as legitimate cries for help as self-injury provides a means of expressing deep emotional pain and can be a method of requesting needed validation and empathy.

“Sometimes it's easier to show something physical that starts the conversation that's like, ‘Hey, you know, are you okay? What's going on?’, and clearly there is something serious going on, than it is for some people to come to us and say, ‘Hey, I'm really not feeling okay’ and feel like they are really going to be taken seriously” (Participant 1).

Participants noted that for some individuals, the fear of not being believed when revealing emotional pain motivated this seemingly extreme way of seeking support.

Defining self-injurious behaviours

Many participants identified difficulties with succinctly defining self-injury and several asked questions about whether or not I would classify certain behaviours as self-injury. Despite these questions, participants clarified that self-injurious behaviour is more than just cutting, a behaviour that was often the first thing that came to their minds. Participants shared a long list of examples of self-injurious behaviours including more “typical” physical forms such as cutting, hitting, burning, scratching, pulling out body hair, addictions, poisoning oneself and interfering with wound healing. Atypical forms of self-

⁷ Dates have been purposely excluded as a measure to protect participant confidentiality.

injury, behaviours that are not extensively covered in the literature, if discussed at all, were noted as well.

“It's not that some people self-harm and other people don't, it's that we all self-harm in different ways, but for some people that's crack and for some people its compulsive hoarding or compulsive cleaning. It's just the same action really, like, lots of people know that saving all the newspapers might cause harm, but it makes them feel better” (Participant 8).

Atypical self-injurious behaviours acknowledged by participants included activities such as blaming and shaming oneself, often for life circumstances beyond the individual's immediate control. Other behaviours included eating disorders, isolating oneself from family and friends, forcing oneself to visit an abusive family member, getting tattoos, getting into a physical fight, staying in an abusive relationship and engaging in sex work. A common theme among some of these more “atypical” forms of self-injury was the framing of choice and the simultaneity of help and harm. For example, a woman with low-income may choose to stay in a relationship she knows to be unhealthy if the tradeoff is greater financial security and safety on the street.

3.1.2. Intersecting Categories

Self-injury is complex. As are the factors contributing to high rates for the target demographic. Impacting these rates are the presence of multifaceted factors such as gendered internalized emotion regulation, experiences of violence and oppression, the presence of mental illness, stress associated with poverty and lack of control, demands associated with caregiving roles, income inequality, increased availability of social comparisons and lack of access to adequate support.

Interactions of multifaceted factors

Self-injury is a coping mechanism utilized to deal with the interactions and presence of multifaceted stressors, it is used in partnership with other coping mechanisms and it is a behaviour that is difficult to stop. Many participants utilized

imagery, akin to intersectionality's traffic intersection imagery⁸, to describe how multilayered factors interact to result in self-injurious behaviour.

One participant spoke of walking across a balance beam to get to the other side. Any slight, seemingly insignificant movement can cause you to teeter, even when you think you are doing a good job (Participant 4). Another spoke of a bomb at the end of a fuse that has become shorter over time; one small spark can cause an explosive reaction (Participant 7). Yet another referred to "the last straw" on top of a "mountain" (Participant 5). All of these images were used to describe the complexity of and effect of multiple factors interacting, and building up over time, to contribute to an intense reaction.

Furthermore, images of vicious cycles and circles were utilized to describe how the shame and emotions women experience after they have self-injured often lead to increased negative emotions and thus increased impetus to self-injure. Additionally, participants noted that members of the target demographic typically used additional coping mechanisms. Alcohol and drug use often supplement self-injurious behaviour.

Internalizing emotions

Based on participant experiences, self-injury was described as more prevalent among women, girls and transgender individuals, than among men and boys. The thematic analysis revealed that gender, along with age and income, influence how individuals regulate their emotions. In particular, men are socialized to externalize negative emotions and women are taught to internalize them which puts them at greater risk to self-injure.

Participants noted that men likely self-injure in ways that are not typically associated with self-injury and they rarely, if ever, talk about it. Men are more likely to act violently or express anger towards others than to cut themselves. Participants expressed

⁸ Kimberle Crenshaw (1989) has been credited with coining the term "intersectionality". She writes of a traffic intersection, with each lane of traffic representing a different facet of identity (i.e. race, sex or class). The point at which each of these identities collide, the intersection, has much greater implications than each lane of traffic taken separately.

many sentiments regarding societal rules and norms for emotion regulation. In particular, men are allowed to express anger and may do so violently. Women are not supposed to express anger and they must be emotionally available to those around them while putting their emotional needs last. Finally, society dictates that women ought to blame themselves for not meeting societal expectations regarding who they should be or how they should act.

Emotion regulation for women, aged 35-49, has added implications. Participants stated that women in this age range, low-income or not, are at a life stage where they are looking back at their lives and evaluating where they are with where they thought they should be or wanted to be. They are also looking to the future, with little hope that things will change.

“Once you reach 35 and you don't feel like you have a lot of control over your life, you're almost more vulnerable than you were at a younger age. It's almost more socially acceptable to go through a really rough time when you are younger, but it seems more solidified into who you are as a person if you are 35-49 and continuing to go through that” (Participant 1).

Further, the circumstances of living in low-income situations create many challenges. Isolation and withdrawal were mentioned by many participants as both passive and active consequences of low-income and self-injury. Without connections and community, one's ability to express emotions and cope with stressors decreases. In some cases, members of the target demographic withdrew from friends due to the inability to pay for social outings such as coffee and lunch dates. In other cases, they faced added stress with respect to paying their bills in the event they had gone out with a friend. Further, exhaustion related to working several jobs and accessing resources to meet basic needs led to diminished capacity for social connection. Some of the target demographic withdrew from friends and family due to stigma associated with self-injurious behaviour and with poverty.

Trauma, mental illness & stigma

Experiences of trauma, the conditions of mental illness and the effects of stigma all contribute to ill mental health and self-injury among the target demographic. Participants spoke of childhood sexual abuse, experiences of trauma throughout

adolescence and adulthood and experiences of violence and discrimination based on gender, income and ethnicity. Many members of the target demographic, particularly indigenous women, suffered from intergenerational trauma as well. However, not only was trauma passed on generationally but coping mechanisms typically were too, including self-injury. Further, participants revealed that the 35-49 age range is frequently a time when childhood trauma surfaces for women.

Members of the target demographic deal with a range of mental health issues such as anxiety, depression, and BPD. These issues further compromise their ability to cope with trauma and stress. Further, both mental illness and self-injury are highly stigmatized and misunderstood. Moreover, some participants stated that low-income makes mental illness and self-injury more visible because of greater and more frequent interaction with social service agencies.

Poverty exacerbates the ability to cope

Participants shared that whether experiencing homeless, in precarious housing and/or working for low-wages, living with low-income is associated with immense daily stress, thereby increasing a person's likelihood of utilizing self-injury as a coping mechanism. Participants disclosed that some members of the target demographic receive income assistance or Assured Income for the Severely Handicapped (AISH) from the GOA and others are working for low-wages. Participants stated that the "working poor" are often employed in precarious positions without benefits. As such, members of the target demographic have a compromised ability to pay for child care costs, transportation, rent, food and clothing. Many participants associated the stress due to low-income with a lack of independence, choice and dignity.

Some members of the target demographic engage in sex work to earn an income and may face additional trauma and abuse. One participant noted that pimps look for self-injury scars when recruiting young women and girls, as they are an indication of vulnerability and prior abuse (Participant 8).

Women's multiple roles

Participants discussed the many roles that women have or are expected to have as contributing to stress in the lives of the target demographic. Many participants spoke of the clash between societal expectations and romantic relationships for women in the 35-49 age range. At this stage in their lives society expects them to be in stable, long-term relationships with men. As such, being single contributes to feelings of being undesirable, especially at an age where the body is going through significant changes. Particularly among the community of individuals that are homeless or in precarious housing situations, romantic relationships have a pronounced emphasis as partners can provide safety on the streets, extra income and social support.

Mothers face extreme judgements by society. Mothers in the target demographic, in precarious housing or living in homeless shelters did not typically have custody of their children. For those with custody two themes emerged. First, these individuals are typically raising their children without a reliable partner and making personal sacrifices to ensure their child's or children's needs are met. Second, they have fears about the future outlook for their children.

Further, the 35-49 age cohort was described as "the sacrifice generation" (Participant 11). This is due to the fact that women in this age group may simultaneously be responsible for caring for children and aging parents. In some cases, their parents abused them in childhood and providing care for them can be re-traumatizing (Participant 8).

Canadian in the twenty-first century

Participants made references to Canadian and western culture throughout the interviews. In particular, many discussed societal values given to wealth and to charity. These values translate into beliefs held by some Canadians that the "poor" should be grateful for all of the hand-outs they are given. Grateful or not, participants noted that synonymous with a reliance on handouts is a deep sense of lack of control, further contributing to self-injurious behaviour.

“I believe that desperation, not feeling independent enough, because you don't have the financial means, really drives this self-destructive behaviour” (Participant 11).

Differences between refugee and immigrant populations in contrast to Canadian born and raised populations were also discussed. One participant noted that the latter self-injure much more frequently than the former (Participant 11). Another participant expressed that as Canada becomes increasingly diverse, self-injury as a coping mechanism is employed by populations that have not typically self-injured in the past (Participant 12).

Additionally, a “scarcity-mindset” was discussed in reference to Canadian born and raised populations (Participant 11). This mindset was described as frustration due to not being able to access needs and wants within a specific timeframe. Further, it was linked to growing income inequality. Whereas recent immigrants and refugees typically expect hardship upon first arriving in Canada, Canadian born and raised populations feel cheated.

“When [people living in low-income] see that some people have so much and some people have so little, they become really, really angry and almost feel hatred toward those that have more income than they do” (Participant 11).

Unique to the twenty-first century is the increasing use and availability of social media. Coupled with increasing advertisements in the physical environment, it is impossible to avoid media consumption. Many participants related this contextual reality to the increased intensity of messages to women that they are not enough. Comparing oneself to other “peers” via crafted identities on social media or through mainstream media portraying images of “normal” women is “normal” behaviour. For the target demographic, there are large gaps between who they are and their life circumstances with where society is telling them they should be, which contributes to stress and anxiety.

Access, equity & systems of power

Access was an important concept that came up throughout the interviews. It was addressed in relation to access to support, whether that be for basic needs, medical or

mental health support. The inaccessibility created by professionalism and siloed services was also discussed by participants. Participants spoke of long wait times to see psychiatrists, counsellors and psychologists. Their clients were able to receive referrals or access free or sliding-fee scale counselling services, but in contrast to the choices available to higher income individuals, access was described as limited. Further, institutional environments were noted by some as unwelcoming and hostile, thereby compromising accessibility.

Participants also discussed the inadequacy of support given to clients admitted to the hospital for self-injury. Often the physical injuries were treated and individuals were simply discharged with instructions to change their bandages. Holistic, integrated-care and non-judgmental care informed by knowledge of the effects of trauma and systems of oppression was thought to be the best method of addressing self-injury and is discussed in further detail in the next section.

3.1.3. Reduction & Prevention of Self-Injury

I asked frontline professionals to identify what could be done to reduce and prevent incidences of self-injury among the target demographic. Three themes emerged from my analysis of their response. First, increased access to mental health services was regarded as essential. Second, the public and helping professions require greater education and awareness with respect to self-injury. Third, prevention must address the root causes of self-injury such as poverty, systemic discrimination and violence against society's most marginalized individuals.

Accessible, integrated, holistic care

Participants discussed the need for greater accessibility to counselling and alternative mental health support within inclusive spaces. Accessibility would be improved by the provision of greater, free, and low-cost mental health options. Some participants noted a lack of women's residential care facilities for addictions in Calgary, in contrast to the number of men's care facilities. Further, it was noted that the majority of care facilities that treat addictions do not treat co-occurring issues.

Several participants referred to a small window of opportunity. When individuals are ready to access counselling and mental health supports, they need to be available promptly. The longer the wait, the greater the chance that the individual will not follow through.

Education & awareness

Many participants discussed the need for greater education and awareness within the general public, with children, and with service providers. In reference to the increased use of social media, particularly at younger and younger ages, some participants suggested that children need to be taught about stress, self-esteem and healthy coping methods in schools.

Other participants suggested that all helping professionals: doctors, nurses, social workers, police, emergency medical technicians, etc. should receive training on self-injury in addition to suicide awareness. Further, some suggested that these same professionals take appropriate awareness training for working with low-income and ethnically diverse populations. Finally, some suggested that media be regulated as representations of self-harm can trigger more self-harm. Participants felt that any educational or awareness initiatives need to address the stigma associated with self-injury and ill mental health.

Systemic change

For many participants, the key to preventing self-injury lies in reforming systems of power and oppression that contribute to inequity and the multifaceted factors impacting self-injury. Policies that would create systemic change, as noted by participants, include policies that ensure increased access to affordable housing and child care, policies to prevent violence against women and girls, anti-poverty policy, recognition of unpaid emotional labour and care work and ensuring gender pay equity.

“If we had prevention, I would honestly say, in 20 years, we'd have a different world. But these women, I can really see where women would be vulnerable in the range you are talking about, because of their income status, because of the limitation of their choices, because of a long history they have carried with them” (Participant 12).

3.2. Academics and Policy Professionals

In this section, by broad thematic category, I present the results of the thematic analysis of interview data from academics and policy professionals. Contents under each heading answer the research question: What policies would prevent or reduce self-injury among the target demographic? The themes include the need to address structural inequality and systems of power, the need for leadership on health prevention and wellness, greater training for helping professionals and public education on self-injury, the integration of knowledge into practice and finally the distribution and allocation of government funding. Participants also shared knowledge about the current policy landscape.

Dismantling structural inequality

Participants agreed that a multifaceted solution is essential to reduce self-injury. Many made distinctions between reactionary strategies and preventative approaches. Primary prevention was considered to be reforming the systems of power that perpetuate inequity in order to prevent trauma, violence and oppression before they occur. Policies that directly address inequity were considered necessary in the long-run to reduce and prevent self-injury.

“When people in distress are not getting their basic needs met, they begin to have all kinds of mental torment and suffering and they find various ways of expressing that; harming others, harming themselves and harming their environment” (Swann, 18 Dec 2015).

The provision of public, affordable child care and housing, the facilitation of meaningful employment opportunities, skills training and education were all discussed as policies that would reduce inequities contributing to high-rates of self-injury. As were addressing insufficient income via pay equity, forms of guaranteed income and tax and transfer policies.

“There are lots of things that happen in the context of Canada with people growing up with racism, with homophobia, and in the context of patriarchy. All of these intersecting systems of power really do play in an accumulative way in people’s lives and really do cause that kind of long term damage and trauma and those are the places where we can think about making interventions” (Hankivsky, 1 Feb 2016).

Some participants acknowledged that these deeply ingrained systems will not change overnight, and in the interim, secondary prevention responses are essential. These include the recognition and promotion of mental wellness and greater access to mental health support.

Leadership prerequisite

Two themes were present with respect to leadership. For the participants situated in Alberta, a designated provincial leadership structure to oversee mental health care provision and health promotion was judged to be a necessary but missing component of Alberta Health's governance infrastructure. Secondly, participants stated that leadership on health and wellness must have a clear focus on shifting priorities towards interdisciplinary and preventative models of care.

Cathy Gladwin (14 Jan 2016) revealed that initiatives to address self-harm and suicide have been fragmented and uncoordinated across the province and speculates that this has been the case since the Alberta Mental Health Board was absorbed into Alberta Health Services. Dr. Swann (18 Dec 2015) noted that for many years there has been ambiguity regarding the roles and responsibilities of both the Department of Health and Alberta Health Services. In addition to greater clarification he believes that a champion for mental health and addictions should be prioritized. Further, he stated that the government ministries of Health, Education, Human Services, Seniors and Housing as well as Justice and Solicitor General, all of which were involved in the mental health review outlined in Chapter 1, need to work together.

“If we're fundamentally going to improve access to care and the quality of the care, all five ministries have to be engaged in this and move forward because we've seen what has happened to past recommendations. They have largely been ignored because of the momentum that the larger health care system has and how easily it sucks up all of the resources for immediate, emergent, medical, physical priorities” (Swann, 18 Dec 2015).

A significant factor that has likely influenced the lack of leadership is that priorities have not shifted at a population level. Dr. Swann (11 Dec 18) notes that political will to act on these issues is informed by the public and the public has not demanded that a preventative health approach be prioritized.

Training, education & awareness

Participants expressed that educating helping professionals and the public about self-injury and the social determinants of health from an intersectional perspective would have a positive impact. Mental health issues and self-injury are highly stigmatized. As such the implications and consequences of experiencing either are not widely understood or treated in the same manner as issues that have achieved greater publicity and understanding.

“Several years ago, I looked at the statistics and I found that women were, far, far more likely to be the victim of interpersonal violence, than they were to get breast cancer. But where is all the attention?” (Thurston, 11 Jan 2016).

Awareness-raising campaigns aimed at reducing the stigma around mental health by getting people to talk about mental health issues are often “powerful interventions” (Hankivsky, 1 Feb 2016). They not only let people know that they are not alone and that their behaviour may be considered a normal response, given their circumstances, but also when more people come forward there is a greater potential to trigger systemic change (Hankivsky, 1 Feb 2016). Dr. Hankivsky (1 Feb 2016) noted that she had not seen any campaigns of this nature with a specific focus on self-harm.

“And for a cultural change to happen, it needs to be at a population level, so that we can start working on attitudes...until we can openly talk about any injury problem, we’re not going to recognize it and properly solve it” (Gladwin, 14 Jan 2016)

Participants felt that, in general, helping professionals had limited understanding of self-injury, including the influences of social determinants of health. Helping professionals were classified as doctors, nurses, psychologists, social workers, police, etc. Dr. Thurston (11 Jan 2016), noted that while working on primary prevention there is no shortage of work to be done.

“In the meantime, we need more trauma-informed, gender-informed, health professionals, social workers, psychologists, police, to deal with those who are the casualties of our existing policies” (Thurston, 11 Jan 2016).

Dr. Swann suggests that competency requirements with respect to social determinants of health be built directly into professional competency standards in conjunction with new research introduced into the post-secondary curriculums of helping professions (18 Dec 2016). The Centre for Injury prevention at the University of Alberta also recommends training medical professionals to recognize and treat depression and mental illness in patients (Gladwin, 14 Jan 2016).

Integrated practice

I identified three themes from the interview data with respect to health care practice. First, participants consider holistic care environments and interdisciplinary communication to be important in addressing issues like self-injury. Second, early intervention is key and third, “de-professionalized”, community-based care is important.

When an individual enters a hospital for an injury resultant from self-harm, their wound is treated but no one is equipped to deal with the root cause (Thurston, 11 Jan 2016). What is needed, according to Dr. Swann (18 Dec 2016) is a system that is holistic, comprehensive and seamless in which all parts of the system are communicating with one another and converging on common goals centered on meeting the needs of individuals and families.

“It’s all part of the same system and it should be seen as a holistic approach to people’s care - mental health, spiritual and social. All have to be considered if we are serious about improving the well-being of people” (Swann, 18 Dec 2015).

Dr. Hankivsky (1 Feb 2016) pointed to a collaborative example in the violence sector to stress the importance of interdisciplinary collaboration. Police, shelter staff, social workers and hospital staff have been more efficient at addressing violence due to coordinating their interventions and services. Further, the alternative is much more costly (Hankivsky, 1 Feb 2016).

The importance of early intervention with respect to mental health concerns was stressed by some participants. This included understanding and identifying risk factors in individuals and families and linking them to basic needs and mental health support as early as possible (Swann, 18 Dec 2015).

Participants also expressed the importance of community based care, tailored to the needs of specific communities and vulnerable populations. Specific suggestions included the use of gender and cultural lenses to ensure appropriate treatment (Swann, 18 Dec 2016) and collecting comprehensive data to identify at risk groups (Gladwin, 14 Jan 2016), Finally, in recognizing that a significant proportion of the target demographic are likely indigenous, care models need to consider the effects of colonialism and inter-generational trauma (Thurston, 11 Jan 2016; Hankivsky, 1 Feb 2016).

Distribution of funding

Mental health care and health promotion require a greater share of provincial health dollars. According to Dr. Swann (18 Dec 2016), a mere 3% of the Alberta Health budget is allocated to health promotion and prevention services. Without strategies and interventions to ensure individuals have basic needs and mental wellness, the result is increased visits to hospital emergency rooms (Swann, 18 Dec 2016). Shannon Stunden Bower (19 Jan 16) agrees that a greater investment in services is required but notes that the provincial government needs to adjust its taxation policies to ensure the proper funds are collected and redistributed to address inequality.

Contextual considerations

A policy window is open in Alberta and Dr. Swann (18 Dec 2015) is very optimistic that Albertans, “will see some real action over the next years” on the specific recommendations put forth as a result of the mental health review. However, budgetary challenges may impede progress.

“In Alberta, at this time, we have a government that's very uniquely faced with serious financial deficits in the province, so, that's going to be doubly difficult for them, at this time, to start making these choices when the past government hasn't been willing to do it in times of significant excess funds” (Swann, 18 Dec 2015).

Dr. Thurston (11 Jan 2016) believes that both the current provincial and federal governments are more likely to take action on poverty in the coming years as well. Some participants stated that self-injury will persist if poverty is not addressed. Particularly as an adequate income is important to having “a reasonable life in the western world” (Swann, 18 Dec 2016).

3.3. Cross Data Themes

Academics and policy professionals echoed wisdom shared by frontline professionals. A number of themes emerged across data sets, including the importance of access to adequate, appropriate support, the impact of mid-life vulnerabilities and gender differences with respect to child-rearing and self-injury.

Appropriate and adequate access

Access was a concern shared by all research participants in this study, both in terms of affordable and appropriate care. Some Canadians have greater access to mental health support, afforded to them by their income, and along with that comes choice (Thurston, 11 Jan 2016; Hankivsky, 1 Feb 2016). With high income,

“you can afford to shop around and find a feminist, private, psychologist or someone who is recommended by other women to be very helpful, as opposed to ending up with somebody who is ill equipped and may do more harm than good” (Thurston, 11 Jan 2016).

A frontline professional further expressed that help is not necessarily always helpful (Participant 4). As such, the choice and the ability to shop around ensure more appropriate support and provide a sense of agency and control.

Mid-life vulnerabilities

Further emphasis on the experiences of trauma for women in the 35-49 age range were expressed by Dr. Hankivsky (1 Feb 2016) and Dr. Thurston (11 Jan 2016). In addition to a buildup of past trauma, many factors contribute to self-injury.

“We also know that as one goes through different stages of the life course, especially around middle-age, there are different kinds of triggers, which make people more vulnerable to feeling those things again. Whether that's illness in family, whether that's aging parents, whether that's sometimes pressures of children, second guessing life choices in terms of careers and professions, deteriorating relationships, separations, divorces. Sometimes they come to a realization about early abuse experiences only as they become older adults and they just don't have the tools to deal with that, and that's how it gets expressed” (Hankivsky, 1 Feb 2016).

Gender and children

Finally, across data sets a theme regarding the presence of children with respect to gender differences between men and women emerged. The idea that women might self-injure, or continue to self-injure instead of commit suicide, out of fear that her kids will not be taken care of in her absence was discussed by some participants. These participants acknowledged that men are not affected in the same way by the presence of children.

Themes from the interview data have illuminated major implications for policy solutions to address the issue of high rates of self-injury among the target demographic. I detail these implications in the next chapter.

Chapter 4. Policy Discussion

As evidenced by the background and thematic analyses, due to multifaceted conditions and stressors coupled with inadequate government policy, self-injury rates associated with the target demographic are too high. The right policy solutions, however, can reduce these rates. In this chapter, I summarize implications drawn from the background and thematic analyses to inform policy action, present considerations for addressing social determinants of health and state prerequisites for the successful implementation of any mental health policy with aims to reduce and prevent self-injury among the target demographic.

4.1. Conclusions for Policy Responses

A number of important implications for the development of policy options arose from the literature and thematic analyses. First, to properly address reduction and prevention, solutions must be developed in recognition that self-injury is a manifestation of deeper issues, rather than the problem in and of itself.

Second, to be effective in the long term, policies must address various levels of prevention. Primary prevention constitutes reforming systems of power and oppression that result in inequitable life experiences such as violence, poverty and discrimination. Secondary prevention includes improving access to basic needs and mental health supports before an individual turns to self-injury as a coping mechanism and tertiary prevention involves increasing access to treatment and resources after self-injurious behaviour has commenced.

Third, increased access to mental health services is key to reducing and preventing further self-injury among the target demographic. Increased access entails the provision of free, or affordable, timely support, delivered in safe environments by

support persons or professionals that practice in non-judgmental and trauma-informed manners. Reducing stigma associated with self-injury and ill mental health also contributes to improved access.

Finally, the target demographic is not a homogenous group. When compared to other demographics, in addition to facing inequities as a group they also experience inequities within the group. Each individual has a unique combination of factors contributing to her self-injurious behaviour. For example, some members of the target demographic are experiencing homelessness, some are in precarious housing and some are in more stable housing. Each situation may impact the effectiveness of a policy solution.

Given these conclusions, in order to successfully and sustainably prevent self-injury, systems of power that create and perpetuate inequity must be reformed. We need to create a more egalitarian society that recognizes and celebrates difference. Then and only then, might we successfully prevent self-injury among specific demographics. However, until the systemic issues referred to are addressed, improved prevention and treatment measures are needed.

I now discuss policy under two categories. First, I address a slate of policy options to address social determinants of health. Second, I outline governance requirements for successful mental health policy implementation. In the proceeding chapter, I detail three policy options as contenders to increase access to mental health services for the target demographic.

4.2. Social Determinants Policy

In recognition that many social factors impact ill health outcomes, it is imperative that policy action be taken to address these factors. Addressing social determinants impacting self-injury will meaningfully reduce and prevent some self-injury, regardless if other policy action is taken. The following sections each outline important policy considerations that were put forth by interview participants.

4.2.1. Increasing income

As established, income is a significant social determinant of health. Low-income conditions increase the likelihood that an individual will engage in self-injurious behaviour. Some frontline professionals expressed that individuals may not be ready or able to deal with mental health issues until their basic needs are met and as such addressing poverty is tantamount. To adequately address self-injury among the target demographic, a poverty reduction strategy aimed at increasing income for those living in poverty is essential. Policy action could include increasing AISH, social assistance rates and minimum wages or implementing a universal guaranteed annual income. Further, a poverty reduction strategy should include policy tools to enforce pay equity legislation and measures to increase access to affordable housing and child care options.

4.2.2. Measure competency requirements

Greater knowledge of the social factors contributing to health inequities will influence the practice of helping professionals in ways that will positively benefit the target demographic. Dr. Swann (18 Dec 2015) suggested that professional associations measure competency with respect to the social determinants of health. The GOA regulates health professions under the Health Professions Act and could work with professional associations to implement mandatory educational and competency requirements for these professions.

4.2.3. Public awareness

Due to deficiencies in public knowledge regarding what self-injury is, what motivates it and what the consequences are, stigma is another social factor impacting self-injury. A province-wide awareness campaign to increase public knowledge of self-injury would be highly beneficial. Further, as cautioned by Rossiter & Morrow (2011) anti-stigma campaigns should avoid tokenizing individuals by relaying how stigma is informed by multiple, intersecting social locations (p.318). Further, Jarvi, Jackson, Swenson & Crawford (2013) state that carefully designed awareness initiatives have the potential to combat the misrepresentation of self-injury as “an effective coping strategy”, thus decreasing the potential for social contagion (p.16). Dr. Hankivsy (1 Feb 2016)

notes that public awareness campaigns should seek to let individuals know that they are not alone and that their behaviour is not shameful. Awareness initiatives have the potential to increase the number of individuals demanding structural change (Hankivsky, 1 Feb 2016).

4.3. Governance Prerequisites

A number of important governance suggestions were put forth by interview participants that should be implemented prior to any of the policy contenders presented in the proceeding chapter. I summarize these suggestions below.

4.3.1. Wellness institution

The need for clearly defined provincial leadership on mental wellness and preventative health practice was discussed in Chapter 3. The GOA has committed to creating a leadership team to implement the recommendations from the mental health review (GOA, 2016c). However, a permanent leadership structure is necessary.

The Centre for Injury Prevention and an Albertan coalition of organizations, institutions and governing bodies support the creation of a “Wellness Foundation”, a provincial institution to oversee primary prevention of disease and injury (Gladwin, 14 Jan 2016; Wellness Alberta, 2015). The foundation would invest in a range of activities to promote health equity as informed by evidence and the social determinants of health (Wellness Alberta, 2015). This model would ensure sustainable funding and investment in wellness.

4.3.2. Transdisciplinary advisory committee

In recognition of the importance of addressing the social determinants of health, a transdisciplinary advisory committee should be created to make recommendations to a wellness foundation on policies and programs to reduce health inequities. Disciplines on the committee should include a range of helping professionals such as doctors, nurses, social workers, psychologists and police and include representatives from each of

Alberta's regional health authorities. Further, it would be extremely beneficial for the committee to have a diverse mix of social identities such as gender, ethnicity, age and ability, to reflect the diversity of Alberta as much as possible. The committee should also include and consult individuals with lived experience of the issues they are undertaking. Representation from diverse individuals and diverse disciplines would ensure a more holistic lens is applied to the problem solving of health issues. More, the committee should be trained in IBPA. Utilizing this method of analysis would help ensure that the target demographic and other at-risk populations are supported by an appropriate governance structure.

Chapter 5. Policy Alternatives

Universal access to a range of mental health and wellness supports would effectively reduce self-injury among the target demographic. Universal access to mental health care would also disrupt current systems of power by allowing mental health issues to be viewed as more “normal” ills. However, due to Canadian federalism and current political and resource restrictions, the plausibility of provincial uptake for this option, at this time, is limited. Alternatively, in this chapter, I present three options that provide different methods of increasing access to mental health services in order to prevent and reduce self-injury among the target demographic. Each option may be viewed as an incremental step on the path toward universal access. These options are titled (1) Wellness Benefits, (2) Primary Care Plus and (3) Community Outreach.

5.1. Wellness Benefits

This policy option expands upon existing health benefits available to low-income Albertans to include coverage for counselling. Income assistance recipients, AISH recipients and low-income adults and families receiving the Alberta Adult Health Benefit (AAHB) plan have access to extended health benefits administered via a “Health Benefits Card” (HBC) (GOA, 2015c). The HBC entitles beneficiaries to insurance coverage for a number of services that are not available to all Albertans via the standard Alberta Health Insurance Plan, including:

- Basic dental services such as extractions and fillings, annual examinations and teeth cleaning;
- One eye exam and glasses every 2 years for adults/each year for dependents under 18;
- A range of prescription drugs, prenatal vitamins and children’s vitamins;

- Ambulance trips; and
- Diabetic supplies (GOA, 2016a).

AISH recipients are additionally covered for approved items to support daily living, such as hearing aids and wheelchairs (GOA, 2014; 2016c).

The stated intent of these health benefits are to ensure low-income Albertans have access to essential services and supplies for good health and well-being (GOA, 2015b). Mental wellness is essential to good health and well-being. As such, renaming the HBC a “Wellness Benefit Card” (WBC) and expanding coverage to include substantial counselling services would significantly increase access to mental health services for the target demographic. A WCB would entitle beneficiaries to full coverage, up to a maximum of 26, fifty-minute counselling sessions, with a RSW or psychologist each year. This quantity permits access to on-going, bi-weekly sessions, as required, or periods of more intensive therapy. Like the other health benefits covered by the HBC, the government would be billed directly.

Currently, there are conditional and income eligibility requirements to access the HBC or the AAHB which could remain the same or be adjusted as needed. Many members of the target demographic already receive AISH or income assistance and thus already have HBC benefits. Others may qualify for the AAHB, and thus the HBC, by income level and the presence of one or more of the following conditions: pregnancy, high or ongoing prescription drug needs and/or transitioning off income supports due to income from other sources (GOA, 2015b). Income eligibility is determined using Table 2.

Table 2: Qualifying Income for AAHB.

Family Type	Maximum Qualifying Income (effective July 2, 2015)
Single	\$16,580
Single parent with 1 child	\$26,023
Single parent with 2 children	\$31,010
Single parent with 3 children	\$36,325
Couple with no children	\$23,212
Couple with 1 child	\$31,237
Couple with 2 children	\$36,634
Couple with 3 children	\$41,594
Couple with 4 children*	\$46,932
*For each additional child add \$4,973	

Source: GOA, 2015b

Further, AAHB beneficiaries must not be receiving health benefits from other government programs and eligibility is reassessed annually (GOA, 2015b). Individuals that transition into higher incomes are rendered ineligible to receive the benefit.

5.2. Primary Care Plus

Alberta Health provides citizens universal access to primary health care with no direct costs to users. Although access issues in rural locations remain, the majority of the target demographic have access to a primary care physician through a walk-in clinic or in the form of a family doctor. Successful interventions have demonstrated the potential in capitalizing on this important point of contact.

Primary Care Plus consists of integrating mental health screening and treatment directly into primary care. Physicians would be trained to respond to patient disclosures of mental health concerns and to identify red flags for mental health concerns exhibited by patients. These red flags would include signs and symptoms of violence, trauma or self-injury and experiences of poverty. Physicians would then complete a short series of pre-determined screening questions to identify appropriate follow up for these patients. Physicians would also have the resources to “prescribe” appropriate referrals for mental

health supports such as counselling. For the greatest success, mental health practitioners such as social workers and psychologists would operate collaboratively with primary care physicians, ideally out of the same location and the utilization of their services would be billed directly to Alberta Health.

There are a number of examples where similar integrative care models have been successful. The Henry Ford Health Care system in Detroit made significant strides in reducing the number of suicides among individuals under its insurance plan (Silberner, 2015). As part of a greater suicide prevention strategy, screening questions were designed and administered with every patient accessing their services, regardless of the reason for the appointment (Silberner, 2015). The questions assessed how often patients had felt “down” in recent weeks as well as how often they had felt little pleasure in doing things they typically enjoy (Silberner, 2015). Physicians responded to the assessment results by prescribing therapy, group counseling and/or drugs (Silberner, 2015). Further, administrative assistants were trained to ensure that all patients requiring follow-up care scheduled their next appointments (Silberner, 2015).

Further, as reported by the Calgary Domestic Violence Collective (CDVC, 2013) primary care screening has led to successful recognition and treatment of domestic violence. In Calgary, hospital emergency departments and urgent care centres screen all patients over the age of 12 with questions pertaining to experiences of violence and follow up with appropriate care and referrals (CDVC, 2013). The CDVC (2013) states that promising practices associated with screening in primary care include utilizing a standardized and research-informed screening tool, ensuring proper training for all staff and building collaborative relationships with inter-disciplinary staff within the organization and in the surrounding community (CDVC, 2013).

A set of screening questions on mental well-being could indicate a myriad of issues underneath the surface, such as issues contributing to self-injurious behaviour. Implementing this integrative care model first and foremost at family medical practices, walk-in clinics, urgent care clinics and emergency departments within Alberta’s least affluent neighbourhoods would help ensure that individuals within the target demographic have greater access to mental health care services.

5.3. Community Outreach

As I stated in Chapter 3, barriers to accessibility for the target demographic are greater than income limitations and waiting lists. The environment in professional care settings and power dynamics in professional relationships make many members of the target demographic feel judged, unsafe and uncomfortable. Therefore, this option consists of creating multidisciplinary community health and wellness teams, coupled with funding for social service agencies and medical centres to house and work collaboratively with these teams one or more days per week. The goal of Community Outreach is to bring mental health services directly to the target demographic and other populations with high mental health needs as a method of increasing access.

Multidisciplinary teams would consist of publicly funded social workers, psychologists, psychiatrists and peer support workers provided by the agency or medical centre. The teams would provide crisis services, counselling services and peer support, including referrals to other services for a range of basic needs and health supports, as needed.

Funding would be provided to partnering community based social service organizations and medical centres in areas without appropriate social services. The funding would cover space for the outreach team to meet with service users, staff time for coordination, peer support staff hours and training to ensure the teams are operating within the philosophies and mandates of their partnering organizations. Depending on the mandate of the social service agency the team would flexibly provide services either on a drop-in basis or by appointments facilitated by the agency. Depending on the needs within a specific community or health region, the teams could also provide services directly in individual's homes or community centres. These teams would require region specific training to account for unique community and cultural needs.

Peer support workers are an essential part of the multidisciplinary team. As discussed in the interviews with frontline professionals, de-professionalized and non-judgmental services are important in accessible care environments. Browne et al. (2011) report that integrated care environments can actively disrupt health inequities by the ways in which they operate and provide services. For example, a primary care centre in

Vancouver offers women-only hours as a safe space for women to connect with other women, eat lunch and meet with physicians, nurses and/or elders (Browne et al., p.299). The centre serves a large population of indigenous women, and based on the needs of this community they employ trauma-informed, harm-reduction, non-judgmental and colonial-informed practice (Browne et al., 2011, p.306). Further, Browne et al., (2011) note that the centre further creates an accessible care environment via the inclusion of activities seemingly unrelated to care, such as crafting, music therapy and shoulder massages (p. 307).

Given information on what would improve access for the target demographic, funding for social service agencies and medical centres to house the community outreach teams would be tied to a list of specifications. The institutions meeting the most criteria in a given community would have priority over the funding and partnerships with the outreach teams. Based on the literature and interviews with frontline professionals, academics and policy professionals, the list of criteria is as follows:

- Serves at least one of Alberta's least affluent neighbourhoods/ serves low-income individuals/families
- Located near accessible transit services
- Provision of bus tickets for individuals accessing services
- Gender-informed practice
- Women's only hours
- Child minding while parents are accessing services
- Non-judgmental practice
- Trauma-informed practice
- Harm-reduction approach
- Drop-in hours
- Provision of community building activities (activities seemingly un-related to care)

- Provision of peer support and/or crisis support
- Provision of basic needs referrals and/or supplies

Overall, Community Outreach would provide greater access to mental health services and supports for the target demographic. In the next chapter I outline the criteria and measures I utilized to analyze each of the options presented in this chapter.

Chapter 6. Evaluation Framework

In this chapter, I present overarching policy objectives as well as detailed criteria and measures which frame the analysis for the policy options discussed in the previous chapter. The framework is informed by the literature, interview data and IBPA.

6.1. Objectives, Criteria & Measures

The overarching purpose of this study is to recommend policy that will effectively reduce and prevent self-injury among the target demographic. Further, as informed by IBPA, the recommended policy must seek social justice by advancing equity. Finally, cost, administrative ease, stakeholder acceptance and also, additional benefits are measured in order to evaluate the plausibility of each option being implemented in Alberta.

6.1.1. Effectiveness

Two criteria are measured to analyze the estimated effectiveness of each option: reduction and prevention. To estimate the capacity of a policy measure to *reduce* self-injury, each option is assessed by its expected ability, based on comparable research and data, to reduce the hospitalization rate of self-injury among the target demographic. Although hospitalizations represent a fraction of overall self-injury, they provide measurable data which also acts as an indicator of the overall self-injury rate.

To assess each policy's capacity to *prevent* self-injury among future cohorts of the target demographic the level of prevention (primary, secondary or tertiary) is evaluated. For the purposes of this measure, policies considered to address primary prevention increase access to mental health services and include provisions to reform traditional mental health service systems that contribute to inequity. Policy options

addressing secondary prevention provide greater access to mental health supports before self-injury occurs and policies addressing tertiary prevention measures consist of intervention to prevent further self-injury after the behaviour has commenced. Primary prevention is considered to be the most effective form of prevention, followed by secondary and tertiary.

6.1.2. Equity

Each policy option is analyzed with respect to two equally important elements of equity labeled “between” and “within”. First, the degree to which the policy option increases equity for members of the target demographic, as compared to other Albertans, is analyzed based on how well the policy option increases their access to mental health services, relative to wealthier Albertans. Currently, mid and high-income Albertans have greater choice and access to a range of mental health supports due to greater insurance coverage and higher levels of disposable income.

Given that the target demographic is not a homogenous group, equity is additionally assessed by the proportion of the target demographic that stand to benefit from the policy option. Policies are measured by the degree to which they deliver benefits to all members target demographic based on other more nuanced identities such as urban/rural locality, income assistance recipient/working poor, housed/in precarious housing or experiencing homelessness, etc.

6.1.3. Cost

As program costs are often significant barriers to policy implementation, annual costs associated with a policy option are given careful consideration and assessed with respect to perceived government acceptability. However, increasing access to mental health services can also be viewed as an investment that will lead to cost savings in other areas, such as decreased hospitalizations for self-injury and other ills. Thus, estimated returns on investment are considered as they impact the degree of government acceptability. Costs are assessed by what percentage increase would

contribute to the Alberta Health Budget. The budget is currently set at 19.7 billion dollars for 2015-2016 (GOA, 2016b, para 1).

6.1.4. Administrative Ease

The degree of administrative ease associated with each policy option is gauged as a complementary consideration to government cost. Administrative functions contribute to overall costs of each policy option as well as impact the on-going ability of the government to provide the services required by each option. Policies are compared against each other based on the level of administrative capacity required to ensure on-going government administration. Considerations are given to the amount of staff required as well as the number of different departments involved. The lesser the impact, the greater the administrative ease.

6.1.5. Stakeholder Acceptance

Policy changes inevitably impact different demographics and stakeholders in different ways. Each policy option is measured by the degree to which groups impacted by the policy are expected to support the policy. Stakeholders groups considered are (1) members of the target demographic, (2) social service agencies and frontline professionals and (3) health infrastructure professionals affected the policy.

6.1.6. Additional Benefits

While the policy options are primarily assessed by their ability to reduce and prevent self-injury among the target demographic, each option provides a range of additional benefits. These might include benefits to the target demographic such as increased support in other areas of their lives. Further, each policy option provides benefits to other populations in need beyond the target demographic. As additional benefits impact the plausibility of implementation, each policy option is comparatively assessed by its associated additional benefits.

6.2. Evaluative Framework Summary

Table 3 includes a summary of each criteria, specification as to how it will be measured and explanation regarding how policies will be ranked according to each measure in order to compare and contrast the policy options.

Table 3: Evaluative Criteria, Measures and Ranking.

	Criteria	Measures	Ranking
Effectiveness	The policy option reduces self-injury among the target demographic (TD)	To what degree will the policy option reduce hospitalizations for self-injury?	High (5-6) = comparable research/data indicate the policy option will reduce self-injury hospitalizations greater than the other options Medium (3-4) = comparable research/data indicate the policy option will reduce hospitalizations for self-injury, but the impact is less certain Low (1-2) = comparable data/research is unavailable or suggests the impact will be limited
	The policy option prevents self-injury among future cohorts of the TD	What level of prevention is addressed by this option?	High (5-6) = Primary prevention addressed Medium (3-4) = Secondary prevention addressed Low (1-2) = Tertiary prevention addressed
Equity	The policy option ensures greater equity between the TD and all other Albertans	To what degree does the policy option increase the TD's access to mental health supports relative to wealthier Albertans?	High (5-6) = TD's access to mental health supports is similar wealthier Albertans access Medium (3-4) = TD's access to mental health supports is greater than status quo Low (1-2) = TD's access to mental health supports does not change as a result of the policy option
	The policy option benefits members of the TD equitably	What proportion of TD benefit from the policy option?	High (5-6) = The majority of the TD benefits from the policy option Medium (3-4) = The policy option improves benefit equity within the TD as compared to the status quo Low (1-2) = The policy does not increase benefit equity within the TD
Cost	Government acceptability of on-going costs associated with the policy option	To what degree would the policy option increase the health budget?	High (5-6) = Less than 2% Alberta Health budget increase. Medium (3-4) = Between 2%-4% Alberta Health budget increase. Low (1-2) = Between 4%-6% Alberta health budget increase.

	Criteria	Measures	Ranking
Administrative Ease	Administrative ease associated with on-going operation of the policy option	How do the policies compare with respect to administrative ease?	High (3) = Policy option with the greatest level of administrative ease Medium (2) = Policy option with neither the greatest, nor the least administrative ease Low (1) = Policy option with the least administrative ease
Stakeholder Acceptance	Stakeholder acceptance of the policy options	What proportion of identified stakeholders support the policy option?	High (5-6) = All stakeholders support the policy option. Medium (3-4) = The majority of stakeholders support the policy option Low (1-2) = Less than half of stakeholders support the policy option.
Additional Benefits	Additional benefits are provided by the policy option	How do the policies compare based on the degree to which they provide additional benefits to the target demographic and other populations in need?	High (3) = Policy option with the greatest additional benefits Medium (2) = Policy option with neither the greatest, nor the least additional benefits Low (1) = Policy option with the least additional benefits

Ranking and Weighting Considerations

For each criterion, each policy is awarded a high, medium or low score associated with a numerical value for the purposes of quantifying the results. A high score receives 4 or 5 points, a medium score is given 3 or 4 points and low scores are given 1 or 2 points. A 6 point scale is used as opposed to a 3 point scale in order to reflect a more detailed level of nuance between the options and more accurately scale the differences.

As a weighting consideration, the administrative ease and additional benefits criteria are ranked on a different scale. Each option is ranked against the other options and receives a score of 1, 2 or 3. Administrative ease is given less weight than the other criteria because it is considered complimentary to cost. In the same vein, the additional benefits criterion is given less weight as these benefits are supplementary to the intended purpose of the policy options. All other measures are given full and equal weight. This includes each measure associated with effectiveness and equity, to reflect

their importance. Points are totaled for each option and the policy with the highest score is recommended for implementation.

Chapter 7. Evaluation of Policy Options

Employing the evaluative framework outlined in the previous chapter, in this chapter, I presents an analysis of each of policy option detailed in chapter 5: (1) Wellness Benefits; (2) Primary Care Plus; and (3) Community Outreach.

7.1. Wellness Benefits

7.1.1. Effectiveness: Reduction

American studies have linked greater mental health access via insurance coverage to reductions in poor mental health and suicide rates (Sipe et al., 2015). Canadian researchers, however, report significant socioeconomic differences in utilization rates of fully covered mental health services, such as those provided by psychiatrists and family physicians (Steele, Glazier & Lin, 2006). As a remedy, they suggest strategies that specifically target low-income groups (Steele et al., 2006).

The provision of Wellness Benefits to low-income Albertans is a targeted approach that substantially increases coverage for counselling. It is fair to estimate that the provision of these benefits will contribute to a decrease in hospitalizations for self-injury among low-income individuals. However, the exact degree of reduction to be expected is unclear. Removing financial barriers does not address other access issues, such as the appropriateness of support or wait times for accessible RSWs and psychologists. This suggests the approach, targeted at low-income Albertans receiving health benefits, is not targeted enough. However, providing the benefit through insurance coverage does allow for individuals to choose by whom they are accessing services. The expected uptake of the benefit is also unclear. Its availability does not guarantee utilization. Based on this information, and due to greater evidence for

hospitalization reductions by the other two options, this option receives a medium rank and score of 3.

7.1.2. Effectiveness: Prevention

For prevention, Wellness Benefits also receives a medium rank and score of 3, as this option includes secondary prevention measures. Benefit recipients, including future cohorts of the target demographic may be able utilize on-going counselling as a coping mechanism alternative to self-injury. Enabling beneficiaries to choose their mental health service providers, rather than assigning them based on services available to low-income people is an important consideration in reforming power structures that contribute to inequity. However, overall the policy does not alter the traditional service delivery model of mental health services in any way. Further, the provision of the benefit is tied to the HBC and low-income eligibility requirements. As such, the stigmas associated with mental health issues and poverty may be reinforced.

7.1.3. Equity: Between

Providing coverage for counselling to low-income Albertans would ensure greater equity between members of the target demographic and wealthier Albertans by increasing the former's access to mental health services. Many mid and high-income Albertans have private or workplace supplemental health insurance plans. These plans typically provide coverage for the same services as are covered by the HBC and often include full or partial coverage for therapy delivered by psychologists and RSWs. For example, employees of the GOA may claim 80% of the costs of counselling up to \$1,000 per year (GOA, 2015a). Federal public service employees are entitled to same benefits but have a greater maximum claim amount of \$2,000 per year (Sun Life Financial, 2014). Further, many mid and high-income Albertans have the income to purchase additional counselling services. Overall, this option provides mental health care coverage to the target demographic that is similar to the access enjoyed by wealthier Albertans. However, a final consideration is that other Albertans are better able to pay for transportation to and from counselling and child care as needed, as well as take time

off work to attend appointments. Overall, this option receives a high rank for this measure of equity and a score of 5.

7.1.4. Equity: Within

While this option does significantly increase access to counselling for low-income Albertans, some members of the target demographic are ineligible for the benefit. Living Wage Canada (2013) states that a living wage in Alberta, ranges from \$13.11 to \$18.15 per hour, based on a full-year, 35 hour work week. An individual must earn this wage rate or higher in order to meet their basic needs and have time to devote to family and community, save for retirement and live in a dignified manner (Vibrant Communities Calgary, 2016). Individuals earning less than a living wage are considered to be living in poverty. The current provincial minimum wage in Alberta is \$11.20. Therefore, minimum wage earning members of the target demographic are living in poverty. Yet, according to the income eligibility levels for the AAHB (Table 2), single, full time minimum wage earners' incomes are too high to qualify for the HBC. Further, according to the conditional eligibility requirements for the AAHB, some members of the target demographic would not qualify for the benefit regardless of meeting income eligibility requirements.

Moreover, some members of the target demographic may not want to seek traditional counselling supports, or receive counselling from a psychologist or RSW. Further, some members of the target demographic may not be able to access supports due to rural locality. Urban centres have much higher concentrations of RSWs and psychologists, as well as a greater range of professionals that are culturally competent and/or practice in non-judgmental, gender and trauma-informed manners.

A final consideration is that the HBC is not available to individuals covered by other health care plans. Therefore, status First Nations, Inuit and Metis members of the target demographic would be excluded from this benefit. These individuals do have access to short-term crisis counselling, up to a maximum of 15, one-hour sessions per mental health crisis, over a 20 week period (Health Canada, 2015). However, this program is inequitable to the Wellness Benefits option. For this measure of equity, this

policy receives a low rank and a score of 1 as it does not increase benefit equity to a greater proportion of the target demographic.

7.1.5. Cost

The Psychologists Association of Alberta (PAA, 2016) recommends that psychologists charge \$190 per standard 50 minute counselling session with an individual. In 2013, there were 59,356 income assistance and AISH recipients in Alberta (The Caledon Institute of Social Policy, 2015, p.34). Although there is variability in the cost of counselling and AAHB benefit recipients are not captured by the number of benefit recipients, these numbers can be used to estimate program costs. By assuming full uptake of the benefit (26 sessions per year), at a cost of \$190 per session by 60,000 individuals, the annual cost would be approximately 296 million. This would entail an Alberta Health budget increase of 1.5%. However, due to the other barriers discussed with regard to equity and effectiveness, full uptake would not be expected.

Due to the current economic crisis due to a drop in oil prices, the number of income assistance recipients is likely higher than 2013 levels. However, estimating the cost using the greatest number of income assistance and AISH recipients in available data since 1997, only results in a budget increase of 2.1%. Further, increased access to counselling will result in decreased hospitalizations and emergency department visits, resulting in savings. In conclusion, government acceptability of costs associated with this option is ranked as high and receives a score of 5.

7.1.6. Administrative Ease

Government administrative staff and mechanisms are currently in place to assess eligibility for the HBC. Thus, this option is administratively simple. Initial communications with stakeholders and coordination of providing payments to therapists and counsellors would need to occur. As well, increased staff time to process payments to social workers and psychologists would be required. However, overall, in comparison to the other two options this option requires the least administrative change and ongoing capacity. Thus, it receives a high rank and score of 3 for administrative ease.

7.1.7. Stakeholder Acceptance

Psychologists and social workers are likely to be supportive of this policy option as it will increase demand for their services. Frontline service providers however may only partially support it. While they would applaud increased access to counselling they may be concerned that many individuals and members of the target demographic are still falling through the cracks. Members of the target demographic may share these concerns and might feel like the benefits are meaningless while they address more pressing needs such as securing permanent housing and higher income. Thus, though there would be some support, this option receives a low rank and a score of 2 for stakeholder acceptance.

7.1.8. Additional Benefits

Beyond the target demographic, all income assistance, AISH and AAHB recipients would also benefit from the provision of Wellness Benefits. Further, the counselling provided is not targeted at self-injury, therefore a range of additional benefits for all recipients that utilize these counselling services could be accrued. For example, some benefit recipients may utilize counselling to treat depression and anxiety or to obtain support to process traumatic events such as sexual assault or domestic violence. Compared to the other two options, however, Wellness Benefits provides the least additional benefits. Thus, for this criteria it receives a low rank and score of 1.

7.1.9. Evaluation Summary

Table 4: Wellness Benefits Evaluation Summary.

Effectiveness		Equity		Cost	Administrative Ease	Stakeholder Acceptance	Additional Benefits	Total
<i>Reduction</i>	<i>Prevention</i>	<i>Between</i>	<i>Within</i>					
3	3	5	1	5	3	2	1	22

7.2. Primary Care Plus

7.2.1. Effectiveness: Reduction

Despite successful screening and treatment examples from the United States and in the violence sector, The Canadian Task Force on Preventative Health Care (2013) states that evidence on the benefits of screening for mental health concerns in primary care settings is inconclusive. Thombs et al. (2012), state that there is significant potential for individuals to be incorrectly screened and/or treated for symptoms that would clear up without intervention. Further, screening for depression did not alter the outcome between test and control groups when the availability of treatment for both groups was the same (Thombs et al., 2012). Despite inconclusive evidence on the screening method, the policy does improve access to mental health treatment overall, which is effective at reducing mental health issues and hospitalizations.

For the target demographic, this option increases the likelihood that they will access mental health support. Primary care physicians may intervene before significant injuries occur and support an individual to access mental health services in a more timely fashion, thus decreasing hospitalizations for self-injury. This option receives a medium rank and a score of 4. Primary care plus will reduce hospitalizations and its expected effectiveness is more certain than the Wellness Benefits option.

7.2.2. Effectiveness: Prevention

From a preventative standpoint this option qualifies as secondary prevention. For many individuals it will serve as tertiary prevention but others may receive mental health support before an issue has manifested into something more serious such as self-injury. In the long run, the provision of greater mental health services integrated into primary care settings will help decrease the stigma associated with ill mental health. Overall, this option receives a medium rank and score of 4.

7.2.3. Equity: Between

While this option ensures that the target demographic has increased access to mental health support in comparison to the status quo, wealthier Albertans still have greater access to a range of services and greater ability to cover transportation costs, child care and time off work as needed. Further, unlike the Wellness Benefits option, members of the target demographic are unable to choose the mental health service providers they access as they are referred to RSWs and psychologists working in partnership with the primary care physician. This policy option is assigned a medium rank and a score of 3.

7.2.4. Equity: Within

Many of the same concerns regarding the proportion of the target demographic that benefit equitably from Primary Care Plus discussed under the Wellness Benefits option are relevant here. Prior experiences with health care professionals that have been dismissive or judgmental could lead members of the target demographic to avoid primary care professionals or not follow through on “prescribed” mental health treatment. Rural locality could limit access to both physicians and mental health professionals. However, in contrast to the Wellness Benefits option, low-income is not an eligibility requirement to access this benefit and status indigenous peoples covered by federal health plans would also be able to benefit from this option. This policy option receives a medium rank and a score of 2 for this measure of equity.

7.2.5. Cost

The United Kingdom has implemented a program with many similarities to Primary Care Plus and spent \$760 million Canadian total in the first seven years of the project (Anderssen, 2015). Costs included opening new centres, training psychologists and providing therapy to hundreds of thousands of citizens (Anderssen, 2015). Assuming similar costing, Primary Care Plus would cost approximately 100 million per year in Alberta, an increase to the health budget of 0.5%. Therefore, this option receives a high rank for cost and a score of 6. Further, this option, like the others, will result in a

reduction of costs in other areas such as hospitalizations and emergency department visits.

7.2.6. Administrative Ease

Administrative work associated with this option would be complex as primary care clinics and urgent care centers would need training and resources to aid in the successful roll-out of this option. Further, the development of research based screening questions and research on the most appropriate treatment methods would be required, coupled with on-going evaluation. Further, a communications strategy to inform the general public is another necessary administrative requirements of this option. Overall, however, Primary Care Plus receives a medium rank and score of 2 for administrative ease as it is less complex than the administrative work required for the Community Outreach option.

7.2.7. Stakeholder Acceptance

Among the target demographic this option would receive some support as many would appreciate greater access to mental health care assessment and support but others may not support the provision of care in a medical or clinical setting. Frontline professionals would support the integrative care aspects of this option as well as increased access to mental health supports for their clients and increased demand for their services. Primary care physician support, however, would be divided. Some physicians would support the option as they understand the importance of an integrative approach to overall health, but others would be opposed to the option as screening requires additional time. Overall, this option receives a medium rank and score of 3 for stakeholder acceptance.

7.2.8. Additional Benefits

Primary Care Plus would ensure that populations other than the target demographic have greater access to mental health services and supports. Like Wellness Benefits, the provision of mental health supports within Primary Care Plus would not be

limited to addressing self-injury. The mental health supports provided would address a range of different issues, potentially reducing hospitalizations for other concerns, such as mental health crises. However, Primary Care Plus does not provide the same degree of additional benefits as are provided by Community Outreach. As such, for this criteria, it receives a medium rank and score of 2.

7.2.9. Evaluation Summary

Table 5: Primary Care Plus Evaluation Summary.

Effectiveness		Equity		Cost	Administrative Ease	Stakeholder Acceptance	Additional Benefits	Total
<i>Reduction</i>	<i>Prevention</i>	<i>Between</i>	<i>Within</i>					
4	4	3	2	6	2	3	2	26

7.3. Community Outreach

7.3.1. Effectiveness: Reduction

Community Outreach mirrors many aspects of Ontario’s Assertive Community Treatment Program which has resulted in an 82% decline in hospitalizations, for various reasons, among program participants over the span of four years (Mental Health Commission of Canada, 2013; Ontario Act Association, 2016). Community Outreach provides access to a range of accessible services to the target demographic, more expansive than traditional counselling. The impact this option will have on reducing self-injury hospitalizations is expected to be significant. Further, this option addresses many of the specific needs of the target demographic thereby increasing its ability to be effective at reducing self-injury. Community Outreach receives a high rank for reduction and a score of 6.

7.3.2. Effectiveness: Prevention

By removing some of the power structures that decrease access to care such as referral requirements, entry through medical clinic settings (for some) and by providing on-going care as needed, this option has elements of primary prevention. The list of

requirements for partnering social service agencies was designed to specifically support safe spaces that address other aspects that prevent members of the target demographic from accessing support. However, overall, this option still has many elements of secondary prevention and tertiary prevention as the provision of services and mental health support are available after an individual has accessed a social service agency or medical centre. As such, it receives a high rank and score of 5 for preventative effectiveness.

7.3.3. Equity: Between

Community Outreach services are delivered within social service agencies, medical centres and people's homes which dramatically improves equity between the target demographic and wealthier Albertans. In general, higher income demographics have access to a range of options for mental health care support and greater time to connect with their families and communities. This option includes specific measures to increase access and service provision for the target demographic and other vulnerable populations by earmarking funding for care directly to social service agencies that serve the target demographic and attend to their specific access and care needs.

While this option substantially increases access to care, it still might not be on par with the care choices other Albertans have. Members of the target demographic receiving care through Community Outreach teams may not get to choose a specific counsellor. However, this model does provide them with access to these services through social service agencies they have already established relationships with. Overall, Community Outreach receives a high rank for this measure of equity and a score of 5.

7.3.4. Equity: Within

Unlike the previous options, Community Outreach is designed to meet specific access needs of the target demographic. Although social service agencies determine whom is eligible for their services, the list of criteria for funding will ensure that agencies serving the target demographic will receive priority for funds. Further, the flexibility of the

team enables them to deliver services in individual's homes or community medical centres. Thereby enabling those with disabilities or in rural areas greater access to a range of appropriate care services. Additionally, Community Outreach teams would be partnered with agencies in accessible locations that may provide bus tickets and child care, further reducing access barriers faced by some members of the target demographic. However, it must be noted that despite a majority benefit, members will not all have access to the same social service agencies and some may provide services, such as childcare, that others do not provide. Overall, Community Outreach receives a high rank for this equity measure and a score of 5.

7.3.5. Cost

The costs associated with Assertive Community Treatment teams, a similar model of care, in the United States, range from \$10,000 to \$15,000 per service user, per year (Miller, 2011). Assuming similar costs, at the high end of the range, this translates to almost \$20,000 per patient, per year, in Canadian dollars. Again, assuming generous uptake by 60,000 Albertans (as was done in the Wellness Benefits cost estimate) the increase to the Alberta Health budget could reach 6%. However, with much greater proven effectiveness, cost savings from reduced hospitalizations, emergency department visits and decreased usage of primary care for mental health needs, will be more substantive with this option than the previous two. Further, the potential for cross-departmental funding exists. The provincial Human Services Ministry could supply funding for social service agencies. Overall, this option receives a low rank for cost and a score of 1.

7.3.6. Administrative Ease

Community Outreach is the most administratively complex option due to involvement of social services agencies and medical professionals. The GOA would need to establish clear requirements for the funding for social service agencies and administer the funding. They would also need to facilitate the creation, training and supervision of multidisciplinary care teams. Further, on-going monitoring and evaluation

is required. As compared to the other options, Community Outreach has the least administrative ease and therefore receives a low rank and score of 1.

7.3.7. Stakeholder Acceptance

Members of the target demographic would support this option as it provides them with greater access to appropriate care within social service contexts they already utilize. Social workers and social service agencies would support the option of increasing their capacity to provide services within their service models, with the support of government funding and staff. Finally, the impacted health infrastructure and staff would support the policy as it does not place unnecessary strain on other supports and services but rather it has the capacity to reduce strain in other areas. Overall, Community Outreach receives a high rank for stakeholder acceptance and a score of 6.

7.3.8. Additional Benefits

Community Outreach provides many benefits in addition to reducing and preventing self-injury among the target demographic. The design of the option ensures that individuals are receiving support beyond traditional mental health supports such as counselling. Working with peer support workers, the provision of activities to build connections and community and child minding services all provide benefits beyond counselling. Further, in need populations other than the target demographic will have access to the same range of services within their communities. Community Outreach has the potential to reduce negative consequences associated with addictions, to support individuals with a range of mental health concerns and to support individuals with low-incomes to access basic needs supports. Community Outreach receives a high rank for this criteria and a corresponding score of 3.

7.3.9. Evaluation Summary

Table 6: Community Outreach Evaluation Summary.

Effectiveness		Equity		Cost	Administrative Ease	Stakeholder Acceptance	Additional Benefits	Total
<i>Reduction</i>	<i>Prevention</i>	<i>Between</i>	<i>Within</i>					
6	5	5	5	1	1	6	3	32

7.4. Summary of Policy Evaluation

Community Outreach achieved the highest score overall (32 points), as illustrated by Table 7. The green boxes highlight the option that received the highest score for each criteria. Community Outreach received the highest score for both measures of effectiveness, tied with Wellness Benefits for the “between” equity measure and achieved the highest scores for “within” equity, stakeholder acceptance and additional benefits. While it receives the lowest scores for both cost and administrative ease, overall it is the best option to effectively reduce and prevent self-injury among the target demographic.

Table 7: Policy Options Evaluation Summary.

	Effectiveness		Equity		Cost	Admin. Ease	Stakeholder Acceptance	Additional Benefits	Total
	<i>Reduction</i>	<i>Prevention</i>	<i>Btwn</i>	<i>Within</i>					
Wellness Benefits	3	3	5	1	5	3	2	1	22
Primary Care Plus	4	4	3	2	6	2	3	2	26
Community Outreach	6	5	5	5	1	1	6	3	32

In the next chapter, I detail my final policy recommendations and discuss considerations for implementation.

Chapter 8. Recommendations and Implementation

In this chapter, I discuss my policy recommendation, Community Outreach, and present considerations for implementation as well as supporting recommendations. I conclude the chapter with a final reflexive analysis.

8.1. Community Outreach

As it received the highest score based on the pre-determined objectives, criteria and measures, I recommend implementing the Community Outreach option to address the policy issue of high rates of self-injury among the target demographic. Ensuring that the target demographic has access to a range of supports provided by multidisciplinary care teams, in spaces that meet many criteria for accessibility, will have a significant impact, both reducing and preventing self-injury. While reducing inequity this option also seeks social justice by providing services and supports in a non-traditional manner. The inclusion of peer support workers and criteria to promote services that are gender and trauma informed, that recognize the importance of non-judgmental and harm-reductive practice and that actively work to create community and inclusion are active choices to reduce inequities.

While Wellness Benefits and Primary Care Plus each have important benefits and could be considered in addition to Community Outreach, given greater governmental administrative and funding capacity, they are in many ways expansions of the status quo. Further, while the goal is to improve access to adequate mental health supports and services for the target demographic, each option considered would provide additional benefits and benefits to other populations in need. Community Outreach, however, will provide the greatest degree of additional and appropriate benefits to both the target demographic and other populations.

8.1.1. Considerations for Implementation

As a first step, CIHI data should be utilized to determine the least affluent neighbourhoods in the province. Next, Alberta Health should hire administrators to manage the implementation of multidisciplinary care teams in each of Alberta's health regions. To strengthen the effectiveness of the Community Outreach initiative, each administrator should engage with potential social service providers in neighbourhoods of highest need in their regions to learn about specific implementation challenges and requirements.

Next, staff within Alberta Health or the Ministry of Human Services should be identified to process funding and liaise with the health region administrators to facilitate partnerships between teams and agencies. Then, a specific communications strategy should be created to advertise the funding and partnership potential to social service agencies and medical centres.

8.1.2. Limitations and Challenges

Community Outreach, without restructuring, is not a plausible option for rural communities that may not even have access to a regular primary care physician. As such, Community Outreach works best in urban areas. However, an adapted version of Community Outreach could be highly beneficial to rural communities. Smaller versions of the Community Outreach teams could be developed to work with several communities. Region or community specific training that covers gender and trauma-informed practice would ensure an increase of appropriate supports in rural areas.

8.1.3. Supporting Recommendations

Based on the results of this study, the DSM-5 definition of NSSI, nor CIHI's description of self-injury are encompassing enough to define self-injury, due to the various ways self-injury manifests for the target demographic. Particularly as some inflicted injuries are not physical or do not result in body tissue damage and are sometimes the result of socially sanctioned activities. I propose to define NSSI as any behavior intentionally causing physical or emotional harm to oneself for the purposes of

temporary emotional relief. Further, I recommended that institutions collecting data on self-injury, such as Alberta Health and the CIHI, utilize this definition and disaggregate data between suicidal behaviours and self-injurious behaviors.

I also recommend that data be collected in hospitals, urgent care facilities and primary care centers on self-injury with corresponding data on the social determinants of health. Over time this will allow for a better understanding of the effects of social determinants, supplying evidence for more appropriate interventions and prevention policies.

A final supporting recommendation is connected to the ethics of confidentiality. During the interview process with frontline professionals I was reminded of the Code of Ethics governing RSWs across Canada. The Code explicitly states that the maintenance of client confidentiality is tantamount in practice, with a few noted exceptions, including if a client discloses that they intend to harm themselves (CASW, 2005). The spirit and intent behind this confidentiality clause is suicide prevention but it is likely that it has the unintended effect of reducing the number of self-injury disclosures. Many RSWs and frontline professionals that provide one-on-one counseling services or crisis support begin interactions with clients by stating these confidentiality obligations. One participant noted that, two years ago, her organization updated their policy due to new information on self-injury. Staff are now told that unless someone discloses more frequent self-injury of greater intensity, they are not required to break confidentiality, as self-injury alone does not imply a life or death situation. As such, the CASW and other social work professional associations may want to update confidentiality ethics to reflect this difference with corresponding communication to their members.

8.2. Areas for Further Research

Given the huge increase in self-injury among teen girls, there are grave implications for future cohorts of the target demographic, as adults tend to return to old coping mechanisms during stressful periods of life. Future research should focus on social media as a self-injury determinant with the goal of early prevention of self-injury.

As mentioned frequently by study participants, indigeneity is another possible social determinant of self-injury and is potentially compounded by rurality. Intersectional research examining rurality and indigeneity with respect to self-injury is another important area of future research. Information regarding rural/urban differences in Alberta with respect to self-injury became available too late during this study to be fully considered. However, it is possible that location is a stronger determinant of the behaviour than gender, age or income.

8.3. Reflexive Analysis

I want to ensure that the knowledge generated from this study is utilized. Many participants that I interviewed partook in the study with hopes of fostering greater understanding regarding self-injury and influencing change. As a gatekeeper to their wisdom, I intend to honour their contributions and do my best to ensure that policy makers and decision makers are made aware of the research findings and policy recommendations presented in this study.

I must acknowledge that this study would have been stronger given the opportunity to speak directly with low-income women, aged 35-49, in Alberta, that have self-injured or continue to do so. Although I do believe that, if implemented, the Community Outreach option will create positive change, I know that another programmatic response is not enough. In conclusion, I will reiterate that addressing prevention by reforming systems and policies that contribute to insuperable inequity and the physical embodiment of injustice are essential.

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Appendix A.

Semi-Structured Interview Schedule: Frontline Professionals

Objectives:

To collect information and insights on what participants feel are the factors that contribute to high rates of self-injury among low-income females, aged 35-49 in Alberta. Specifically addressing gender, income and age and how they interact.

To collect information and insights from participants on current supports, barriers and potential solutions.

Section 1: Intro

Thank you for taking the time to contribute to this research study. You have all been invited to participate based on your frontline professional work with low-income women in Alberta, between the ages of 35-49, that have self-injured or are currently doing so.

The purpose of this interview is to discuss topics that will shed light on why rates of self-injury are so high within this demographic. The contents of 10-12 interviews will be analyzed and the data will be utilized within a solution focused policy analysis paper as a component of my Master's degree in Public Policy.

Please note that for the purpose of confidentiality you should not share case specific information. Rather, I'm interested in your opinions and knowledge on the topic. Finally, as noted on your consent form, you have the right to withdraw your participation from this study anytime, without consequence, up until January 31, 2016.

Section 2: Semi-Structure topics with potential probes

Can you tell me a little bit about your frontline work?

1. Definitions of self-injury – what is it, what does it include?
 - a. Cutting
 - b. Poisoning (pills, alcohol)
 - c. Punching
 - d. How does it differentiate from suicide?

2. Who self-injures?
 - a. Gender
 - b. Age
 - c. Income Status
 - d. Ethnicity
 - e. Other socio-economic categories?
3. Focusing on low-income females aged 35-49 – what motivates them to self-injure?
 - a. Mental Health
 - b. Childhood trauma
 - c. Sexual trauma
 - d. Depression
 - e. Stress
 - f. Anxiety
 - g. Why are they (depressed/anxious/stressed)?
 - h. Economic situation
4. What connections (if any) do you perceive between gender and self-injuring behaviour in females aged 35-49? / How does gender influence self-injury?
 - a. What are differences between men and women?
 - b. In the injury
 - c. In the motivations
 - d. Responsibilities
 - e. Domestic violence
5. What is unique about this age group?/What is going on for women aged 35-49?
 - a. Sandwich generation
 - b. Children/elders
 - c. General stresses for this age group

6. How does low-income affect self-injury?
 - a. Income level
 - b. Income status
 - c. Income rank (comparisons to other people)?
7. What are the consequences of self-harm?
 - a. To the individual
 - b. To their family/community
8. What supports are out there?
 - a. Reactive
 - b. Preventative
9. What is needed to address this issue?/ Where are the gaps?
10. Is there anything you would like to add? Anything I forgot to address.

Section 3: Concluding Remarks

Thank you for taking the time to participate today. Your input has been very valuable. If there is anything you would like to contribute after leaving today, please feel free to get in touch with me.

Appendix B.

Consent Form for Frontline Professionals

Gender, Low-Income and Health: Addressing the problem of self-injury in females, aged 35-49 in Alberta

Principal Investigator – Leah Kelley, School of Public Policy, Simon Fraser University,
[REDACTED]

Supervisor – Dr. Judith Sixsmith, School of Public Policy, Simon Fraser University

As a requirement of my Master of Public Policy degree, I am conducting research on the factors that contribute to high rates of self-injury among low-income females, aged 35-49 in Alberta.

Purpose of the study

The purpose of this study is to better understand the links between gender, low-income and self-injury among females aged 35-49 in Alberta, and the factors that contribute to high rates of self-injury among this demographic. Finally, this study will examine policy responses to address the issue.

I am inviting people like you to participate in the study to share your expertise, perspectives, and ideas about this topic.

Your participation is voluntary

Your participation is voluntary. You have the right to refuse to participate in this study. If you decide to participate, you may still choose to withdraw from the study until January 31, 2016.

Study Procedures

If you choose to participate, your participation will involve one interview with me lasting approximately 40 - 60 minutes. The interview can be done by phone or in person and will be audio recorded with your permission.

Potential risks of the study

Given that the topics of self-injury and self-harm are topics you have encountered professionally and the discussions will relate to your frontline professional experience, the risks of participation are minimal. However, as self-injury is a topic that has the potential to elicit an emotional response, your consent to participate must come with acknowledgement and understanding of this risk. In addition to signing the consent form, please initial this paragraph to indicate you fully accept the risks involved in participation.

A list of community resources and their contact information will be provided, should you choose to seek community or professional support in the event your participation in this study elicits an unexpected emotional response.

Your organization/employer's name will not be used, referred to or connected to your comments in anyway. Permission from your employer has not been obtained for your involvement in this study. This is your responsibility should you be required to do so. By not obtaining required permission, negative consequences could occur, including but not limited to being reprimanded or fired by your employer.

Potential benefits of the study

You may or may not benefit from participating in this study. Potential benefits include a sense of accomplishment from contributing to important research. In the future, others may benefit from what we learn through this research.

Confidentiality

Your confidentiality will be respected. Information that discloses your identity will not be released without your consent.

The information will be stored and maintained on a password protected laptop during the course of the project. Only the Principal Investigator (Leah Kelley) and Research Supervisor (Dr. Judith Sixsmith) will have access to the information you provide. When the study concludes, content from interviews and general communications will be saved as a word document with all of the contact information and personal identities removed. The information will be saved for two years and then destroyed. Following this, all email communication will be deleted.

All efforts will be made to ensure your confidentiality throughout the entire interview and communication process. However, depending on the medium of communication, and because some of the information will be quoted directly in the final study, absolute confidentiality cannot be assured. In the interview, to ensure the confidentiality of others, do not share information about individual cases or reveal information about others.

Interviews conducted by phone: Your confidentiality of identity cannot be absolutely guaranteed because telephones are not a 100% secure communications medium.

For interviews conducted in person or by phone: If you provide permission to audio record the interview, only the Principal Investigator (Leah Kelley) and Research Supervisor (Dr. Judith Sixsmith) will have access to the recordings. The recordings will be stored on a password-protected laptop during the course of the project. The recordings will be saved until the completion of the thesis, as the researcher may need them until this time. After this time, they will be destroyed.

Use of Quotations: The contents of the interview might be used for direct quotations in the final report. Pseudonyms and/or generic terms such 'Frontline Professional', 'Registered Social Worker (RSW)', 'Community Worker', 'Community Practitioner' and 'Mental Health

Practitioner' will be used in the final report. All efforts will be taken to remove your name, title, and identity in the study. It may still be possible for readers to identify your comments through the context in which they are written. If you are affiliated with a small, vocal, or local organization, readers may be able to infer your position/identity through the process of elimination from direct quotes.

Withdrawal

If you choose to enter into this study and then decide to withdraw at a later time, all information you provided will be destroyed. You may withdraw up until January 31, 2016. There are no adverse consequences to withdrawing from this study.

Study results

The results of this study will be reported in a graduate thesis and may also be published in journal articles and books. If you would like to receive an electronic executive summary of the research findings please let me know and I will do so once completed.

Contact for more information about this study

If you would like more information about this research, please contact me by email

██████████.

Contact for complaints

If you have any concerns about your rights as a research participant and/or your experiences while participating in this study, you may contact Dr. Jeff Toward, Director, Office of Research Ethics ██████████

Future contact

Upon completing the interview process, you may be contacted for follow-up questions/details within a period of 6 months. After this 6 month period, no further contact will be made.

Participant consent and signature

Taking part in this study is entirely up to you. You have the right to refuse to participate in this study. If you decide to take part, you may choose to pull out of the study until January 31, 2016 without giving a reason.

- Your signature below indicates that you have received a copy of this consent form for your own records
- Your signature indicates that you consent to participate in this study.

Participant Signature

Date (yyyy/mm/dd)

Printed name of the participant signing above

Do you consent to having the interview audio recorded? *(Please check one)*

Yes _____ No _____

Do you consent to me contacting you for any follow-up after the interview up to a maximum of 6 months after the interview? *(Please check one)*

Yes _____ No _____

Appendix C.

Consent Form for Academics and Policy Professionals

Gender, Low-Income and Health: Addressing the problem of self-injury in females, aged 35-49 in Alberta

Principal Investigator – Leah Kelley, School of Public Policy, Simon Fraser University,
[REDACTED]

Supervisor – Dr. Judith Sixsmith, School of Public Policy, Simon Fraser University

As a requirement of my Master of Public Policy degree, I am conducting research on the factors that contribute to high rates of self-injury among low-income females, aged 35-49 in Alberta.

Purpose of the study

The purpose of this study is to better understand the links between gender, low-income and self-injury among females aged 35-49 in Alberta, and the factors that contribute to high rates of self-injury among this demographic. Finally, this study will examine policy responses to address the issue.

I am inviting people like you to participate in the study to share your expertise, perspectives, and ideas about this topic.

Your participation is voluntary

Your participation is voluntary. You have the right to refuse to participate in this study. If you decide to participate, you may still choose to withdraw from the study until January 31, 2016.

Study Procedures

If you choose to participate, your participation will involve one interview with me lasting approximately 40 - 60 minutes. The interview can be done by phone or in person and will be audio recorded with your permission.

Potential risks of the study

Given that the topics of self-injury and self-harm are topics you may have encountered professionally and the discussions will relate to academic or policy expertise related to the topic, the risks to participation are minimal. However, as self-injury is a topic that has the potential to elicit an emotional response, your consent to participate must come with acknowledgement and understanding of this risk. In addition to signing the consent form, please initial this paragraph to indicate you fully accept the risks involved in participation.

A list of community resources and their contact information will be provided, should you choose to seek community or professional support in the event your participation in this study elicits an unexpected emotional response.

Potential benefits of the study

You may or may not benefit from participating in this study. Potential benefits include increased visibility and/or contacts by being quoted or referred to in publications resulting from this research. In the future, others may benefit from the results of this study.

Confidentiality

Your confidentiality will be respected. Information that discloses your identity will not be released without your consent.

The information will be stored and maintained on a password protected laptop during the course of the project. Only the Principal Investigator (Leah Kelley) and Research Supervisor (Dr. Judith Sixsmith) will have access to the information you provide. When the study concludes, content from interviews and general communications will be saved as a word document with all of the contact information and personal identities removed. The information will be saved for two years and then destroyed. Following this, all email communication will be deleted.

All efforts will be made to ensure your confidentiality throughout the entire interview and communication process. However, depending on the medium of communication, and because some of the information will be quoted directly in the final study, absolute confidentiality cannot be assured. In the interview, to ensure the confidentiality of others, do not share information about individual cases or reveal information about others.

Interviews conducted by phone: Your confidentiality of identity cannot be absolutely guaranteed because telephones are not a 100% secure communications medium.

For interviews conducted in person or by phone: If you provide permission to audio record the interview, only the Principal Investigator (Leah Kelley) and Research Supervisor (Dr. Judith Sixsmith) will have access to the recordings. The recordings will be stored on a password-protected laptop during the course of the project. The recordings will be saved until the completion of the thesis, as the researcher may need them until this time. After this time, they will be destroyed.

Use of Quotations: The contents of the interview might be used for direct quotations in the final report. In the event you do not give consent to have your name, title and organization used in the final graduate thesis and subsequent publications, pseudonyms will be used. It may still be possible for readers to identify your comments through the context in which they are written. If you are affiliated with a small, vocal, or local organization, readers may be able to infer your position/identity through the process of elimination from direct quotes.

Withdrawal

If you choose to enter into this study and then decide to withdraw at a later time, all information you provided will be destroyed. You may withdraw up until January 31, 2016. There are no adverse consequences to withdrawing from this study.

Study results

The results of this study will be reported in a graduate thesis and may also be published in journal articles and books. If you would like to receive an electronic executive summary of the research findings please let me know and I will do so once completed.

Contact for more information about this study

If you would like more information about this research, please contact me by email [redacted].

Contact for complaints

If you have any concerns about your rights as a research participant and/or your experiences while participating in this study, you may contact Dr. Jeff Toward, Director, Office of Research Ethics [redacted].

Future contact

Upon completing the interview process, you may be contacted for follow-up questions/details within a period of 6 months. After this 6 month period, no further contact will be made.

Participant consent and signature

Taking part in this study is entirely up to you. You have the right to refuse to participate in this study. If you decide to take part, you may choose to pull out of the study until January 31, 2016 without giving a reason.

- Your signature below indicates that you have received a copy of this consent form for your own records
- Your signature indicates that you consent to participate in this study.

Participant Signature

Date (yyyy/mm/dd)

Printed name of the participant signing above

Do you consent to having your name, title, and organization used when referencing your comments/quotes provided during the interview process for the study, entitled, “**Gender, Low-Income and Health: Addressing the problem of self-injury in females, aged 35-49 in Alberta** ”?

(Please check one)

Yes _____ No _____

Do you consent to having the interview audio recorded? *(Please check one)*

Yes _____ No _____

Do you consent to me contacting you for any follow-up after the interview up to a maximum of 6 months after the interview? *(Please check one)*

Yes _____ No _____

I have permission to speak on behalf of my employer. *(Please check one. Note: It is your responsibility to obtain permission from your employer should you be required to do so. Incorrectly checking yes on this box could lead to negative consequences, including but not limited to being reprimanded or fired by your employer.)*

Yes _____ No _____ Not applicable _____