Does Canada need a national suicide prevention strategy?

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STRATEGY

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Canada is the only G8 country without a national suicide prevention strategy – indeed one of the few industrialized countries in the world without one. The United States, Australia, Japan, Scotland, England, and Finland are just some of the countries with working national policies in place. Even Guyana, a developing nation, is drafting its own national strategy to address its alarmingly high suicide rates.

Canada has enjoyed a bedrock of support for a federal strategy for many years. The Canadian Association for Suicide Prevention (CASP) has been calling for a national strategy since the 1990s. In fact, it was one of the principal reasons the organization was originally established. In 2004, CASP released their *Blueprint for a Canadian National Suicide Prevention Strategy* followed by a 2nd edition in 2009. The call for a national strategy remains a crucial rallying point of their agenda.

Canada has high rates of suicide. The overall rate is high and certain demographics suffer disproportionately high rates: our youth, men, and some of our Indigenous communities are among those with the highest rates in the world. Considering these numbers, Canada's failure to develop and implement a national strategy for suicide prevention is nothing short of irresponsible.

Despite high rates, the actual number of deaths may seem small to the average person. Many Canadians may ask why it is important for our country to have a formal plan for a phenomenon that is relatively rare and seemingly affects so few. After all, the most recent figures are 12 suicides for every 100,000 people (Statistics Canada, 2015). While this might initially seem like a very small number, it equates to 4,000 lost lives annually. Additionally, experts across our country will testify that this number is understated: the actual number of suicide deaths is much higher. Upon further contextual examination, 4,000 is not insignificant. Consider these comparisons: 4,000 people is the equivalent of losing a town the size of Jasper from our national map every year. It is like 12 747 jets crashing and killing everyone on board every year. It is like losing a large high school every year. It is more than double the annual number of traffic fatalities and nearly 10 times the

number of homicides. These are unnecessary, preventable losses – the loss of life of the person who dies plus the grief of all the people touched by that person.

The impact of suicide goes beyond the person who dies. Research tells us that 6–20 people are profoundly affected by each suicide death and as many as 135 people may be less severely affected (Cerel, et al., 2016; Shneidman & Cain, 1972). Direct and indirect costs amount to more than $1,000,000 per death. Direct costs are the health costs arising from a suicide. Indirect costs are productivity losses that society must bear over time – they can be thought of as discounted future earnings due to potential years of life lost (SMARTRISK, 2009). These costs of suicide affect every Canadian.

But there is hope. Suicide is preventable. However, just as suicide affects every Canadian, so must every Canadian advocate for widespread prevention. A national strategy is the flagship of this collective action. A national strategy is a formal declaration that suicide is a major public health crisis that demands action. A national strategy signals to both the citizenry and the world that a government is unequivocally committed to combating the problem of suicide and it will no longer be tolerated.

Does having a national suicide prevention strategy make a difference?

Does a national suicide prevention strategy simply become yet another government document? A wealth of current evidence indicates that having, resourcing and implementing a national suicide prevention strategy makes a difference. An influential survey by Matsubayashi and Ueda (2011) of 21 nations from 1980–2003, found that suicide was reduced after a country introduced a national strategy. This reduction was especially noticeable within demographics such as the elderly and young people.

Finland was an early adopter of a national strategy because of their exorbitantly high rates of suicide in the 1980s. They believed that implementing a strategy would alleviate the suicide epidemic and indeed, after implementation, their suicide rate decreased by 9% over 10 years. Even more impressive, Scotland's strategy in 2002 achieved an 18% reduction in suicides by 2012 (World Health Organization [WHO], 2014). A strategy is much more than the paper on which it is written: implemented, it is a road map to saving lives.

The United Nations (UN) published a declaration in 1996 recommending that all countries develop a national suicide prevention strategy entitled *Prevention of Suicide: Guidelines for the Formulation and Implementation of National Strategies.*

The United States, subsequently, implemented a strategy in 2001, and England followed suit in 2002. The list of countries that have a national strategy now numbers in the mid-20s. Canada is noticeably absent.

CASE STUDY: SUICIDE PREVENTION STRATEGIES IN ACTION

Québec: Help for life

To illustrate how a coordinated prevention strategy can be successfully implemented, let us look at a provincial example. In the 1980s, the province of Québec was experiencing extremely high rates of suicide.

At the time, there was a patchwork of local and regional organizations devoted to suicide prevention strewn across the province and little collaboration or contact between them. In 1986, an attempt to remedy this dysfunctional situation resulted in the creation of the Association Québécoise de prévention du suicide (AQPS) or the Québec Suicide Prevention Association.

The mandate of AQPS to form an alliance among these independently operating organizations helped set the stage for further coordination and cooperation in the years ahead.

Unfortunately, the suicide rate continued to climb. In 1990, the rate was 16 per 100,000, and reached a peak of 22.2 per 100,000 in 1999 (AQPS, 2015).

By 1995, though, it was felt that enough was enough. A decision to draft a provincial strategy was made. The strategy, called *Help for Life*, was implemented in 1998. It incorporated many of the recommendations mentioned in the UN declaration of 1996, including reduction of access to means of suicide, responsible media coverage, an increase in education and research, and others, such as coordinated crisis intervention and suicide awareness campaigns.

But the most crucial piece of this initiative was the effective demonstration of leadership that the Québec Ministry of Health and Social Services carried. They bore all responsibility for both the implementation of the plan, and the facilitation of its funding. Even more impressive, the Ministry absorbed and consolidated existing regional boards and created a three-tiered coordinated system entirely devoted to the prevention of suicide.

An annual budget of $700,000 was allotted to support the strategy, and the rates of suicide began to fall. From the high rate of 22.2 per 100,000 in 1999, the total provincial number of suicides fell from 1620 to 1102 in 2012 – the rate declining to 13.7 per 100,000. There was also a substantial decease of 50% in the teen and young adult demographic.

What is in a strategy? How does it help?

As previously mentioned, a national suicide prevention strategy is a road map which works to reduce risk factors for suicide while enhancing factors that build resilience both on a public health or population level, and on an individual or mental health level. It outlines a plan to implement a coordinated, cross-societal approach to close gaps and harmonize efforts.

The WHO recommends that any suicide prevention strategy contain the following best practices: timely access to mental health care, responsible and non-sensational media reportage, reduction of access to means of suicide, and education – including awareness raising, stigma reduction, gatekeeper training, research and surveillance (WHO, 2014).

A national suicide prevention strategy must involve all sectors of government including representation from municipal and provincial levels, as well as community input. This allows for the transparent identification of stakeholders, whose roles will, ideally, be clearly designated and defined. This helps to ensure consistency throughout jurisdictions, whether federal, provincial, or regional, and helps reduce or avoid duplication of services (WHO, 2014).

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Additionally, they recommend that a national strategy be both coordinated and multi-pronged. Strong leadership with financial commitment is crucial to sustain the plan over an extended period to achieve optimal results. A strategy sets out the plan for the long haul.

CAN'T SUICIDE JUST BE IDENTIFIED IN A NATIONAL MENTAL HEALTH STRATEGY?

Research clearly indicates that to significantly impact the suicide rate, suicide must be addressed distinctly, with its own prevention strategy, as opposed to being a subset of a larger mental health strategy. Mental health issues are extremely marginalized and stigmatized and suicide is exponentially more so. The strategy must focus directly on suicide and suicide prevention; otherwise there is a danger that the prevention message will be diluted, ignored, or lost altogether. Suicide affects all areas of society – community, workplace, schools, families, criminal justice system, and education, among others. Including suicide within a larger plan under the purview of a single governmental department will not effectively address it with the necessary broad scope. All departments and sectors are touched by suicide (Matsubayashi & Ueda, 2011; Eggerston & Patrick, 2016).

Who is responsible for a national strategy?

Mental health or public health? Is suicide prevention a mental health issue or a public health issue? The answer is: both. As evidenced in the WHO recommendations, suicide must be combatted both on an individual level and on a population level to realize a large-scale impact. Suicide obviously affects the individual at risk most directly, and such an individual requires mental health care. Many people at risk of suicide never seek mental health care or experience barriers when they do seek it. Our mental health system needs to become more responsive to people at risk and more progressive in its service delivery.

Mental health care on its own, however, cannot prevent suicide across a population – it must be complemented with public health policy which targets the collective health of all Canadians. Public health policy is much broader than mental health policy. Public health policy can restrict access to lethal means, such as erecting bridge barriers, controlling firearms, requiring blister packaging on medication, and regulating pesticides. Public health policy can educate a community through awareness campaigns, stigma reduction messaging and skills training. Public health policy can engage the media with responsible, thoughtful discussions about suicide to break the silence surrounding it without glamourizing or sensationalizing it. Thus, a concerted prevention strategy should have complementary mental health and public health efforts (Centres for Disease Control and Prevention, 2016).

A helpful parallel to this blended model is that of vaccination policy. Individually, a person is vaccinated to protect him or herself from a contagious disease. This is provided by an individual clinical health care source, which is comparable to individual mental health care. The individual benefits from the vaccination; however, the power of vaccination policy comes when the focus is on the population as a whole. When everyone is vaccinated, the disease is eradicated. This example illustrates the interdependence between and reciprocity of individual and collective care. Suicide prevention strategies must similarly contain provisions from both mental and public health to achieve widespread effectiveness (Hawton, 1998; Alberta Health Services, 2013).

COMMUNITY PREVENTION AND GRASSROOTS INITIATIVES

In practice, suicide prevention actions involve everyone. The health care system cannot possibly treat all who may potentially be at risk, nor should it be expected to on its own. Most people at risk of suicide do not require a psychiatrist's care; however, they do require care. Initiatives at the community level, whether prevention, intervention, or postvention, can support and extend health care initiatives in undoubtedly cost-effective and individualized ways.

A strong leadership component is essential for a strategy to be effective; however it cannot be wholly top-down in its design: there must be movement from the bottom up as well. Community endeavours developed at the grass-roots level must be included to allow for locally-relevant approaches from local perspectives and (often) faster implementation. This two-way exchange of ideas and practices will ideally generate the best results (U.S. Department of Health and Human Services, 2012).

CASE STUDY: SUICIDE PREVENTION STRATEGIES IN ACTION

Galt Museum & Archives
L-R: Dr. Jean Collins, Dr. Menno Boldt, Dr. Robert Arms, Tom Wickersham, Mary Oordt & Bob Tarleck

The "Alberta Model"

Alberta has had a significantly different historical experience with suicide prevention at the provincial level.

In the 1970s, Alberta was at the forefront of efforts in suicide prevention the world over. In 1973 a government study into motor vehicle fatalities morphed into a task force on suicide. It was spearheaded by sociologist Menno Boldt and others resulting in the 1976 *Boldt Report*. The report made several key recommendations, one of which was the creation of the Office of the Provincial Suicidologist mandated to investigate suicide across multiple sectors. This pioneering appointment, made in 1978, was the first of its kind in the world.

Later, a Ministerial Order created a citizen committee to work with the Provincial Suicidologist and the Canadian Mental Health Association (CMHA) to implement a 4 part "Alberta Model" of suicide prevention. Three of these parts were adopted, including a coordination of community interagency suicide prevention outreach programs (CISPP), which still exists as the Suicide Prevention Resource Centre in Grande Prairie, as well as the implementation of province-wide education and training programs.

Education and training were conducted by the newly created Suicide Information and Education Centre (SIEC) mandated to collect and disseminate suicide research and information and the Suicide Prevention Training Programs (SPTP) which provided suicide intervention skills-training throughout the province. This was the earliest iteration of the Applied Suicide Intervention Skills Training (ASIST) workshop, considered the gold standard of intervention training. These two entities evolved into our present-day Centre for Suicide Prevention (CSP), a branch of the CMHA.

This whirlwind of activity, however, began to calm in the 1990s when the Provincial Suicidologist position was eliminated and many provincial outreach programs were cancelled. Provincial budget cuts decimated public sector spending, including funding for mental health, and the political will to address suicide was gradually lost.

These efforts identified Alberta as a world leader in suicide prevention.

These efforts identified Alberta as a world leader in suicide prevention. An expert panel with major Alberta representation from the former founders of SIEC/SPTP and current founders of LivingWorks Education held an historic meeting in Banff in 1993. It was called the UN/WHO Interregional Experts Meeting on the Formulation of National Strategies for the Prevention of Suicide, and the experts who attended ultimately influenced the UN document published in 1996.

Amid the declining momentum, a provincial strategy was published in 2005, titled *A Call to Action*. It is distressing to note that this document remains on the shelf and has neither been resourced nor implemented. It is a sad reminder of the once vital progress made in suicide prevention that has now been rendered virtually impotent. Given the current state of the issue at both our provincial and federal levels, Canada continues to lag behind much of the world with regard to implementing a working national suicide prevention strategy.

Going forward

There is room for optimism, though! Lacking a federal framework to draw from, several municipalities, provinces, and regions have developed their own suicide prevention strategies.

CITY OF EDMONTON, A MUNICIPAL SUICIDE PREVENTION STRATEGY

The *Edmonton Suicide Prevention Strategy* was published fall 2016. Its origins can be traced to the work of concerned agencies and community members (including bereaved individuals) that encouraged Edmonton's municipal government to install safety barriers on the city's "suicide hotspot", the High Level Bridge. Phones directly wired to the crisis line were installed and bridge barriers were built. Having gained momentum, the Edmonton Suicide Prevention Advisory Committee (ESPAC) was formed at the request of City of Edmonton Administration to create a comprehensive suicide prevention strategy for their region. This committee has multi-level, multi-sector participation from diverse community organizations, municipal stakeholders and includes engaging with Edmontonians personally affected by suicide and suicide attempts. It has the (rare) support from the City of Edmonton – "rare" because often municipal strategies are developed but not endorsed by the local government – and the committee hopes to one day integrate with provincial and national strategies. Integration with these strategies and alignment with other related initiatives will be addressed in the development of an *Implementation Plan for the Strategy*, anticipated to be complete by the fall of 2017. Hopefully this initiative will inspire other regions to create their own local strategies.

NUNAVUT SUICIDE PREVENTION STRATEGY, A TERRITORIAL INITIATIVE

The territory of Nunavut has had an elevated rate of death by suicide since the 1970s when the first and subsequent generations of Inuit began living in settlements. In 2008, the Government of Nunavut (GN), Nunavut Tunngavik Incorporated (NTI), the Royal Canadian Mounted Police V-Division (RCMP) and the Embrace Life Council (IIKELC) formed a partnership to create a strategy to prevent suicide. In 2010, the *Nunavut Suicide Prevention Strategy* (NSPS) was released.

An action plan (2011–2014) followed suit to actualize the goals outlined in the strategy. An extension of the action plan was added in 2014 for evaluative purposes. A coroner's inquest into suicide was held in September 2015 which heard testimony from family members, clinicians, researchers and partners of the NSPS. Over 50 recommendations were made, including the declaration of a state of emergency in Nunavut and the designation of a cabinet minister responsible for suicide prevention. A call for another action plan was made in 2016 to implement these recommendations, resulting in the publication of *Resiliency Within: An Action Plan for Suicide Prevention in Nunavut 2016–2017* released in 2016.

The efforts in Nunavut show that high suicide rates are not easily solved. On the contrary, they require sustained efforts. The rates of suicide in Nunavut remain over 10 times the national average but the continued governmental support demonstrates an unwavering commitment to battle the epidemic.

INUIT TAPIRIIT KANATAMI, AND ITS INUIT-SPECIFIC SUICIDE PREVENTION STRATEGY

The Inuit Tapiriit Kanatami (ITK), the national representational organization for Canada's 60,000 Inuit in the four regions of Canada's Arctic, collectively known as Inuit Nunangat (including Inuvialuit in the Northwest Territories), Nunavut and Nunavik (Northern Québec), and Nunatsiavut (Northern Labrador) released the *National Inuit Suicide Prevention Strategy* in 2016.

In the strategy ITK identified taking action to prevent suicide among Inuit as its top priority. They felt this strategy should focus on the circumstances that are particular to Inuit and their shared history and social and economic

experiences. The multi-layered effects of historical and intergenerational trauma, including severe childhood adversity and inequities, are experiences that have contributed to major mental health crises, as well as elevated rates of suicide.

Overall, the suicide rate in the four regions of Inuit Nunangat remains high. From 2009–2013, suicide rates ranged from 60 per 100,000 in the Inuvialuit Settlement Region to 275 per 100,000 in Nunatsiavut. Both Nunavik and Nunavut had rates 10 times the national rate during this period.

The *NISPS* addresses the social and economic inequities which affect all of Inuit Nunangat and manifest in high rates of suicides in many of its constituent communities. It outlines six priority areas for action and investment that are necessary for guiding regional and community suicide prevention efforts.

ITK's message to Ottawa is clearly that the Inuit cannot wait for Canada to act, and that the ongoing epidemic in our country's northern regions needs to be addressed immediately (Eggertson, L. & Patrick, K., 2016).

What about the Federal Framework for Suicide Prevention?

In Canada, the Framework was legislated by the Federal Government in 2012 and published by the Public Health Agency of Canada (PHAC) in November 2016.

But a framework is a hollow substitute for a strategy. It does not identify the necessary jurisdictional mandates or resources; responsibilities are not defined in a clear way, and there are no definitive timelines. Simply put, a framework does not have the sheer weight or power of an official strategy (Eggerston, L. & Patrick, K., 2016).

Is a national strategy achievable?

While we support CASP in its call for a national strategy and remain hopeful the Federal Government will lead and implement it, we would be remiss to not recognize the many barriers that need to be scaled, the largest arguably being our federated health system.

In Canada, health falls under the purview of the provinces and territories. Health Canada enacts policies but the implementation of such policies is the responsibility of the provinces and territories. For anything to be ratified on a federal level, such as a national strategy, all provinces must be on board. This is no easy task.

But with strong federal leadership, it is not insurmountable. If the Prime Minister and his government can get the provinces to uniformly agree that this indeed is a public health crisis that must urgently be met head-on, it is achievable. There was unprecedented cooperation and coordination between the federal and provincial governments to deal with the SARS epidemic of 2003 (which resulted in the creation of PHAC) and the HINI pandemic of 2009 (Canada, Parliament, Senate, 2010). We need the suicide crisis in Canada to be treated with the same sense of urgency as an epidemic or pandemic. The present Prime Minister, Justin Trudeau, has the vision, leadership, and the personal commitment to mental health necessary to forge a united front between the Federal and Provincial/Territorial governments.

> It is time suicide is treated as the crisis that it is. Only then will we reach a cross-Canada consensus of preventing suicide and reducing rates.

Perhaps the road to a Canada-wide strategy is through a PanCanadian model whereby Minsters of Health from all provinces and territories come together as equals to give equal input into the decision-making process. Suicide affects all of Canada. Each province and territory needs to bring its own regional self-determination and self-interest to the table, together with Health Canada. There is a growing awareness of the suicidal crisis and Canada and a continued and escalating support for suicidal prevention efforts in every region of Canada. It is time suicide is treated as the crisis that it is. Only then will we reach a cross-Canada consensus of preventing suicide and reducing rates.

But it cannot be done without the will of the people and currently there are more people determined to do something about suicide than ever before. We continue to lose a significant portion of our citizenry every year – middle-aged men, young Canadians, Indigenous peoples, members of the LGBTQ community and military veterans. Today, we are seeing a reduction of the stigma associated with suicide, and evidence of a growing willingness to talk about it. What we need now is for our Federal and Provincial governments to validate this progress with an emphatic legislative commitment via a Canadian suicide prevention strategy: a Pan-Canadian Strategy. Such legislation must be wide-reaching and powerful enough to meet the current challenges of suicide prevention directly and with the force that we, as Canadians, deserve.

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