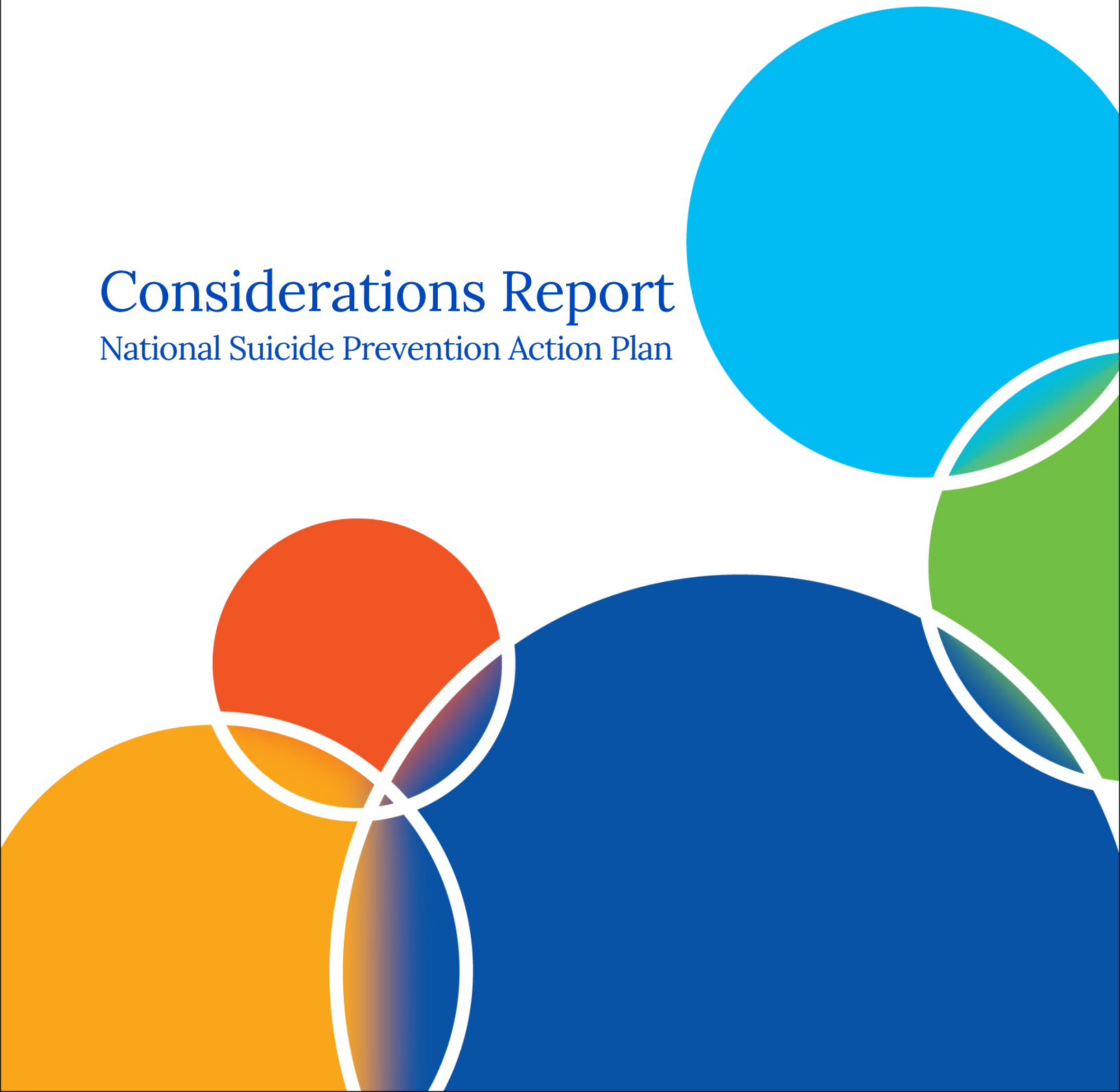
centre *for* suicide prevention

Mental Health Commission of Canada

Commission de la santé mentale du Canada

Considerations Report

National Suicide Prevention Action Plan



Acknowledgements

This document was drafted by the Centre for Suicide Prevention and the Mental Health Commission of Canada in consultation with many stakeholders and experts in the mental health and suicide prevention field.

We wish to thank the following people, whose contributions including reviewing and providing feedback on the development of this Considerations Report:

- Mary Bartram
- Pat Doyle
- Brandon Hey
- Sean Krausert
- Jason Oliver
- Uyen Ta
- Crystal Walker
- Dammy Damstrom-Albach
- Sandra Gosling
- Jennifer Jeffery
- Ed Mantler
- Logan Seymour
- William Wahl

Project team, CSP

- Robert Olson
- Karin Lavoie
- Mara Grunau

Project team, MHCC

- Natalia Uribe
- Lisa Cowley
- Nitika Rewari

Ce document est disponible en français

Citation information

Suggested citation: Mental Health Commission of Canada & Centre for Suicide Prevention. (2023). *Considerations report: National suicide prevention action plan.* https://www.mentalhealthcommission.ca

ISBN: 978-1-77318-319-0

Legal deposit National Library of Canada

Health Canada Santé Canada

The views represented herein solely represent the views of the Mental Health Commission of Canada. Production of this material is made possible through a financial contribution from Health Canada.

Contents

Introduction 1
- Background 2
  - Strategies and action plans 2
- Method 3

Assessment of Findings 4
- M-174 themes 4
- 1. Data infrastructure 4
  - What's happening internationally? 4
  - What do the strategies and plans within Canada say? 5
- 2. Evidence-based best practices 7
  - Need for continued research 8
  - What's happening internationally? 8
  - What do the strategies and plans within Canada say? 8
- 3. Safe and responsible reporting 10
  - What's happening internationally? 11
  - What's happening in Canada? 12
- 4. An online resource hub 13
  - What's happening internationally? 13
  - What's happening in Canada? 13
- 5. Culturally appropriate, community-based programs 14
  - What's happening internationally? 16
  - What's happening in Canada? 16
- 6. Training standards 17
  - What's happening internationally? 18
  - What's happening in Canada? 19
- Notable considerations not represented in Motion 174 20

References 26

Appendix 33
- International strategies and plans 33
- Provincial and territorial strategies and plans 34
- Population-based strategies and plans 35

Introduction

Each year in Canada, about 4,500 people die by suicide. Among young people (15-24) it is the second leading cause of death, an incidence rate further magnified by its affects on families, individuals, and communities across the country (and worldwide). The reasons for suicide are complex: they include biological, psychological, social, cultural, spiritual, economic, and other factors. According to a leading researcher in the field, the people who think about and attempt suicide are seeking to end deep and intense psychological pain.[1] Despite the complexities, there is reason for hope. A combination of mental health and public health approaches can reduce Canada's suicide rate and its impact.

In 2016, the government of Canada released its *Federal Framework for Suicide Prevention*, which contributed to the implementation of the Mental Health Commission of Canada's (MHCC's) *Changing Directions, Changing Lives: The Mental Health Strategy for Canada*. The framework reinforced the value of using a public health approach to suicide prevention and set out the government's strategic objectives, guiding principles, and commitments. In 2019, Parliament built on this by unanimously passing Motion 174 (M-174), a private member's motion calling for the creation of a national suicide prevention action plan (NSPAP). Its several provisions included the creation of a national public health monitoring program for suicide prevention and national standards for training people engaged in this area.

To support the federal government's development of the NSPAP, the MHCC and the Centre for Suicide Prevention (CSP) conducted an environmental scan of active provincial-territorial, national, and international strategies on suicide prevention. Its analysis, which is the basis for this report, offers insights on a repository of evidence-based initiatives in Canada and around the world.

The report consolidates M-174's provisions under six themes: (1) data infrastructure, (2) evidence-based best practices, (3) safe and responsible reporting, (4) an online resource hub, (5) culturally appropriate, community-based programs, and (6) training standards.

Overall, the analysis shows that Canada has implemented many foundational steps within each of these themes, including the publication and dissemination of safe media reporting guides as well as several crisis support resources (online and by text or phone). However, significant gaps and challenges remain for each of these themes nationally, and there is also a need to streamline existing efforts in the provinces and territories.

Further, while the text of M-174 mentions First Nations, Inuit, and Métis people, it does not consider specific language, cultural, and geographical factors. These include the meaningful inclusion of additional vulnerable populations such as 2SLGBTQI+ persons; racialized people; individuals living in rural and remote communities; youth; military veterans; post-secondary students; older adults; immigrants, refugees, and newcomers; those who work in high-risk industries and occupations.

Background

Strategies and action plans

Efforts to codify best practices for national suicide prevention strategies and action plans began in the 1990s with the United Nations' (UN's) publication of *Prevention of Suicide: Guidelines for the Formulation and Implementation of National Strategies* and the World Health Organization's (WHO's) *Preventing Suicide: A Global Imperative* in 2014.

WHO recommends that any suicide prevention strategy contain timely access to mental health care, responsible and non-sensational media reporting, the reduction of access to means of suicide, and education — including awareness raising, stigma reduction, gatekeeper* training, research, and surveillance.[2]

While definitions differ from country to country, national suicide prevention strategies generally aim to "develop comprehensive and integrated public health responses to suicide and a structural framework to support prevention activities and evaluation" (p. 2).[3] WHO recommends that national strategies precede action plans and serve as the overall framework the action plans (as tactical implementation roadmaps) are based on.[4] While strategies "should be tailored to each country's cultural and social context," action plans should "specify clear objectives, targets, indicators, timelines, milestones, designated responsibilities and budget allocations" (p. 5).[5]

The ultimate goal of these strategies and action plans is fewer suicide deaths, which WHO quantified in 2013 by setting a global reduction target of 10 per cent among member states that made commitments to its objectives in *Mental Health Action Plan 2013-2020*.[6]

As of 2019, 38 countries had adopted a national suicide prevention strategy.[7] There is also "an increasing number of countries with a national framework, national programs for specific sub-populations, or where suicide prevention is integrated into the national (mental) health plan" (p. 77).[8] As an example, Australia has both a national suicide prevention strategy and a related *National Mental Health and Suicide Prevention Plan*.

Evidence indicates that having, resourcing, and implementing a national suicide prevention strategy can help reduce suicide rates. A survey of 21 OECD nations by Matsubayashi and Ueda[9] found that many had reduced such rates after introducing a national strategy.[10] For example, over different 10-year periods Finland reduced suicide rates by nine per cent, while Scotland did so by 18 per cent.[11] Matsubayashi and Ueda concluded that a national strategy can be an effective means for reducing suicide rates.[12]

M-174 was presented by NDP MP Charlie Angus and endorsed by many pan-Canadian mental health organizations. It was also informed by pivotal national documents, such as the Canadian Association for Suicide Prevention's (CASP's) *Blueprint for a Canadian National Suicide Prevention Strategy* and the MHCC's *Mental Health Strategy for Canada*.

* Generally, *gatekeepers* are individuals (not necessarily clinicians) who identify suicidality and refer people to appropriate services. See the Training Standards section for further information.

After the *Federal Framework for Suicide Prevention* was released in 2016, many organizations, experts, people impacted by suicide loss, and persons with lived and living experience of suicidal ideation or attempted suicide have been calling for an action plan that would focus on tangible activities, investments, and policies that can be implemented at various levels.[13,14]

After M-174's passing in 2019, the Public Health Agency of Canada (PHAC) responded by facilitating the development of such an action plan with relevant departments, agencies, and key stakeholders. PHAC's 2022 Progress Report outlined the status of those efforts while reviewing the federal framework's impact and promising that the forthcoming plan will "set out concrete actions and performance indicators to improve crisis support and suicide prevention for people most affected by suicide risk, attempt and loss" (p. 4).[15] In acknowledging the need for a renewed commitment and updated vision of suicide prevention, PHAC plans to engage with other government departments, provinces and territories, Indigenous communities, and people with lived and living experience to inform the development of the NSPAP. While PHAC continues such work, mental health organizations in Canada continue to draw attention to key considerations that should be reflected in the national action plan as it is being created.

Before presenting the results of the MHCC-CSP environmental scan, it is important to note the impacts of COVID-19 on suicidal behaviour. Reports from the early stage of the pandemic revealed significant increases in symptoms of anxiety and depression among people in Canada as well as increases in loneliness, social isolation, and problematic substance use.[16] Some reports also noted increases in suicidal behaviour and self-harm.[17] In addition, health-care providers saw an increased demand for mental health services while their capacity to meet patients' needs was being limited due to their own illness and increased anxiety and depression, all of which contributed to longer waits and staff shortages.[18]

Call rates to the national crisis service "increased 185% over the course of the pandemic and are 200% higher than the same time period in 2019" (p. 448).[19] COVID-19 has therefore amplified the need to focus on mental health and suicide prevention. While help-seeking behaviours across Canada have risen, wait times remain at an all-time high. A unified effort coordinated by the federal government would help ensure that everyone receives quality care and timely access to mental health and suicide supports.

Method

In completing the environmental scan for this report, the project team looked at published grey literature and various government documentation, searching academic databases such as EBSCO, Google Scholar, and the CSP library database. Much of the grey literature was captured through searches on Google.

In conducting the search, the team created a spreadsheet with five tabs (international and national suicide prevention strategies, provincial and territorial strategies, regional and municipal strategies, priority populations, and key research) and included active strategies and action plans published in English. An exception to this search criteria was made for Quebec, so that all provinces and territories could be assessed equally. For each strategy the project team recorded the date of implementation, gave a brief description, and noted its currency and

evaluation status. Each entry also included an assessment in terms of the six M-174 themes mentioned.

The results of the scan in the next section are organized according to these same themes. Also included is a section on strategy and action plan elements that M-174 did not outline but which should be considered as the NSPAP continues to be developed.*

Assessment of Findings

M-174 themes

1. Data infrastructure

> The government should (a) establish a national suicide prevention action plan, including among its provisions [the] creation of programs to identify, and to attempt to fill, gaps in knowledge relating to suicide and its prevention, including timely and accurate statistical data . . . (Motion 174)

Strategies implemented before 2010 tended not to single out data infrastructure as a key element of suicide prevention, even though it was identified as a goal in the UN's 1996 guidelines document. Yet almost all national strategies since 2010 contain data surveillance as a critical element. In 2014, WHO's highly influential *Preventing Suicide: A Global Imperative* highlighted surveillance as a key component of a national strategy.[20] More recently, it identified certain kinds of data sources to guide suicide prevention activities, including "civil registration and vital statistics, health and police records, verbal autopsies and population-based surveys" (p. xi).[21]

The scan analysis reveals a number of crucial considerations about data infrastructure, such as the improvement of the overall process, the expansion of data to include suicidal behaviour (in addition to deaths by suicide), and the importance of using multi-sectoral partnerships to collect, analyze, and use data.

What's happening internationally?

International action plans highlight the significance of the ongoing and systematic collection of data related to suicide. In the U.S., the Centers for Disease Control and Prevention expanded the National Violent Death Reporting System from 18 to 32 states in 2014, which significantly improved the data collection infrastructure for suicide prevention.[22] England's action plan has focused on improving standardization in data collection through partnerships with coroners, resulting in improvements to real-time suicide surveillance.[23] For example, the U.K. Health Department undertook a pilot project (now ongoing) of national real-time data monitoring in the national health system that works with a subset of local areas with existing surveillance

* Note: The project team asked several experts in mental health and suicide prevention to review a draft of this report to validate or refine its content wherever possible.

systems.[24] Similarly, Ireland's national strategy focuses on having real-time and better integrated data surveillance systems to monitor suicidal behaviour.[25]

This more general focus on suicidal behaviour is aligned with Iskander and Crosby's recommendations of "a clear need for suicide-related data that is more complete and timely, is of higher quality, and includes not just deaths by suicide but the full spectrum of suicidality encompassing thoughts and behaviors" (p. 2).[26] International action plans, such as in Scotland, have also focused on "work[ing] closely with partners to ensure that data, evidence and guidance is used to maximise impact. Improvement methodology will support localities to better understand and minimise unwarranted variation in practice and outcomes" (p. 17).[27]

What do the strategies and plans within Canada say?

SUICIDE STATISTICS

In Canada, the data collection of suicide statistics is a laborious process that can often take two years or more from the reception of data at the provincial-territorial level to public release by Statistics Canada.[28] Many factors contribute to the time lag, including the determination of the cause of an individual death and the varying levels of granularity that each province or territory uses to track suicides. All provinces break down the statistics by age and sex, but some track by the month and means of suicide. Only Saskatchewan provides data on ethnicity within death records. While other provinces and territories may collect such information, only Saskatchewan makes this information publicly available.

CORONERS AND MEDICAL EXAMINERS

The absence of an accreditation system for coroner and medical examiner offices and any national standards for death classification (and for submission to Statistics Canada for final analysis and publication) makes the collection process much more cumbersome;[29] but this occurs because coroners and medical examiners do not use the same format to submit or even collect information.[30,31] It is also important to note the many challenges of obtaining suicide surveillance information for Indigenous populations in Canada, which have been attributed to factors such as under-reporting, data access, and geographical access.[32,33]

TIMELY AND EFFICIENT DATA

The scan revealed that, since 2018, provincial-territorial strategies have sought to capture data in a timely and efficient manner, an approach routinely mentioned as a chief objective. For example, Saskatchewan's *Pillars for Life* strategy identified explicit year-one actions to better track "gender, race, age and communities with respect to means of self-harm and suicide," although it did not specify how this would be accomplished (p. 7).[34] The province also pledged to support research and evaluation, yet it is unclear whether this means research and evaluation of the suicide prevention plan itself or suicide data.[35] At present, Saskatchewan tracks suicides in two ways: by year, sex, and age group and by year, sex, and race.

REGIONAL APPROACHES

At the municipal level, Edmonton's *Living Hope* plan explicitly prioritizes the collection of data related to suicide, such as demographic and situational data. Objective 7 states that the

approach must "ensure initiatives and policies are driven by the most current research and surveillance data" (p. 46).[36]

Prince Edward Island's *Building Blocks of Hope* strategy stresses the need to increase the "quality and timeliness" of suicide data. One of its 65 recommendations for action identifies the importance of establishing an "integrated data collection system which serves to identify vulnerable groups, individuals, and situations" (p. 5).[37]

Through its newly launched strategy, Quebec details how the province has already started monitoring suicidal ideation through new indicators introduced because of the pandemic.[38] These efforts include the creation of additional indicators to track suicide deaths along with self-harm and mental health care service utilization as preventive measures to deter suicide before it happens.[39]

FIRST NATIONS, INUIT, AND MÉTIS APPROACHES

The First Nations Information Governance Centre (FNIGC) has created a set of data principles known as OCAP® (ownership, control, access, and possession). Developed by and for First Nations, the principles ensure that they alone have "control over data collection processes in their communities [and] own and control how this information can be stored, interpreted, used, or shared" (para. 3).[40]

In 2021, the National Collaborating Centre for Indigenous Health released *Visioning the Future: First Nations, Inuit, & Metis Population and Public Health*, which includes knowledge and reports on Indigenous self-determination and public health, assessment, and response to Indigenous well-being, and Indigenous population health data (IPHD).[41] IPHD is holistic and contextualizes quantitative data on persistent systemic racism while representing strengths-based, whole-of- community data.[42] Approaches to IPHD creation include *the grandmother perspective*,* independent creation by Indigenous communities, meaningful partnership with population health bodies, and *two-eyed seeing*,† among others.[43,44] The governance of such data aligns with the data governance principles of specific First Nations, Inuit, and Métis communities under their care and stewardship.[45]

The FNIGC has noted that First Nations communities who applied the OCAP principles have "passed their own privacy laws, established research review committees, entered data-sharing agreements, and set[] standards to ensure OCAP® compliance" (FAQ, section 4, para 2),[46] Some First Nations communities have also adopted their own unique interpretations of the OCAP principles to suit their needs. It is important to note that these principles were developed with First Nations communities and understandings in mind. They operate based on First Nations rather than Indigenous principles, meaning that OCAP may not be applicable to other Indigenous communities.

* A British Columbia's Office of the Human Rights Commissioner report describes *the grandmother perspective* as an "approach centred on the importance of relationship: First Nations governments are not wanting to operate with the Big Brother mentality that we've all been groomed into believing in relation to what data does to us—it's more like we want to come from the grandmother perspective. We need to know because we care" (p.8).

† Martin (see endnote 58) refers to two-eyed seeing as "a theoretical framework that embraces the contributions of both Indigenous and Western 'ways of knowing'" (p. 21).

Additional resources that discuss Indigenous data ownership include *The First Nations Health Transformation Agenda*, which highlights current challenges in collecting and collating First Nations health data, along with key priorities and actions for the path forward. The challenges it identifies include a lack of consistent approaches to collecting health data. Among its solutions are setting standards in the handling, use, and sharing of data through the OCAP principles, capacity improvements (e.g., funding and staff upskilling) to meet the data demands, and investments in community supports to facilitate relevant data sharing between systems.

Inuit Tapiriit Kanatami's (ITK's) *National Inuit Strategy on Research: Implementation Plan* outlines five priorities for its implementation and evaluation — one is to "ensure Inuit access, ownership, and control over data and information" (p. 15).[47] Further objectives involve Inuit self-determination in the collection, verification, analysis, and dissemination of Inuit-specific data, as well as ownership of such data by Inuit-appointed entities. The implementation plan also calls for the use of Inuktitut in data platforms and information management.

Similar to the OCAP principles, all Métis health information should be under the ownership and control of the Métis Nation, in accordance with OCAS (ownership, control, access, stewardship) principles.[48] However, there continues to be a general lack of comprehensive health data for Métis peoples, as data collection is often hindered by uncertainty over identity and jurisdiction regarding Métis individuals and communities.[49] In 2018, the federal government committed $6 million over five years to support the Métis Nation in gathering health data and developing a health strategy.[50]

2. Evidence-based best practices

> . . . the establishment of national guidelines for best practices in suicide prevention based on evidence of effectiveness in a Canadian context. . . (Motion 174)

While suicide is complex and multifactorial, many researchers and organizations have sought to identify evidence-based best practices* for whole-population suicide prevention efforts. Though M-174 does not expressly define evidence-based best practices, several have been widely identified as such: awareness campaigns, gatekeeper training, means restriction and means safety, responsible reporting, and early identification, treatment, and followup care.[51,52,53] While supporting documentation varies, all strategies and action plans the scan reviewed claim to be evidence based — even though the ones with evaluative reports are easier to validate and verify in this regard. A key drawback of national suicide prevention strategies, however, is the challenge involved in providing evidence for the efficacy of certain recommended best practices. While overall suicide rates may seem to have decreased after governments initiate nationwide suicide prevention programs,[54] some researchers emphasize the difficulty of evaluating such programs as a whole, given the multiple factors that can affect these rates and the constraints of post-implementation evaluation periods (signaling the need for longer lasting observation periods).[55]

* PHAC defines best practice as "an intervention, program, or initiative that has, through multiple implementations, demonstrated: high impact (positive changes related to the desired goals), high adaptability (successful adaptation and transferability to different settings), and high quality of evidence (excellent quality of research/evaluation methodology, confirming the intervention's high impact and adaptability evidence)."

Need for continued research

The scan analysis revealed calls for continued research to (1) identify and validate evidence-based practices and their transferability to the Canadian context, (2) develop national guidelines to improve the coordination of suicide prevention supports across the country, and (3) conduct ongoing evaluations to measure the progress and impact of actions taken.

What's happening internationally?

In many European nations, pharmaceutical self-poisoning is the second most common method of suicides and suicide attempts (after hanging, strangulation, and suffocation, which are grouped together).[56] One means safety initiative in Britain was to introduce reduced package sizes and individual packaging (i.e., blister packs) for over-the-counter acetaminophen (i.e., paracetamol [Tylenol]).[57] Globally, pesticide ingestion is a particularly common means of suicide (responsible for an estimated one in seven suicide deaths), particularly in Sri Lanka, India, and China.[58] Sri Lanka imposed restrictions on the sale of pesticide agents most toxic to humans in the 1990s. The 50 per cent reduction in the suicide rate over the next decade was driven by the decline in poisoning (non-poisoning suicide rates remained the same).[59]

Means safety, one of the most well-known evidence-based best practices, has been shown to reduce rates at the population level.[60] The goal of means safety, unlike means restriction, "is not to indefinitely restrict access to [means] per se, but rather to ensure short- and long-term safety [and] promote a therapeutic alliance between the clinician and [the patient], as well as garner the trust of individuals exposed to public health suicide prevention efforts" (p. 239).[61]

In addition to having national guidelines on means safety, countries with an action plan have sought to create evidence-based guidelines to improve suicide prevention efforts. Australia's action plan, for example, developed guidelines to improve the coordination of treatment and supports for people with severe and complex mental illness.[62] These national guidelines emphasize the importance of clarifying roles and responsibilities for health and community sectors, improving the use of electronic health records, and promoting screening, detection, and treatment for suicide risk.[63]

What do the strategies and plans within Canada say?

Regarding means safety, more than three-quarters of suicide deaths in Canada are a result of suffocation, poisoning, and firearms.[64] Currently, Canada does not have any national guidelines related to means safety. Unfortunately, each means, including its related safety and other concerns, falls under various areas of governance. For example, pharmaceutical blister packs fall under Health Canada's jurisdiction, rail safety is regulated by Transport Canada, and firearms safety is a concern of Public Safety Canada.

The Bloor Street Viaduct in Toronto, the Jacques Cartier Bridge in Montreal, and the High Level Bridge in Edmonton are "means" that fall under municipal control. Notably, all three cities have installed barriers to curb suicides (bridges outside municipalities tend to be regulated by Transport Canada). Currently, no central framework or process exists that would encourage collaboration between different areas of government to help coordinate action for means safety at the national level.

PANDEMIC IMPACTS

Treatment and follow-up care, through practices such as safety planning and ongoing crisis support, greatly depend on the timeliness and access of such care. Yet health-system wait times in Canada have increased for procedures such as organ transplants, surgeries, and cancer management due to the pandemic.[65] According to a study by Gagliardi and colleagues on the mental health of patients who must wait for these procedures due to COVID, "most patients and caregivers reported anxiety, depression and poor quality of life, which deteriorated with increasing wait time" (p. 978).[66] For those seeking mental health support, long wait-lists, few affordable options, and overburdened therapists pose numerous challenges.[67] Several cases across the country have detailed emergency department visits for suicidal ideation (after previous suicide attempts) in which people were turned away after being told that psychiatrists were unavailable.[68] Access to mental health care is even more limited for rural and remote communities and for other marginalized populations, with little or no access to professional care providers.[69]

REGULAR REPORTING

According to the 2012 *Federal Framework for Suicide Prevention Act* the government must report on its progress every two years (starting in 2016). While the act does not outline what is required, past reports have included information on new developments in suicide prevention at the national level, progress on the act's strategic objectives, and areas for future action. For example, the 2020 progress report mentions partnering with Statistics Canada and others to enhance the country's suicide surveillance system, advancing *life promotion* for First Nations people, and implementing the NSPAP.[70] The 2022 version indicated that future reports would outline progress on key milestones under the objectives of the act and the NSPAP.[71]

PROVINCIAL STRATEGIES

Prince Edward Island's strategy emphasizes the need to increase access points for care, both inside and outside hospital settings.[72] Reflecting on the province's long wait times for mental health services, P.E.I. began looking to its Atlantic neighbour, Newfoundland and Labrador, which recently reduced wait times for mental health care by 67 per cent.[73] PEI is now following suit by implementing Stepped Care 2.0, a model aimed at providing timely and holistic services through a range of methods such as telehealth, web-based services, and walk-in clinics.[74] Stepped Care 2.0 is organized around nine steps, including informational self-directed care, acute care, systems navigation, case management, and advocacy. To implement the model, organizations select services (e.g., e-mental health interventions, self-guided support, peer support, group programming, and in-person therapy) that align with the structure and number of steps appropriate for each community.[75]

Quebec's recent strategy, *Rallumer l'espoir*, establishes four priorities: mental health promotion and suicide prevention awareness, the prevention of suicidal ideas and suicide attempts, training and support for professionals and speakers, and development and knowledge integration and updating practices. Each axis has its own set of measurement indicators, ranging from raising awareness among the general population to creating gatekeeper programs in workplaces and supporting new research projects.[76]

3. Safe and responsible reporting

> . . . the development of tools to promote responsible and safe reporting of suicide and its prevention by media [and] comprehensive analyses [of] the role that social media plays with respect to suicide and suicide prevention [and] means to reduce stigma associated with being a consumer of mental health . . . (Motion 174)

Safe and responsible media reporting has long been a key element in national suicide prevention strategies. It figures prominently in the UN's prevention of suicide guidelines, the CASP blueprint, and WHO's preventing suicide report. Nevertheless, television series such as *13 Reasons Why* and the coverage of Robin Williams's suicide in 2014 have encouraged further research in this area, along with analyses of the use and usefulness of media guidelines and reporting.[77,78] In both instances, elevated rates of suicide deaths occurred that can be attributed to the unsafe coverage of Williams's suicide and the series, which included graphic and sensational depictions of suicide means.[79,80]

The main danger from such harmful or unsafe coverage is suicide contagion, which can be described as "exposure to suicide or related behaviours [that] influences others to contemplate, attempt or die by suicide" (p. 870).[81] Such imitation is also known as copycat suicide. Because youth are particularly vulnerable when exposed to suicide,[82] prevention strategies and action plans have paid great attention to safe and responsible reporting. Findings from the scan analysis demonstrate the need to develop online measures that can identify harmful content and promote safe messaging related to suicide and its prevention.

In a systematic review of social media's potential to prevent suicide, Robinson and colleagues acknowledge that "social media platforms can reach large numbers of otherwise hard-to-engage individuals, may allow others to intervene following an expression of suicidal ideation online, and provide an anonymous, accessible and non-judgmental forum for sharing experiences" (p. 103).[83] Yet they also identify challenges to the possibility of fulfilling this potential, including "difficulties controlling user behaviour and accurately assessing risk, issues relating to privacy and confidentiality and the possibility of contagion" (p. 103).[84]

One examination of the role of social media in encouraging contagion was conducted on a youth suicide cluster in Ohio between August 2017 and March 2018. In this study, Swedo and colleagues found that, while social media posts about suicide can help promote education about mental health, they can also "contain distressing or sensationalized content, normalize suicide as a response to one's problems, and spread information about suicide location and methods, all of which may increase suicidal behaviors" (p. 3).[85] The authors concluded that evidence-informed practices for social media and suicide prevention such as *#chatsafe* show significant benefits, though they have yet to be widely adopted.[86]

ACCOUNTABILITY OF PLATFORM PROVIDERS

An emerging but insufficiently addressed area of safe messaging is the accountability of platform providers. Suicides due to social media accounts of suicidal behaviour are more prevalent among the young (under 25), and social media is a major conveyor of their spread.[87] An article by Hawton and colleagues suggests that effective intervention following a suicide should include a response group to provide support for susceptible individuals and the larger

community. This support can also include social media as it "can provide a powerful means for disseminating information and reaching young people at risk" (p. 58).[88]

Artificial intelligence technologies that detect and flag users who express suicidal behaviours are becoming more sophisticated and efficient. However, issues of privacy, personal autonomy versus safety, and other ethical concerns arise whenever such measures are introduced on social media.[89]

An area that should also be addressed is "pro-suicide" web sites, which are the very antithesis of safe messaging and reporting guidelines. Not only do they openly encourage suicide and recommend various means of doing so, there is a lack of research and actionable evidence linking these sites to suicide.[90] Like suicide contagion, young persons tend to be the most vulnerable to these pro-suicide messages.[91]

What's happening internationally?

Many countries have established guidelines for safe reporting that are similar to Canada's *Mindset* from the Canadian Journalism Forum on Violence and Trauma. These include England's *Samaritans' Media Guidelines*, Australia's *Mindframe*, and the U.S.'s SAVE guidelines. Though unique to their geographical context, all provide detailed parameters that promote responsible reporting and illustrate harmful content to help reporters avoid sensationalizing stories of suicide.

Social media guidelines for safe online conversations have not been as widely developed or adopted internationally. One of the few examples is *#chatsafe* developed in Australia by Orygen (in partnership with young people). The purpose of these guidelines is to support to those who might be responding to suicide-related content posted by others or who might want to share their own experiences with suicidal thoughts, feelings, or behaviours.[92] A separate study by Robinson and colleagues that explored its adaptation to an international audience found that the guidelines were widely downloaded and had reached over one million young people across 38 countries.[93] The authors concluded that *#chatsafe* would require minimal adaptation and emphasized the need to have an abbreviated version and a suite of social media assets (including templates) for sharing personal stories.[94]

Finland's action plan calls for the imposition of "obligatory supervisory measures for social media platforms . . . including obligations for identifying harmful content which promotes suicide, content which indicate [sic] suicidal thoughts or intentions, as well as developing a steering system for those at risk of suicide" (p. 55).[95] And although legislation banning pro-suicide websites was enacted in Australia and Japan, social and legal issues like censorship and access to information will inevitably need to be addressed.[96] Mishara and Weistub have recommended avoiding censorship or legislative control by focusing on alternative solutions such as "suicide prevention activities . . . to counterbalance suicide promotion activities" (p. 73).[97] They also suggest pursuing other avenues such as self-regulation, filtering techniques, and blocking access to sites, among others.[98]

What's happening in Canada?

MEDIA GUIDELINES

There are numerous media reporting guidelines in Canada, such as the Canadian Psychiatric Association's *Media Guidelines for Reporting on Suicide* and *Mindset: Reporting on Mental Health*, a collaboration between journalists and mental health professionals. Both encourage safe and responsible reporting through respect for the privacy and grief of loved ones, the publication of local helplines readers can reach out to for support, and the representation of suicide as preventable. They also discourage romanticizing suicide, characterizing it as a solution to an individual's problems, detailing methods used, and publishing suicide notes.[99,100]

The *Federal Framework for Suicide Prevention* makes no mention of social media, media reporting, or suicide contagion; however, M-174 calls for a comprehensive analysis of the role social media plays in suicide.

SOCIAL MEDIA

Talk Suicide Canada, a countywide suicide prevention service, provides 24-hour, bilingual support to anyone who is "facing suicide." The website encourages the use of "died by suicide" instead of "committed suicide" and prioritizes people-first language. The service's media guide stresses the importance of using safe language, stories and messages of hope, including all people affected by suicide (without portraying them as victims), and advising people where to seek help. Its four approaches to suicide reporting also recommends what not to do: sensationalize, describe the method, mention the location, and link to potentially harmful content (e.g., older stories about suicide or content from social media like hashtags, threads, videos, or images). Overall, the guidelines seek to "reduce suicide exposure effects," Talk Suicide Canada's preferred term for "suicide contagion."[101]

ONLINE SAFETY

The federal government is working to develop new legislation to address harmful online content. In a major study of "cyber-enabled harmful activities" published in 2023, the Council of Canadian Academies cited several studies showing that "youth, women and the LGBTIQ+ community are common targets of online harassment" (p. 45). The report also noted that "the distribution of non-consensual intimate content can lead to shame, anxiety, declining physical health, and damaged relationships" (p. 40).[102]

PROVINCIAL APPROACHES

Generally, strategies and plans within Canada emphasize the importance of safe and responsible communication through various media. P.E.I.'s strategy calls for promoting "the implementation of media guidelines to support responsible reporting of suicide in print, broadcasting and social media" (p. 5)[103] and using media channels to foster "positive mental health, good news stories and help seeking behaviours" (p. 17).[104]

Nova Scotia's 2020 framework directly raises the issue of suicide prevention on social media, noting that "the availability of inappropriate portrayals of suicide and uncensored suicidal acts on social media and the internet are of particular concern, as controlling these sources is challenging" (p. 17).[105] Despite these challenges, it recognizes that promoting responsible media

reporting and messaging through social media can reduce suicide exposures and potentially reduce stigma for help-seeking behaviours.[106]

To address some of these same concerns, Alberta's action plan focuses on the support of "social media campaigns to reduce stigma of mental illness and suicide" and the need to "follow guidelines for responsible media reporting and monitoring of media reports" (p. 25).[107]

4. An online resource hub

> . . . the creation of a national online hub providing essential information and guides to accessing services, in English, French, selected Indigenous languages, and other languages spoken widely in Canada for suicidal individuals, their families and friends, people bereaved by a loved one's suicide, workplaces and other stakeholders concerned with suicide prevention . . . (Motion 174)

The scan of strategies and implementation plans did not reveal any explicit references to online resource hubs, nor accessibility to them. The formative documents recommending best practices either contain goals such as "ensure access to appropriate and adequate health, wellness and recovery services for all Canadians in keeping with the *Canada Health Act*" (p. 17)[108] or elements such as "access to services" and "awareness"[109] that address similar concerns.

Findings from the scan underscore the need to coordinate and build on the lessons of existing resources through one countrywide online hub, while ensuring that its educational materials and services reach rural and remote communities. Since many suicide prevention resources are developed at the national level, and provinces and territories also provide information on locally available services, these resources need to be organized so they operate seamlessly.

What's happening internationally?

While few action plans in the scan explicitly mention a national online hub, specific plans do aim to increase access to such information through other initiatives. The *Talk to Me 2: Suicide and Self Harm Prevention Action Plan for Wales 2015-2020* seeks to address the information and support needs of people bereaved or affected by suicide and self-harm via the country's *Suicide and Self Harm Prevention* website, which is managed by the National Advisory Group on Suicide and Self-Harm Prevention.

Scotland's action plan mentions working with partners to develop and support the delivery of digital technology innovations that build a "strong online suicide prevention presence across Scotland that caters for all ages" (p. 15).[110] Its renewed strategy from 2022 discusses the country's commitment to fund online digital resources, though these are limited to those bereaved by suicide.[111]

What's happening in Canada?

Several Canadian strategies and action plans mention the importance of providing access to digital supports for information purposes. For example, Quebec's 2022 strategy seeks to increase access to educational material and resources through online activities and tools.[112] One such resource is *suicide.ca*, which is both a resource hub and a suicide prevention lifeline for anyone thinking about suicide, people concerned about someone who may be thinking about

suicide, and those who have lost someone to suicide.[113] Although many provinces, territories, and population groups provide access to virtual supports, few strategies and action plans expressly mention coordination of cohesive online hubs.

In addition to *suicide.ca*, the country has multiple online initiatives, such as *Talk Suicide Canada*, *Wellness Together Canada*, and *Together to Live*, as well as several alternatives in each province and territory (and for specific populations). While these initiatives contain evidence-based educational content and other resources, most operate independently of one another.

ACCESS TO DIGITAL INFORMATION

In addition to the lack of coordination between such initiatives, one of the most significant challenges is the lack of connection to digital resources for rural and remote populations across the country.[114] According to a February 2022 *Pilot Magazine* article, Canada's high-speed internet access rate of 87.4 per cent sat at 98.6 per cent for urban centres but "just 45.6 per cent in rural regions and 34.8 per cent of households on First Nations reserves" (para. 7).[115] In 2021, an ITK report indicated that only "one of 51 Inuit communities has access to fixed highspeed broadband and is connected to the country's fibre optic grid" (p. 11).[116] As the *Pilot* article concludes, "the rural-urban divide has always existed. But now it's become a digital divide, separating those Canadians with reliable internet access and the millions still without" (para. 8).[117]

In response, building on a core principle in *Canada's Digital Charter* aims to improve the country's digital landscape through universal access,[118] *Canada's Connectivity Strategy* seeks to connect 98 per cent of Canadians to high-speed internet by 2026 (100 per cent by 2030).[119]

5. Culturally appropriate, community-based programs

> . . . commitment to the actions and resources required to establish culturally appropriate community-based suicide prevention programs as articulated by representative organizations of the Inuit, First Nations, and Métis peoples [and] the creation of a national public health monitoring program for the prevention of suicide and identification of groups at elevated risk . . . and the risk factors specific to each such group, the degree to which child sexual abuse and other forms of childhood abuse and neglect have an impact on suicidal behaviour, the barriers to Canadians accessing appropriate and adequate health, wellness and recovery services, including substance use, addiction and bereavement services [and] the use of culturally appropriate suicide prevention activities and best practices . . . (Motion 174)

Community-based suicide prevention resources and actions are important parts of reducing the impact of suicide. WHO has noted that, while governments need to take the lead in such activities, "top-down suicide prevention must go hand-in-hand with local bottom-up processes" (p. 2).[120] Such programs can reduce the risk of suicide through awareness campaigns, helping gatekeepers identify and extend supports to vulnerable individuals, engaging in follow-up care, and supporting those bereaved by suicide, all through culturally appropriate lenses.[121,122]

In some instances, suicide should be addressed by means of an alternative perspective. For example, in many Indigenous communities, terms like *life promotion* or *wellness* are more suitable when broaching the subject. The *First Nations Mental Wellness Continuum Framework* — developed by the Thunderbird Partnership Foundation with Indigenous and non-Indigenous partners (including Health Canada) — identifies hope, meaning, belonging, and purpose as underpinning many Indigenous ways of knowing. As the framework explains, aligning these four aspects in a person's everyday life brings that person a feeling of wholeness that protects them and acts as a buffer against mental health risks and potential suicidal behaviours.[123]

Barriers to resource accessibility for racialized populations have also been identified as a challenge. These include language barriers, cultural stigma, financial hardship, and discrimination.[124]

SUBSTANCE USE AND SUICIDE PREVENTION

Concerning access to substance use services, there is widespread acknowledgment of the intersection between substance use and suicidal behaviours. A recent scan conducted by the MHCC and the Canadian Centre on Substance Use and Addiction identified research on priority populations — including youth, Indigenous peoples, 2SLGBTQI+ populations, and older adults (particularly older men) — that reflects this connection.[125] The influence of certain substances on suicide are also well-documented; for example, alcohol, which has a stronger association with suicide than cannabis.

Yet a system-wide lack of coordination exists among organizations who deliver substance use and suicide prevention services, though some positive strides are being made with combined services for individuals who have lived and living experience of substance use. Government policy is another area for optimism: Actions to address substance use and suicide prevention as interrelated are being formalized, most noticeably in the creation of Health Canada's mental health and addictions portfolio (with accompanying funds for a myriad of initiatives).[126]

Still, most treatment centres focus solely on the use of substances rather than underlying factors that may have led to it; for example, 12-step programs that, according to Olson, encourage "participants to accept the idea that substance addiction is a disease that is progressive and incurable." As Olson and other researchers have pointed out, such an approach may not help everyone:

> . . . for many — particularly trauma survivors and other vulnerable individuals — this 12 Step model can be a very ineffectual treatment. It is very common for someone who has been abused or victimized to develop an inherent belief in their own powerlessness. Thus, participating in a program that demands admitting and believing in their own powerlessness as its chief hallmark might ultimately be counterproductive to helping one [regain power] over their life.[127] (para. 14)

In addition, not all substance use treatment centres screen for suicidal behaviours, even though they would be ideal locations for doing so. Because an individual can be screened for suicidality as well as concurrent disorders during in-take, these centres offer an opportunity to look beyond the presenting issue (substance use) for any co-occurring disorders that are involved.

CRISIS STABILIZATION CENTRES

Crisis stabilization (respite) centres are one promising alternative to hospital or emergency department treatment. Such centres offer a safe space for those experiencing a mental health or suicide crisis who may also have had adverse experiences with the health system.[128] Because most of them employ a harm-reduction approach, many people who use substances will not be denied entry. Often, these centres are staffed by peers and present a more welcoming environment for those experiencing a mental health crisis.[129] Evidence suggests that these alternative centres "can meet the needs of some individuals experiencing high-intensity suicidal crisis" (p. 7) while reducing dependency on hospital emergency departments and mental health-related calls to ambulance and police.[130]

What's happening internationally?

New Zealand's *Every Life Matters* is one of the most thorough examples of a national strategy that targets Indigenous suicide. Co-developed by Māori organizations and communities, the strategy itself integrates Māori people, culture, and language.

The *Plan for Suicide Prevention among the Sámi people in Norway, Sweden and Finland* was developed through a joint effort between a regional branch of the Norwegian health system and the Saami Council, a pan-Sámi non-governmental organization.

Countries tend to separate substance use strategies and action plans from suicide prevention approaches. As an example, Australia's *National Drug Strategy 2017-2026* aims to provide a national framework to identify priorities relating to alcohol, tobacco, and other drugs.

What's happening in Canada?

First Nations, Inuit, and Métis in Canada have been among the most disproportionately affected populations in relation to suicide risk. Compared to the country's non-Indigenous people, suicide rates are nine times as high among Inuit, three times as high among First Nations, and two times as high among Métis.[131] The most recent estimates of suicide in these communities, according to the 2011 *Canadian Census Health and Environment Cohorts* (CanCHEC) and Statistics Canada, put these rates at 72.3 per 100,000 for Inuit, 24.3 per 100,000 for First Nations (about 60 per cent of bands have a zero suicide rate), and 14.7 per 100,000 for Métis.*,[132]

These disparities in suicide mortality are so stark that prevention has become a public health priority for governments and many Indigenous communities. Yet, as noted, high rates do not exist in all Indigenous communities. According to research by Chandler and Lalonde, lower suicide rates are "strongly related to measures of 'cultural continuity' [that] include efforts to regain legal title to traditional lands and to re-establish forms of self-government, to reassert control over education and other community and social services, and to preserve and promote traditional cultural practices" (p. 238).[133]

Researchers have also drawn attention to unique suicide risk factors among Indigenous peoples related to collective trauma. Historical and colonial violence have resulted in intergenerational

* In 2023, the rate is about 11 per 100,000 people for Canada as a whole.

trauma, abuse, early childhood adversity, the erasure of family structures, a lack of access to health services and education, and increased substance use.[134,135]

There are two national suicide prevention strategies among Indigenous people in Canada: the *National Inuit Suicide Prevention Strategy* by ITK and the *National Aboriginal Youth Suicide Prevention Strategy* by the federal government.

Through the provincial lens are the *Saskatchewan First Nations Suicide Prevention Strategy* created by the Federation of Sovereign Indigenous Nations and *Honouring Life*, an Alberta initiative targeting Indigenous youth well-being, which is augmented by CSP's *Community-Led Life Promotion Plans for Indigenous Youth and Communities Guide* and the Thunderbird Partnership Foundation's *Strengthening Our Connections to Promote Life: A Life Promotion Toolkit by Indigenous Youth*.

While no distinct Métis suicide prevention plan exists, the Métis Nation of Alberta's *Life Promotion Guide: Weaving Together Métis Knowledge and Practice* seeks to support the development, implementation, and evaluation of programming that connects young people to life. The strategy is based on principles of Métis identity, community belonging, and *life promotion*, which "recognizes distress, suffering, and suicide in the overall context of life itself and chooses to shift from an exclusive focus on individual problems to one that centers on community strength and capacity in the face of oppressive policies and conditions" (p. 7).[136]

When it comes to substance use and suicide prevention, one encouraging initiative from the Mental Health and Addictions portfolio is the recent release of new national standards for mental health and addictions services. This is the first step in helping to formalize high-quality, timely, and culturally appropriate mental health and substance use services across Canada.[137]

6. Training standards

> . . . establishment of national standards for the training of persons engaged in suicide prevention, whose contact with potentially vulnerable populations provides an opportunity to identify at-risk individuals and direct them to appropriate assessment and treatment . . . (Motion 174)

Training standards are widely mentioned across various strategies and plans included in the environmental scan. Findings from the scan analysis highlight the importance of training programs for health-care providers on the prevention of suicide and related behaviours, specialized training for 988 responders, training sessions on treatment and follow-up care following a suicide attempt, and culturally tailored gatekeeper training in various regions.

Regarding treatment and follow-up care, studies have pointed to the benefits of safety planning and ongoing crisis support. Safety plans seek to reduce suicide risk for individuals experiencing suicidal ideation and behaviour and increase their sense of self-efficacy and control. Developed jointly with a health-care provider, such plans include personalized coping strategies, crisis support resources, and information about restricting access to lethal means.[138] They have long been considered a best practice for reducing suicide risk for these individuals.[139] Recent comparison studies showed that patients who received such interventions were half as likely to

exhibit suicidal behaviour and more than twice as likely to attend mental health treatment during the six-month follow-up period, compared to patients who did not receive them.[140]

When drafting a safety plan following a suicide attempt, recommended case management is to ensure contact within one week, followed by six months of ongoing psychological support.[141] While some researchers have found limitations in safety planning — for example, two different studies of veteran populations concluded that completing a safety plan does not necessarily translate into a reduction in future attempts or hospitalizations — the same authors believe that they can improve critical practices and should be enhanced.[142,143] A recent systematic review of 26 studies also found safety planning to be a "valuable indicated intervention for general adult and veteran populations experiencing suicide-related distress" (p. 1044).[144]

Suicide risk assessments have also been widely identified as fundamental screening tools for health-care organizations. With several different models available, health-care practitioners are encouraged to tailor them to different circumstances, cultures, and contexts.[145] At the same time, while they are considered a crucial element of clinician training, sole reliance on assessment scales is discouraged. A main criticism is their inaccuracy in suicide prediction, including a tendency to report false positives.[146] Therefore, as their use continues in clinical settings, there is "growing support for a renewed risk assessment approach that is collaborative, client-centered, and needs-based" (p. 252).[147] The suicide prevention program issued by the Health Standards Organization calls for standardized, routine training for the screening of suicide risk to ensure that all team members of health-care and social service agencies are equipped with the knowledge to identify warning signs of suicide.[148]

Gatekeepers can be defined as "individuals in a community who have face-to-face contact with large numbers of community members as part of their usual routine [that] may be trained to identify persons at risk of suicide and refer them to treatment or supporting services as appropriate" (p. 139).[149] Gatekeeper training has and continues to be a key component of suicide prevention strategies. It is prominent in the vast majority of national, provincial, and territorial strategies targeted toward priority populations. Ideally, suicide prevention gatekeeper training standards must be met and maintained.

What's happening internationally?

In the U.S., according to a 2017 implementation assessment report, gatekeeper and clinical suicide prevention training goals had been attained across the country. The national initiatives on gatekeeper training included the military, schools, and Indigenous communities.[150] Since the launch of the country's strategy in 2012, training for the clinical workforce to improve suicide risk assessment and treatment led to the eventual publication of *Suicide Prevention and the Clinical Workforce: Guidelines for Training* in 2014. While their use is voluntary, the guidelines act as a framework for the development, adoption, and adaptation of training efforts for all health-care professionals. The National Action Alliance for Suicide Prevention's clinical workforce preparedness task force, which developed the guidelines, continues to ensure that they are adopted into graduate training and continuing education and by credentialing, accreditation, and licensing bodies.[151]

Studies have found that, since the July 2022 launch of the 988 national suicide prevention number in the U.S., training has not been rolled out in a standard way across the country. A

survey by Cantor and colleagues to ascertain preparedness for the launch found that 55 per cent of jurisdictions had specifically trained staff to interact with children and adolescents, 46 per cent with persons experiencing homelessness, and 45 per cent with LGBTQIA+ individuals. The authors also found that less than 60 per cent of respondents reported using LivingWorks' Applied Suicide Intervention Skills Training (ASIST), despite the fact that those who had taken the training reported better caller outcomes.[152]

What's happening in Canada?

PHAC has provided multi-year funding toward creating a national network of crisis services (the Canada Suicide Prevention Service, now known as Talk Suicide Canada). Since its implementation, training for crisis-line staff has followed the standards and guidelines of the National Suicide Prevention Lifeline in the U.S., which include having "clinicians to oversee clinical triage, assessment of risk of suicide, practice of active engagement and collaboration, and use least invasive intervention" (p. 449).[153] Different provinces and territories have carried out their own training sessions while rolling out regional three-digit suicide prevention helplines. These programs are being assessed prior to the formal 988 launch in November 2023.

Many programs are available to train gatekeepers in Canada, including ASIST, safeTALK, and Question, Persuade, Refer (QPR). Some research shows that these are particularly effective for increasing knowledge about suicide prevention, changing beliefs and attitudes about suicide, and increasing feelings of self-efficacy to intervene and use their skills,[154,155] although one systematic review found that these positive effects can diminish over time.[156]

Edmonton's *Living Hope* plan includes an objective to "train more community 'gatekeepers' so they are able to effectively support individuals at risk of suicide" by increasing availability and accessibility to suicide prevention training — especially those focused on "trauma informed practice, healthy brain development, and the impacts of the Social Determinants of Health on mental health and suicide" (p. 35).[157]

Saskatchewan's *Pillars for Life* plan details several actions on training. These include expanding Mental Health First Aid and ASIST, supporting specialized skill development for mental health clinicians, and helping "the Saskatchewan Health Authority in their efforts to host a range of cultural responsiveness trainings to ensure the health system is more accommodating to First Nations and Métis patients and their families" (p. 6).[158]

Nunavut's plan relies on a community-led action framework based on six key themes: mental health services, youth resilience, early childhood development, communications, research and evaluation, and intervention training. In the training component, the territory has emphasized trauma-informed practices and cultural competency education; for example, its ASIST program was "translated and adapted for Nunavut . . . under the name Uqaqatigiiluk" (p. 24). It has also delivered culturally tailored suicide intervention gatekeeper training to people who work with vulnerable segments of the population, such as Inuit youth, men, persons bereaved by suicide, and those who experience suicidal ideation. Further, it plans to "hold regional gatherings on community-based, Inuit healing programs . . . bringing together community wellness champions . . . to share knowledge, participate in training and strengthen networks" (p. 17).[159]

Notable considerations not represented in Motion 174

> . . . the creation of a national public health monitoring program for the prevention of suicide and identification of groups at elevated risk [and] the risk factors specific to each such group . . . (Motion 174)

M-174 specifically names the First Nations, Inuit, and Métis peoples of Canada. This section outlines high-level considerations for other priority population groups mentioned by many of the country's action plans and strategies, while noting lessons and examples at the international level.

PEOPLE WITH RECURRING SUICIDALITY

M-174 does mention ongoing supports for those bereaved by a suicide but not those who experience thoughts of suicide or have attempted suicide. People who attempt suicide are at elevated risk of subsequent attempts and death, particularly within the first 12 months. In a study by Bostwick and colleagues, 81.8 per cent of individuals who attempted suicide died by suicide within a year (80 per cent of those were men).[160]

One national strategy that includes support for people experiencing "suicidal behaviour" is New Zealand's *Every Life Matters — He Tapu te Oranga o ia Tangata*. The strategy and action plan lists responding to suicidal behaviour as a key intervention activity. Specifically, the strategy indicates an intention to "work with Māori and people with lived experience of suicidal behaviours to develop national guidelines for managing suicide risk" (p. 21).[161] While this activity makes no explicit mention of people who previously attempted suicide, the plan includes it in the definition of suicidal behaviour (p. 39).

The previously mentioned crisis stabilization (respite) centres can be effective for people who are potentially at risk of suicide (or have recurring suicidality). One program specifically designed for people with recurrent thoughts and/or attempts is Skills for Safer Living, which hosts support groups in several Canadian cities. This program sees suicidal behaviour as a condition in its own right: Rather than being a result of mental illness or a specific diagnosis, suicide is part of a continuum of behaviours, ranging from "living to die" to "dying to live." This patient-centred, psycho-educational, skills-building program acknowledges a person's current state of mental health and coping strategies, which can include substance use. Its aim is to work with those who have attempted suicide (and may attempt again) to achieve a more positive state of being through "choosing to live and to live more safely."[162,163]

2SLGBTQI+ COMMUNITIES

Within the broader 2SLGBTQI+ population, the most extensively studied area has been the relationship between LGB youth and suicide. Among them is a recent analysis of U.S. and Canadian national survey data by Salway and colleagues, which found that LGB youth have a higher risk for suicide and suicide attempts than the general population.[164]

While an earlier Canadian study of gay adult men found high rates of attempted suicide and higher risks of suicide relative to the rest of the population,[165] the need for supports is particularly acute for transgender people. Many studies confirm that "40 per cent or more of trans people have attempted suicide at least once in their lifetime" (para. 1).[166] Trans men have

an even higher risk for suicide compared to other gender identities due to increased depressive moods, suicidal ideation, and suicide attempts.[167] In addition, a 2022 Statistics Canada study of bullying found that "sexually and gender diverse youth (aged 15 to 17) were most at risk." Those who were bullied "reported the highest incidence of negative mental health outcomes [and] were the most likely to report that they considered taking their own life in the past year (27%)" (p. 1).[168] In light of such findings, the Centre for Addiction and Mental Health (CAMH) has called for suicide prevention strategies for the trans population that consider external factors such as parental supports for gender identity and actions that address social inclusion, transphobia, and access to medical transition.[169]

In general, strategies tailored to 2SLGBTQI+ groups are scarce. In noting this absence, Ferlatte and colleagues have called for targeted suicide prevention programs for sexual and gender minorities in Canada. And while suicide prevention gatekeeper training is available to support some priority populations (most notably youth and Indigenous), none is yet available for others such as newcomers and 2SLGBTQI+ individuals.[170]

YOUTH SUICIDE PREVENTION

In 2019, suicide accounted for 27 per cent of all deaths at ages 15 to 24 in Canada with the rate dropping to 20 per cent in 2020.[171] Suicide is the second leading cause of death for youth and young adults aged 15 to 24 after accidents (unintentional injuries).[172] For youth aged 10 to 14, suicide is the third leading cause of death, after accidents and malignant neoplasms (cancerous tumors).[173] Its many causes among young people include internal stressors, such as mental illness, trauma, overwhelming emotional pain, and struggles with gender identification or sexual orientation, and external stressors, such as bullying, homelessness or stressful events.[174] COVID-19 also proved to be an added stressor for student well-being. According to *Findings From the 2021 Ontario Student Drug Use and Health Survey*, 25.5 per cent of students in grades 7 to 12 had experienced serious psychological distress (up from 20.6% in 2019), 20 per cent had considered self-harm (up from 14.9% in 2019), and 18.4 per cent had engaged in suicidal ideation (up from 16.4% in 2019).[175]

Provincial and territorial strategies have often foregrounded youth as priority populations. Several provinces have created youth suicide prevention plans. Interestingly, after Quebec implemented its suicide prevention strategy in 1999, the province experienced a significant reduction in suicides, including a 50 per cent decrease in youth suicide. Among its targeted measures were special training for specific environments and populations, a telephone helpline, the development of networks in schools, and suicide awareness campaigns.[176]

Three strategies in Canada highlight the importance of focusing on youth suicide prevention.

The *National Aboriginal Youth Suicide Prevention Strategy* from 2013 emphasizes a strengths-based approach that recognizes traditional and cultural knowledge. Its primary prevention activities include connecting youth to Elders, decreasing social isolation, engaging youth in planning and implementing suicide awareness initiatives, and connecting youth to "community, the land, each other, Elders, [and] their family" (p. 110).[177]

Manitoba's *Reclaiming Hope* youth suicide prevention strategy (2008) is based on five key components: assessment and planning; mental health promotion; awareness and understanding; prevention, intervention, and postvention; and data, surveillance, research and

evaluation. Its holistic and community-based recommendations include youth subcommittees, traditional gathering events and forums, empowerment initiatives, community recreation funds, life-skills training, Mental Health First Aid, bereavement support, and crisis and treatment services in the North.

Alberta's *Building Strength, Inspiring Hope* (2019) focuses on reducing the rate of youth suicides and suicide attempts. Among the several actions it recommends are increasing culturally relevant and transitional supports, increasing peer-to-peer support and training, reducing access to lethal means, and decreasing stigma. The plan also highlights the "many risk factors [that] are the result of adverse childhood experiences" (p. 11),[178] which put youth who are exposed to them at a higher risk for suicide and mental health issues. The risk factors it identifies — "marginalization, inequality, racism, harassment, discrimination or isolation" — are seen to affect several priority populations: "Indigenous youth, immigrants, newcomers, and refugees, and LGBTQ2S+ youth" (p. 14).[179]

Internationally, the New Zealand strategy and action plan mentions youth as a vulnerable and target population and includes priorities on improving child and youth well-being, along with eliminating family and sexual violence and overhauling the welfare system. It also highlights the need to establish supports for youth in transition from care or the youth justice system.

SUICIDE PREVENTION FOR MILITARY VETERANS

Active military personnel and veterans of military service are distinct priority populations whose suicide rates exceed those of the general population. While men in Canada's general population are more likely to die by suicide than women, the risk for country's male veterans was 1.4 times as high as civilian men, according to the 2019 *Veteran Suicide Mortality Study* conducted by Veterans Affairs Canada (VAC). Younger male veterans (under 55) were most at risk, with a suicide rate 2.5 times as high as civilian men of the same age. Female veterans were also at higher risk than civilian females at 1.9 times as high.[180] Additionally, a 2016 Life After Service Studies (LASS) poll found that 8 per cent of regular force veterans seriously considered suicide in the previous year, while 21.7 per cent considered suicide in their lifetime.[181]

The *Joint Suicide Prevention Strategy* by the Canadian Armed Forces (CAF) and VAC acknowledges the prevalence of suicide in both the military and among veterans and shows a firm collaborative resolve between the CAF and VAC to address the issue. The strategy includes provisions for a peer support program for CAF members, veterans, and their families who have been impacted by an operational stress injury, mental health awareness and resilience training, services to assist members as they become veterans, and funding for new research and services. In all, "there are over 160 actions underway" (p. 15)[182] to prevent suicide deaths among CAF members and veterans. These include suicide awareness and prevention training for leaders, crisis support, veteran Mental Health First Aid training, operational stress injury clinics, a Veterans Justice Outreach initiative, and a Military Family Support program.

SUICIDE PREVENTION IN POST-SECONDARY INSTITUTIONS

Post-secondary students are particularly at risk for suicide, with high levels of anxiety and depression as they struggle with feelings of being overwhelmed.[183] The 2016 Canadian *National College Health Assessment* revealed that 13 per cent of students had seriously considered suicide, and 2.1 per cent had attempted suicide in the previous year.[184] In a 2020 review of

mental well-being and stress in post-secondary institutions, male students in the U.S. were found to attribute suicidal behaviours to academic competition, financial pressure, and workload, whereas female students identified family pressure, personal heartbreak, and mental health challenges as the main contributors to their suicidal behaviour.[185]

Post-secondary institutions are unique environments with diverse populations that intersect with several priority groups (youth, 2SLGBTQI+, international students, and others). Many Canadian academic institutions have mental health plans and strategies; however, both the University of Alberta and the University of Calgary have suicide prevention frameworks that highlight the need to address suicide specifically. Mount Royal University in Calgary has also published a suicide prevention framework.

The National Standard of Canada for Mental-Health and Well-Being for Post-Secondary Students is a set of voluntary guidelines to help post-secondary institutions improve student mental health and well-being by reducing stressors or risk factors, considering protective factors, and taking a system-wide or holistic approach. Key outcomes of the standard include increased awareness of mental health, decreased stigma around mental illness, healthier and safer environments, opportunities for student success and flourishing, and the promotion of life and resiliency skills. Although the guide describes suicide prevention activities as important, none are specifically recommended.

OLDER ADULTS

Suicide rates among older adults are high in Canada.[186,187] While there are many recommended and targeted interventions for this population, it is another priority group without a comprehensive suicide prevention strategy. Among Canadians aged 65 and older, 6.4 per cent have reported having thoughts of suicide during their lifetime, 1.3 per cent in the last 12 months. Whereas older women are more likely to attempt suicide, older men are more likely to die by suicide. In fact, it is higher than any other group, with the use of more lethal means a possible contributing factor. Other potential factors to suicide deaths in older adults include major life changes, experiences of loss, fewer relationships and connections, feelings of being a burden, declining health, the downsizing of homes, retirement, and chronic illness and pain.[188]

In 2020, PHAC reported that 8.3 per cent of Canadians aged 65 to 74 had considered suicide in their lifetime, compared to 5.1 per cent aged 75 or older.[189] Higher rates of mental health concerns and conditions are also reported among older adults (50 and up) who experience chronic homelessness. This includes anxiety (35%), depression (55%), bipolar disorder (15%), schizophrenia (3%), post-traumatic stress disorder (22%), personality disorder (9%), and psychotic disorder (3%).[190]

While older adults are at higher risk for suicide and need more targeted prevention efforts, few strategies or action plans include activities or recommendations specific to older adults. There are, however, innovative efforts to improve mental health outcomes for older adults in Canada. For example, Dr. Marin Heisel of Western University has developed a support group for older males who may face mental health challenges upon retirement. Known as Meaning-Centred Men's Groups, it involves "a 12-session existentially oriented, community-based, psychological group intervention designed to enhance psychological resiliency and prevent the onset or exacerbation of suicide ideation among men who are concerned about or struggling with the

transition to retirement" (Objectives, para. 1). Early evaluative findings of this intervention are encouraging.[191]

IMMIGRANTS, REFUGEES, AND NEWCOMERS

Newcomers to Canada (which include immigrants and refugees) may be at risk for suicidal behaviours. A 2019 study suggests that suicide and self-harm rates among recent immigrants are lower than long-term residents, whereas refugees were at higher risk than non-refugee immigrants. The study noted that country of origin accounted for some variability in suicide and self-harm rates among refugees.[192] The authors also found that Canada's immigration selection and settlement policies could explain this lower risk of suicide among immigrants, since the country's "immigration and settlement policies . . . target healthy and highly educated individuals, with high labor force participation," which may serve as a protection from suicide (p. 784).[193] A second study of suicide risk among immigrants to Europe found that non-European women, particularly South Asian and Sub-Saharan women, were at higher risk for attempted suicide.[194]

Newcomers may have experienced different types of violence or persecution in the past, along with current post-traumatic stress disorder or other challenges to their mental well-being.[195,196] People seeking asylum in Canada may have fears about disclosing thoughts of suicide, suicidal behaviours, or mental health challenges. In addition, they may be unsure of how doing so might affect their settlement process and fear cultural stigma from their own immigrant community.[197] The MHCC has long advocated for a distinct strategy to address mental health issues (including suicidality) among refugees and other newcomers to Canada.

Besides the possibility of facing discrimination, newcomers may also be unable to clearly communicate their thoughts and emotions, which can lead to feelings of frustration, hopelessness, and despair. In addition, when mental health services are not offered in a language they are comfortable with, they may find it difficult to communicate with mental health professionals when seeking help.[198,199]

OCCUPATIONAL RISKS

Suicide prevention is needed both in the workplace and in certain high-risk industries and occupations, such as those with greater access to lethal means, exposure to occupational trauma, and high job stress and insecurity.

A 2014 systematic review of workplace suicide prevention activities identified certain priority occupational groups, including farmers, police, and construction workers,[200] which significantly, are male dominated and often involve isolated settings and heavy emphasis on self-reliance.[201] A 2018 MHCC report also highlights heightened risk for suicide among physicians (especially female) and first responders.[202]

Some organizations, such as Wounded Warriors, have developed training programs to improve mental health outcomes for members of the occupation groups they serve. This Canadian organization was created to provide mental health services to veterans, first responders, and their families. One trauma-informed workplace training session, called Before Operational Stress, was developed in partnership with the Canadian Institute for Public Safety Research and Treatment and the Wayfound Mental Health Group, with financial support from PHAC. Its

purpose is to help public safety personnel identify risk factors for operational stress and learn how to reduce them through specific tools and strategies. The program is targeted to police officers, paramedics, firefighters, corrections officers, nurses, and personal support workers.

THE IMPORTANCE OF INTERSECTIONALITY

Intersectionality explores the dynamics between co-existing social identities (e.g., intersections between gender and race) and systems of power or oppression.[203] It is important to recognize the compounding effects that these multiple marginalized identities may have on individuals belonging to many of the previously mentioned groups.

References

[1] Shneidman, E. (1993). Suicide as psychache [Commentary]. *Journal of Nervous and Mental Disease*, 181 (3), 145-147. https://doi.org/10.1097/00005053-199303000-00001

[2] World Health Organization. (2014). *Preventing suicide: A global imperative*. https://tinyurl.com/tvsr582w

[3] Rochford, S., Dodd, P., & Austin, C. (2023). The public health approach to suicide prevention in Ireland. *Irish Journal of Psychological Medicine*, 40(1), 97-102. https://doi.org/10.1017/ipm.2021.72

[4] World Health Organization. (2018). *National suicide prevention strategies: Progress, examples and indicators* [Brochure]. https://www.who.int/publications/i/item/national-suicide-prevention-strategies-progress-examples-and-indicators

[5] World Health Organization. (2018). *National suicide prevention strategies: Progress, examples and indicators* [Brochure].

[6] World Health Organization. (2018).

[7] World Health Organization. (2021). *Suicide* [Fact sheet]. https://www.who.int/news-room/fact-sheets/detail/suicide

[8] Platt, S., Arensman, E., & Rezaeian, M. (2019). National suicide prevention strategies — Progress and challenges. *Crisis*, 40(2), 75-82. https://doi.org/10.1027/0227-5910/a000587

[9] Matsubayashi, T., & Ueda, M. (2011). The effect of national suicide prevention programs on suicide rates in 21 OECD nations. *Social Science and Medicine*, 73(9), 1395-1400. https://doi.org/10.1016/j.socscimed.2011.08.022

[10] Matsubayashi & Ueda. (2011). The effect of national suicide prevention programs on suicide rates in 21 OECD nations.

[11] World Health Organization. (2014). *Preventing suicide: A global imperative*.

[12] Matsubayashi & Ueda. (2011).

[13] Eggertson, L. (2017, January 16). Federal suicide prevention framework underwhelms [Editorial]. *Canadian Medical Association Journal*, 189(2), E96-E97. https://doi.org/10.1503/cmaj.109-5367

[14] Olson, R. (2016). *Does Canada need a national suicide prevention strategy?* Centre for Suicide Prevention. https://www.suicideinfo.ca/wp-content/uploads/2016/12/iE22-National-Strategy.pdf

[15] Public Health Agency of Canada. (2023). *2022 progress report: The federal framework for suicide prevention*. https://tinyurl.com/4vr6v9p3

[16] Canadian Centre on Substance Use and Addiction & Mental Health Commission of Canada. (2021). *Mental health and substance use during COVID-19: Summary report*. https://tinyurl.com/428m6fek

[17] Canadian Mental Health Association, University of British Columbia, Agenda Collaborative, Mental Health Foundation, & Maru/Matchbox. (n.d.). *Mental health impacts of COVID-19: Wave 2*. https://tinyurl.com/286rxt37

[18] Mehta, S., Machado, F., Kwizera, A., Papazian, L., Moss, M., Azoulay, É., & Herridge, M. (2021). COVID-19: A heavy toll on health-care workers. *Lancet Respiratory Medicine*, 9(3), 226-228. https://doi.org/10.1016/S2213-2600(21)00068-0

[19] Crawford, A. (2021). Advancing public mental health in Canada through a national suicide prevention service: Setting an agenda for Canadian standards of excellence [Editorial]. *Canadian Journal of Psychiatry*, 66(5), 446-450. https://doi.org/10.1177/0706743721989153

[20] World Health Organization. (2014).

[21] World Health Organization. (2021). *Live life: An implementation guide for suicide prevention in countries*. https://apps.who.int/iris/bitstream/handle/10665/341726/9789240026629-eng.pdf

[22] U.S. Department of Health and Human Services & Substance Abuse and Mental Health Services Administration. (2017). *National strategy for suicide prevention implementation assessment report*. https://tinyurl.com/3vhn2vsu

[23] U.K. Department of Health. (2012). *Preventing suicide in England: A cross-government outcomes strategy to save lives*. https://tinyurl.com/y47znree

[24] U.K. Department of Health. (2021). *Preventing suicide in England: Fifth progress report of the cross-government outcomes strategy to save lives*. https://tinyurl.com/2p8scyxd

[25] Ireland Department of Health. (2015). *Connecting for life: Ireland's national strategy to reduce suicide 2015-2024*. https://www.gov.ie/en/publication/7dfe4c-connecting-for-life-irelands-national-strategy-to-reduce-suicide-201/

[26] Iskander, J. K., & Crosby, A. E. (2021). Implementing the national suicide prevention strategy: Time for action to flatten the curve. *Preventive Medicine*, 152, Article 106734. https://doi.org/10.1016/j.ypmed.2021.106734

[27] Scottish Government. (2018). *Scotland's suicide prevention action plan: Every life matters*. https://tinyurl.com/yakbh4hm

[28] Olson, R. (2021). *The accuracy and reliability of suicide statistics: Why it matters* [Editorial]. Centre for Suicide Prevention. https://www.suicideinfo.ca/local_resource/accuracy-suicide-statistics/

[29] Olson, R. (2021). *The accuracy and reliability of suicide statistics: Why it matters*.

[30] Kelsall, D., & Bowes, M. J. (2016, February 16). No standards: Medicolegal investigation of deaths [Editorial]. *Canadian Medical Association Journal*, 188(3), 169. https://doi.org/10.1503/cmaj.160041

[31] Chief Coroners, Chief Medical Examiners, and Public Health Collaborative. (2021). *Identifying data gaps/evidence needs in Canada on suicide and its prevention* [Presentation]. Public Health Agency of Canada. https://tinyurl.com/5nueyuv6

[32] Pollock, N. J., Healey, G. K., Jong, M., Valcour, J. E., & Mulay, S. (2018). Tracking progress in suicide prevention in Indigenous communities: A challenge for public health surveillance in Canada. *BMC Public Health*, 18(1), Article 1320, 1-17. https://doi.org/10.1186/s12889-018-6224-9

[33] Ansloos, J. (2018). Rethinking Indigenous suicide. *International Journal of Indigenous Health*, 13(2), 8-28. https://doi.org/10.32799/ijih.v13i2.32061

[34] Saskatchewan Ministry of Health. (2020). *Pillars for life: Saskatchewan's suicide prevention plan.* https://tinyurl.com/yy82mbva

[35] Saskatchewan Ministry of Health. (2020). *Pillars for life: Saskatchewan's suicide prevention plan.*

[36] City of Edmonton. (2018). *Living hope: A community plan to prevent suicide in Edmonton 2018-2021.* https://www.edmonton.ca/sites/default/files/public-files/documents/PDF/living-hope-suicide-prevention-plan.pdf

[37] Prince Edward Island & Canadian Mental Health Association (P.E.I. Division). (2018). *The building blocks of hope: A suicide prevention strategy for Prince Edward Island.* https://tinyurl.com/y387h2pn

[38] Québec ministère de la Santé et des Services sociaux. (2022). *Rallumer l'espoir: La stratégie nationale de prévention du suicide 2022-2026.* https://publications.msss.gouv.qc.ca/msss/document-003383/

[39] Lévesque, P., Bardon, C., & Gariépy, G. (2021). *Vigie des idéations suicidaires et des tentatives de suicide en période de COVID-19 à partir du Système d'information de gestion des urgences*. https://tinyurl.com/yc8p5wha

[40] First Nations Information Governance Centre. (2023). *The First Nations principles of OCAP.* https://fnigc.ca/ocap-training/

[41] National Collaborating Centre for Indigenous Health. (2021). *Visioning the future: First Nations, Inuit, & Métis population and public health.* https://tinyurl.com/ybr2jub9

[42] National Collaborating Centre for Indigenous Health. (2021). *Visioning the future: First Nations, Inuit, & Métis population and public health.*

[43] British Columbia Office of the Human Rights Commissioner. (2020). *Disaggregated demographic data collection in British Columbia: The grandmother perspective*. https://tinyurl.com/5xyhjfpt

[44] Martin, D. H. (2012). Two-eyed seeing: A framework for understanding Indigenous and non-Indigenous approaches to Indigenous health research. *Canadian Journal of Nursing Research Archive*, 44(2), 20-43. https://tinyurl.com/2y5v83jv

[45] National Collaborating Centre for Indigenous Health. (2021).

[46] First Nations Information Governance Centre. (2023). *The First Nations principles of OCAP.*

[47] Inuit Tapiriit Kanatami. (2018). *National Inuit strategy on research: Implementation plan.* https://www.itk.ca/national-inuit-strategy-on-research-implementation-plan/

[48] National Collaborating Centre for Indigenous Health. (2021).

[49] National Collaborating Centre for Aboriginal Health. (2021).

[50] Government of Canada. (2018). *Budget 2018: Advancing reconciliation*. https://tinyurl.com/46mfrr7f

[51] World Health Organization. (2021). *Live life: An implementation guide for suicide prevention in countries*.

[52] Brodsky, B. S., Spruch-Feiner, A., & Stanley, B. (2018). The zero suicide model: Applying evidence-based suicide prevention practices to clinical care. *Frontiers in Psychiatry*, 9(33), 1-7. https://doi.org/10.3389/fpsyt.2018.00033

[53] van der Feltz-Cornelis, C. M., Sarchiapone, M., Postuvan, V., Volker, D., Roskar, S., Grum, A. T., Carli, V., McDaid, D., O'Connor, R., Maxwell, M., Ibelshäuser, A., Audenhove, C. V., Scheerder, G., Sisask, M., Gusmão, R., & Hegerl, U. (2011). Best practice elements of multilevel suicide prevention strategies. *Crisis*, 32(6), 319-333. https://tinyurl.com/mrxjzftc

[54] Matsubayashi & Ueda. (2011).

[55] Lewitzka, U., Sauer, C., Bauer, M., & Felber, W. (2019). Are national suicide prevention programs effective? A comparison of 4 verum and 4 control countries over 30 years. *BMC Psychiatry*, Article 19, 1-10. https://doi.org/10.1186/s12888-019-2147-y

[56] Värnik, A., Kõlves, K., van der Feltz-Cornelis, C. M., Marusic, A., Oskarsson, H., Palmer, A., Reisch, T., Scheerder, G., Arensman, E., & Aromaa, E. (2008). Suicide methods in Europe: A gender-specific analysis of countries participating in the "European Alliance Against Depression." *Journal of Epidemiology and Community Health*, 62(6), 545-551. http://dx.doi.org/10.1136/jech.2007.065391

[57] Barber, C. W., & Miller, M. J. (2014). Reducing a suicidal person's access to lethal means of suicide: A research agenda. *American Journal of Preventive Medicine*, 47(Suppl. 3), S264-S272. https://doi.org/10.1016/j.amepre.2014.05.028

[58] Mew, E. J., Padmanathan, P., Konradsen, F., Eddleston, M., Chang, S.-S., Phillips, M. R., & Gunnell, D. (2017). The global burden of fatal self-poisoning with pesticides 2006-15: Systematic review. *Journal of Affective Disorders*, 219, 93-104. https://doi.org/10.1016/j.jad.2017.05.002

[59] Barber & Miller. (2014). Reducing a suicidal person's access to lethal means of suicide: A research agenda.

[60] Zalsman, G., Hawton, K., Wasserman, D., van Heeringen, K., Arensman, E., Sarchiapone, M., Carli, V., Höschl, C., Barzilay, R., Balazs, J., Purebl, G., Kahn, J. P., Sáiz, P. A., Lipsicas, C. B., Bobes, J., Cozman, D., Hegerl, U., & Zohar, J. (2016). Suicide prevention strategies revisited: 10-year systematic review. *Lancet Psychiatry*, 3(7), 646-659. https://tinyurl.com/bdd474up

[61] Stanley, I. H., Hom, M. A., Rogers, M. L., Anestis, M. D., & Joiner, T. E. (2017). Discussing firearm ownership and access as part of suicide risk assessment and prevention: "Means safety" versus "means restriction." *Archives of Suicide Research*, 21(2), 237-253. https://doi.org/10.1080/13811118.2016.1175395

[62] Australian Department of Health and Aged Care. (2022). *National guidelines to improve coordination of treatment and supports for people with severe and complex mental illness*. https://tinyurl.com/yfwjjxzm

[63] Australian Department of Health and Aged Care. (2022). *National guidelines to improve coordination of treatment and supports for people with severe and complex mental illness*.

[64] Liu, L., Capaldi, C. A., Orpana, H. M., Kaplan, M. S., & Tonmyr, L. (2021). Changes over time in means of suicide in Canada: An analysis of mortality data from 1981 to 2018. *Canadian Medical Association Journal*, 193(10), E331-E338. https://doi.org/10.1503/cmaj.202378

[65] Gagliardi, A. R., Yip, C. Y. Y., Irish, J., Wright, F. C., Rubin, B., Ross, H., Green, R., Abbey, S., McAndrews, M. P., & Stewart, D. E. (2021). The psychological burden of waiting for procedures and patient-centred strategies that could support the mental health of wait-listed patients and caregivers during the COVID-19 pandemic: A scoping review. *Health Expectations*, 24(3), 978-990. https://doi.org/10.1111/hex.13241

[66] Gagliardi, et al. (2021). The psychological burden of waiting for procedures and patient-centred strategies that could support the mental health of wait-listed patients and caregivers during the COVID-19 pandemic: A scoping review.

[67] Butler, C. (2022, December 5). *Demand for mental health services has surged, pushing some providers to their limits.* CBC News. https://www.cbc.ca/news/canada/london/mental-health-wait-times-1.6672157

[68] French, C. (2021, March 1). *N.B. teen's death exposes shortcomings of public mental health supports in Canada*. CTV News. https://tinyurl.com/573r6bch

[69] Barry, R., Rehm, J., de Oliveira, C., Gozdyra, P., & Kurdyak, P. (2020). Rurality and risk of suicide attempts and death by suicide among people living in four English-speaking high-income countries: A systematic review and meta-analysis. *Canadian Journal of Psychiatry*, 65(7), 441-447. https://doi.org/10.1177/0706743720902655

[70] Public Health Agency of Canada. (2021). *The federal framework for suicide prevention — Progress report 2020*. https://tinyurl.com/bdcntd7m

[71] Public Health Agency of Canada. (2023). *2022 progress report: The federal framework for suicide prevention*.

[72] Prince Edward Island & Canadian Mental Health Association (P.E.I. Division). (2018).

[73] Yarr, K. (2022, December 19). *P.E.I. looks to Newfoundland to reduce mental health care waits.* CBC News. https://tinyurl.com/2upty7r3

[74] Yarr, K. (2022, December 19). *P.E.I. looks to Newfoundland to reduce mental health care waits.*

[75] Mental Health Commission of Canada. (2023). *Stepped care 2.0*. https://tinyurl.com/ycksfzx5

[76] Québec ministère de la Santé et des Services sociaux. (2022). *Rallumer l'espoir: La stratégie nationale de prévention du suicide 2022-2026*

[77] Whitley, R., Fink, D. S., Santaella-Tenorio, J., & Keyes, K. M. (2019). Suicide mortality in Canada after the death of Robin Williams, in the context of high-fidelity to suicide reporting guidelines in the Canadian media. *Canadian Journal of Psychiatry*, 64(11), 805-812. https://doi.org/10.1177/0706743719854073

[78] Sinyor, M., Williams, M., Tran, U. S., Schaffer, A., Kurdyak, P., Pirkis, J., & Niederkrotenthaler, T. (2019). Suicides in young people in Ontario following the release of *13 Reasons Why*. *Canadian Journal of Psychiatry*, 64(11), 798-804. https://doi.org/10.1177/0706743719870507

[79] Niederkrotenthaler, T., Stack, S., Till, B., Sinyor, M., Pirkis, J., Garcia, D., Rockett, I. R., & Tran, U. S. (2019). Association of increased youth suicides in the United States with the release of *13 Reasons Why*. *JAMA Psychiatry*, 76(9), 933-940. https://doi.org/10.1001/jamapsychiatry.2019.0922

[80] Carmichael, V., & Whitley, R. (2019). Media coverage of Robin Williams' suicide in the United States: A contributor to contagion? *PLoS ONE*, 14(5), Article e0216543. https://doi.org/10.1371/journal.pone.0216543

[81] Swanson, S. A., & Colman, I. (2013). Association between exposure to suicide and suicidality outcomes in youth. *Canadian Medical Association Journal*, 185(10), 870-877. https://doi.org/10.1503/cmaj.121377

[82] Bohanna, I. (2013). Suicide "contagion": What we know and what we need to find out [Commentary]. *Canadian Medical Association Journal*, 185(10), 861-862. https://doi.org/10.1503/cmaj.130678

[83] Robinson, J., Cox, G., Bailey, E., Hetrick, S., Rodrigues, M., Fisher, S., & Herrman, H. (2016). Social media and suicide prevention: A systematic review. *Early Intervention in Psychiatry*, 10(2), 103-121. https://doi.org/10.1111/eip.12229

[84] Robinson, et al. (2016). Social media and suicide prevention: A systematic review.

[85] Swedo, E. A., Beauregard, J. L., de Fijter, S., Werhan, L., Norris, K., Montgomery, M. P., Rose, E. B., David-Ferdon, C., Massetti, G. M., Hillis, S. D., & Sumner, S. A. (2021). Associations between social media and suicidal behaviors during a youth suicide cluster in Ohio. *Journal of Adolescent Health*, 68(2), 308-316. https://doi.org/10.1016/j.jadohealth.2020.05.049

[86] Swedo, et al. (2021). Associations between social media and suicidal behaviors during a youth suicide cluster in Ohio.

[87] Hawton, K., Hill, N. T., Gould, M., John, A., Lascelles, K., & Robinson, J. (2020). Clustering of suicides in children and adolescents. *Lancet Child and Adolescent Health*, 4(1), 58-67. https://doi.org/10.1016/S2352-4642(19)30335-9

[88] Hawton, et al. (2020). Clustering of suicides in children and adolescents.

[89] Zhang, H., Wang, Y., Zhang, Z., Guan, F., Zhang, H., & Guo, Z. (2021). Artificial intelligence, social media, and suicide prevention: Principle of beneficence besides respect for autonomy. *American Journal of Bioethics*, *21*(7), 43-45. https://doi.org/10.1080/15265161.2021.1928793

[90] Mishara, B. L., & Weisstub, D. N. (2013). Challenges in the control and regulation of suicide promotion and assistance over the internet. In B. L. Mishara & D. N. Weistraub (Eds.), *Suicide prevention and new technologies* (pp. 63-75). Palgrave Macmillan. https://doi.org/10.1057/9781137351692_5

[91] Minkkinen, J., Oksanen, A., Näsi, M., Keipi, T., Kaakinen, M., & Räsänen, P. (2015). Does social belonging to primary groups protect young people from the effects of pro-suicide sites? *Crisis*, *37*(1). https://doi.org/10.1027/0227-5910/a000356

[92] Robinson, J., Hill, N., Thorn, P., Teh, Z., Battersby, R., & Reavley, N. (2018). *#chatsafe: A young person's guide for communicating safely online about suicide*. Orygen. https://tinyurl.com/28f8xznh

[93] Robinson, J., Teh, Z., Lamblin, M., Hill, N. T. M., La Sala, L., & Thorn, P. (2021). Globalization of the #chatsafe guidelines: Using social media for youth suicide prevention. *Early Intervention in Psychiatry*, *15*(5), 1409-1413. https://doi.org/10.1111/eip.13044

[94] Robinson, et al. (2021). Globalization of the #chatsafe guidelines: Using social media for youth suicide prevention.

[95] Finland Ministry of Social Affairs and Health. (2020). *National mental health strategy and programme for suicide prevention 2020-2030*. https://tinyurl.com/y438xwvf

[96] Pirkis, J., Neal, L., Dare, A., Blood, R. W., & Studdert, D. (2009). Legal bans on pro-suicide web sites: An early retrospective from Australia. *Suicide and Life-Threatening Behavior*, *39*(2), 190-193. https://tinyurl.com/fmtt8pue

[97] Mishara & Weisstub. (2013). Challenges in the control and regulation of suicide promotion and assistance over the internet.

[98] Mishara & Weisstub. (2013).

[99] Canadian Journalism Forum on Violence and Trauma. (2020). *Mindset: Reporting on mental health*. https://www.mindset-mediaguide.ca/

[100] Sinyor, M., Schaffer, A., Heisel, M. J., Picard, A., Adamson, G., Cheung, C. P., Katz, L. Y., Jetly, R., & Sareen, J. (2018). Media guidelines for reporting on suicide: 2017 update of the Canadian Psychiatric Association policy paper. *Canadian Journal of Psychiatry*, *63*(3), 183-196. https://doi.org/10.1177/0706743717753147

[101] Talk Suicide Canada. (2023). *Suicide safe language*. https://talksuicide.ca/understanding-suicide/suicide-safe-language

[102] Council of Canadian Academies. (2023). *Vulnerable connections: The expert panel on public safety in the digital age*. https://cca-reports.ca/reports/public-safety-in-the-digital-age/

[103] Prince Edward Island & Canadian Mental Health Association (P.E.I. Division). (2018).

[104] Prince Edward Island & Canadian Mental Health Association (P.E.I. Division). (2018).

[105] Province of Nova Scotia. (2020). *Preventing and reducing the risk of suicide: A framework for Nova Scotia*. https://tinyurl.com/yckwfnv7

[106] Province of Nova Scotia. (2020). *Preventing and reducing the risk of suicide: A framework for Nova Scotia*.

[107] Alberta Government. (2019). *Building strength, inspiring hope: A provincial action plan for youth suicide prevention 2019-2024*. https://open.alberta.ca/publications/9781460140987

[108] Canadian Association for Suicide Prevention. (2009). *The CASP blueprint for a Canadian national suicide prevention strategy*. https://tinyurl.com/bdfeasjj

[109] World Health Organization. (2014).

[110] Scottish Government. (2018). *Scotland's suicide prevention action plan: Every life matters*.

[111] Scottish Government. (2022). *Creating hope together: Suicide prevention strategy 2022 to 2032*. https://www.gov.scot/publications/creating-hope-together-scotlands-suicide-prevention-strategy-2022-2032/

[112] Québec ministère de la Santé et des Services sociaux. (2022).

[113] Québec ministère de la Santé et des Services sociaux. (2022).

[114] Innovation, Science and Economic Development Canada. (2019). *High-Speed access for all: Canada's connectivity strategy*. https://tinyurl.com/2p8dsabd

[115] Zarum, D. (2022, February 14). Rural internet could hold the key to Canada's economic future. *Pivot Magazine*. https://www.cpacanada.ca/en/news/pivot-magazine/2021-02-14-rural-internet

[116] Inuit Tapiriit Kanatami. (2021). *The digital divide: Broadband connectivity in Inuit Nunangat*. https://www.itk.ca/the-digital-divide-broadband-connectivity-in-inuit-nunangat/

[117] Zarum, D. (2022). Rural internet could hold the key to Canada's economic future.

[118] Innovation, Science and Economic Development Canada. (2023). *Canada's digital charter*. https://tinyurl.com/rtbcwsm4

[119] Innovation, Science and Economic Development Canada. (2023). *High-Speed internet for all Canadians*. https://ised-isde.canada.ca/site/high-speed-internet-canada/en

[120] World Health Organization. (2018). *Preventing suicide: A community engagement toolkit*. https://tinyurl.com/bddksra9

[121] World Health Organization. (2014).

[122] World Health Organization. (2018). *Preventing suicide: A community engagement toolkit*.

[123] Thunderbird Partnership Foundation. (2015). *First Nations mental wellness continuum framework.* https://thunderbirdpf.org/?resources=first-nations-mental-wellness-continuum-framework

[124] Lipsicas, C. B., & Mäkinen, I. H. (2010). Immigration and suicidality in the young. *Canadian Journal of Psychiatry*, 55(5), 274-281. https://journals.sagepub.com/doi/pdf/10.1177/070674371005500502

[125] Canadian Centre on Substance Use and Addiction & Mental Health Association of Canada. (2023). *Intersections of substance use and suicide: Evidence and key takeaways* [Unpublished manuscript].

[126] Health Canada. (2022). *Minister of mental health and addictions and associate minister of health pocket book.* https://tinyurl.com/nv7v5t6p

[127] Olson, R. (2013). *Trauma, substance abuse and suicide prevention* [Editorial]. Centre for Suicide Prevention. https://www.suicideinfo.ca/local_resource/traumaandsuicide/

[128] Fitzpatrick, S. J., & River, J. (2018). Beyond the medical model: Future directions for suicide intervention services. *International Journal of Health Services*, 48(1), 189-203. https://doi.org/10.1177/0020731417716086

[129] Fitzpatrick & River. (2018). Beyond the medical model: Future directions for suicide intervention services.

[130] Black Dog Institute. (2020). *What can be done to decrease suicidal behaviour in Australia? A call to action*. https://tinyurl.com/245ztshf

[131] Statistics Canada. (2017). *Health indicators, by Aboriginal identity, age-standardized rates, four-year period estimates* (Table 13-10-0458-01 [formerly CANSIM 105-0513]). https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1310045801

[132] Kumar, M. B., & Tjepkema, M. (2019). *Suicide among First Nations people, Métis and Inuit (2011-2016): Findings from the 2011 Canadian census health and environment cohort (CanCHEC).* https://tinyurl.com/ym33fm3r

[133] Chandler, M. J., & Lalonde, C. E. (2008). Cultural continuity as a protective factor against suicide in First Nations youth. *Horizons*, 10(1), 68-72. https://tinyurl.com/34d7mpj7

[134] Crawford, A. (2016). Suicide among Indigenous peoples in Canada. *Canadian Encyclopedia.* https://www.thecanadianencyclopedia.ca/en/article/suicide-among-indigenous-peoples-in-canada

[135] Fast, E., & Collin-Vezina, D. (2019). Historical trauma, race-based trauma, and resilience of Indigenous peoples: A literature review. *First Peoples Child and Family Review*, 14(1), 166-181. https://tinyurl.com/5n6uet8t

[136] Métis Nation of Alberta Department of Health. (2022). *Life promotion guide: Weaving together Métis knowledge and practice.* https://albertametis.com/app/uploads/2022/03/Life-Promotion-Guide-V5.pdf

[137] Health Canada. (2022, March 14). Government of Canada begins work with partners on national standards for mental health and substance use services [News release]. https://tinyurl.com/2p9xv5wv

[138] King, C. A., Horwitz, A., Czyz, E., & Lindsay, R. (2017). Suicide risk screening in healthcare settings: Identifying males and females at risk. *Journal of Clinical Psychology in Medical Settings*, 24(1), 8-20. https://doi.org/10.1007/s10880-017-9486-y

[139] Moscardini, E. H., Hill, R. M., Dodd, C. G., Do, C., Kaplow, J. B., & Tucker, R. P. (2020). Suicide safety planning: Clinician training, comfort, and safety plan utilization. *International Journal of Environmental Research and Public Health*, 17(18), Article 6444. https://doi.org/10.3390/ijerph17186444

[140] Stanley, B., Brown, G. K., Brenner, L. A., Galfalvy, H. C., Currier, G. W., Knox, K. L., Chaudhury, S. R., Bush, A. L., & Green, K. L. (2018). Comparison of the safety planning intervention with follow-up vs usual care of suicidal patients treated in the emergency department. *JAMA Psychiatry*, 75(9), 894-900. https://doi.org/10.1001/jamapsychiatry.2018.1776

[141] Struszczyk, S., Galdas, P. M., & Tiffin, P. A. (2019). Men and suicide prevention: A scoping review. *Journal of Mental Health*, 28(1), 80-88. https://doi.org/10.1080/09638237.2017.1370638

[142] Gamarra, J. M., Luciano, M. T., Gradus, J. L., & Stirman, S. W. (2015). Assessing variability and implementation fidelity of suicide prevention safety planning in a regional VA healthcare system. *Crisis*. https://doi.org/10.1027/0227-5910/a000345

[143] Green, J. D., Kearns, J. C., Rosen, R. C., Keane, T. M., & Marx, B. P. (2018). Evaluating the effectiveness of safety plans for military veterans: Do safety plans tailored to veteran characteristics decrease suicide risk? *Behavior Therapy*, 49(6), 931-938. https://doi.org/10.1016/j.beth.2017.11.005

[144] Ferguson, M., Rhodes, K., Loughhead, M., McIntyre, H., & Procter, N. (2022). The effectiveness of the safety planning intervention for adults experiencing suicide-related distress: A systematic review. *Archives of Suicide Research*, 26(3), 1022-1045. https://doi.org/10.1080/13811118.2021.1915217

[145] Mental Health Commission of Canada. (2012). *Changing directions, changing lives: The mental health strategy for Canada.* https://mentalhealthcommission.ca/resource/mental-health-strategy-for-canada/

[146] Bryan, C. J., Allen, M. H., & Hoge, C. W. (2023). Weighing the costs and benefits of universal suicide risk screening in primary care: An evidence-based approach. *Psychiatric Services*, 74(1), 79-81. https://doi.org/10.1176/appi.ps.202100611

[147] Hawgood & De Leo. (2016). Suicide prediction — A shift in paradigm is needed. *Crisis*, 37(4), 251-255. https://doi.org/10.1027/0227-5910/a000440

[148] Health Standards Organization. (2022). CAN/HSO 5064:2023 — *Suicide prevention program.* https://tinyurl.com/4bm88t9h

[149] U.S. Department of Health and Human Services Office of the Surgeon General & National Action Alliance for Suicide Prevention. (2012). *2012 National strategy for suicide prevention: Goals and objectives for action.* https://tinyurl.com/yfd7ep98

[150] U.S. Department of Health and Human Services & Substance Abuse and Mental Health Services Administration. (2017). *National strategy for suicide prevention implementation assessment report.*

[151] U.S. Department of Health and Human Services & Substance Abuse and Mental Health Services Administration. (2017).

[152] Cantor, J. H., Holliday, S. B., McBain, R. K., Matthews, S., Bialas, A., Eberhart, N. K., & Breslau, J. (2022). *Preparedness for 988 throughout the United States: The new mental health emergency hotline*. RAND Corporation. https://tinyurl.com/3kfs3brp

[153] Crawford, A. (2021). Advancing public mental health in Canada through a national suicide prevention service: Setting an agenda for Canadian standards of excellence.

[154] Burnette, C., Ramchand, R., & Ayer, L. (2015). Gatekeeper training for suicide prevention: A theoretical model and review of the empirical literature. *Rand Health Quarterly*, 5(1). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5158249/

[155] Holmes, G., Clacy, A., & Lagopoulos, J. (2018, November 28-30). *Alliance against depression and suicide: Gatekeeper training, engagement, and retention in a regional community* [Poster presentation]. Society for Mental Health Research (SMHR) Conference, Noosa, Australia. https://tinyurl.com/yc2e5wmr

[156] Holmes, G., Clacy, A., Hermens, D., & Lagopoulos, J. (2021). The long-term efficacy of suicide prevention gatekeeper training: A systematic review *Archives of Suicide Research*, 25(2), 177-207. https://doi.org/10.1080/13811118.2019.1690608

[157] City of Edmonton. (2018). *Living hope: A community plan to prevent suicide in Edmonton* 2018-2021. https://www.edmonton.ca/sites/default/files/public-files/documents/PDF/living-hope-suicide-prevention-plan.pdf

[158] Saskatchewan Ministry of Health. (2020).

[159] Government of Nunavut, Nunavut Tunngavik, Royal Canadian Mounted Police V-Division, & Embrace Life Council. (2017). *United for life: Inuusivut Anninaqtuq action plan* 2017-2022. https://tinyurl.com/frbbwhnt

[160] Bostwick, J. M., Pabbati, C., Geske, J. R., & McKean, A.J. (2016). Suicide attempt as a risk factor for completed suicide: Even more lethal than we knew. *American Journal of Psychiatry*, 173(11), 1094-1100. https://doi.org/10.1176/appi.ajp.2016.15070854

[161] New Zealand Ministry of Health. (2019). Every life matters — He tapu te oranga o ia tangata: Suicide prevention strategy 2019–2029 and suicide prevention action plan 2019–2024 for Aotearoa New Zealand.

[162] Bergmans, Y., Gordon, E., & Eynan, R. (2017). Surviving moment to moment: The experience of living in a state of ambivalence for those with recurrent suicide attempts. *Psychology and Psychotherapy*, 90(4), 633-648. https://doi.org/10.1111/papt.12130

[163] Gaffney, A., & Bergmans, Y. (2022). Healing from recurrent suicide attempts: The impact of being a peer facilitator. *Social Work in Mental Health*, 20(5), 542-558. https://www.tandfonline.com/doi/abs/10.1080/15332985.2022.2033904

[164] Salway, T., Gesink, D., Ferlatte, O., Rich, A. J., Rhodes, A. E., Brennan, D. J., & Gilbert, M. (2021). Age, period, and cohort patterns in the epidemiology of suicide attempts among sexual minorities in the United States and Canada: Detection of a second peak in middle adulthood. *Social Psychiatry and Psychiatric Epidemiology*, 56(2), 283-294. https://doi.org/10.1007/s00127-020-01946-1

[165] Lee, C., Oliffe, J. L., Kelly, M. T., & Ferlatte, O. (2017). Depression and suicidality in gay men: Implications for health care providers. *American Journal of Men's Health*, 11(4), 910-919. https://doi.org/10.1080/23761407.2017.1316221

[166] Dickey, L. M., & Budge, S. L. (2020). Suicide and the transgender experience: A public health crisis. *American Psychologist*, 75(3), 380-390. https://doi.org/10.1037/amp0000619

[167] Price-Feeney, M., Green, A. E., & Dorison, S. (2020). Understanding the mental health of transgender and nonbinary youth. *Journal of Adolescent Health*, 66(6), 684-690. https://doi.org/10.1016/j.jadohealth.2019.11.314

[168] Prokopenko, E., & Hango, D. (2022). *Bullying victimization among sexually and gender diverse youth in Canada*. Statistics Canada. https://www150.statcan.gc.ca/n1/pub/75-006-x/2022001/article/00010-eng.htm

[169] Centre for Addiction and Mental Health. (2020). *Suicide prevention: A review and policy recommendations.* https://tinyurl.com/msbxp9nw

[170] Ferlatte, O., Salway, T., Oliffe, J. L., Saewyc, E. M., Holmes, C., Schick, L., Purdie, A., Damstrom-Albach, D., Mantler, E. R. G., Ho, D., & Knight, R. (2020). It is time to mobilize suicide prevention for sexual and gender minorities in Canada. *Canadian Journal of Public Health*, 111(5), 737-742. https://doi.org/10.17269/s41997-020-00316-3

[171] Statistics Canada. (2022). *Leading causes of death, total population, by age group* (Table 13-10-0394-01). https://tinyurl.com/yc5jz5js

[172] Statistics Canada. (2022). *Leading causes of death, total population, by age group* (Table 13-10-0394-01).

[173] Statistics Canada. (2022). *Leading causes of death, total population, by age group* (Table 13-10-0394-01).

[174] Zenere, F. J., & Lazarus, P. J. (2009). The sustained reduction of youth suicidal behavior in a urban, multicultural school district. *School Psychology Review*, 38(2), 189–199. https://doi.org/10.1080/02796015.2009.12087831

[175] Boak, A., Elton-Marshall, T., & Hamilton, H. A. (2021). *The well-being of Ontario students: Findings from the 2021 Ontario Student Drug Use and Health Survey*. Centre for Addiction and Mental Health. https://tinyurl.com/583jkhey

[176] Dupuis, P., Marchand, B., & Association québécoise de prévention du suicide (2013, September 24-28). *Decrease in suicide rates in Quebec: A brief look at four strategies* [Poster presentation]. The XXVII World Congress of the International Association for Suicide Prevention, Oslo, Norway. https://www.iasp2013.org/images/book_of_abstracts_IASP2013.pdf

[177] Health Canada. (2013). National Aboriginal youth suicide prevention strategy (NAYSPS) program framework. https://www.sac-isc.gc.ca/eng/1576092066815/1576092115467

[178] Alberta Government. (2019). *Building strength, inspiring hope: A provincial action plan for youth suicide prevention* 2019-2024.

[179] Alberta Government. (2019).

[180] Simkus, K., Hall, A., Heber, A., & Van Til, L. (2020). *2019 Veteran suicide mortality study: Follow-up period from 1976 to 2014*. Veterans Affairs Canada. https://tinyurl.com/btrs4y9h

[181] Van Til, L., Sweet, J., Poirier, A., McKinnon, K., & Pedlar, D. (2017). *Well-being of Canadian regular force veterans: Findings from LASS 2016 survey* (Research directorate technical report). Veterans Affairs Canada. https://tinyurl.com/ympvcbfh

[182] Canadian Armed Forces & Veterans Affairs Canada. (2017). *Joint suicide prevention strategy*.

[183] Treleaven, S., (2022, November 14). Inside the mental heatlh crisis at Canadian universities. *Macleas's*. https://education.macleans.ca/feature/inside-the-mental-health-crisis-at-canadian-universities/

[184] Porter, S. (2019). A descriptive study of post-secondary student mental health crises. *College Quarterly*, *22*(1). https://tinyurl.com/mt8sane3

[185] Linden, B., & Stuart, H. (2020). Post-secondary stress and mental well-being: A scoping review of the academic literature. *Canadian Journal of Community Mental Health*, 39(1), 1-32. https://doi.org/10.7870/cjcmh-2020-002

[186] Canadian Coalition for Seniors' Mental Health. (n.d.). *Suicide risk and prevention of suicide*. https://ccsmh.ca/projects/suicide/

[187] Centre for Suicide Prevention. (2019). *Older adults and suicide* [Fact sheet]. https://tinyurl.com/yv75pkub

[188] Mental Health Commission of Canada. (2022). Older adults and suicide [Fact sheet]. https://tinyurl.com/bddybs33

[189] Public Health Agency of Canada. (2020). *Aging and chronic diseases: A profile of Canadian seniors* (Catalogue No. HP35-137/1-2020E-PDF). https://tinyurl.com/mrxsas9p

[190] Milaney, K., Kamran, H., & Williams, N. (2020). A portrait of late life homelessness in Calgary, Alberta. *Canadian Journal on Aging*, 39(1), 42-51. https://doi.org/10.1017/S0714980819000229

[191] Heisel, M. J., Moore, S. L., Flett, G. L., Norman, R. M. G., Links, P. S., Eynan, R., O'Rourke, N., Sarma, S., Fairlie, P., & Wilson, K. (2020). Meaning-centered men's groups: Initial findings of an intervention to enhance resiliency and reduce suicide risk in men facing retirement. *Clinical Gerontologist*, 43(1), 76-94. https://doi.org/10.1080/07317115.2019.1666443

[192] Saunders, N. R., Chiu, M., Lebenbaum, M., Chen, S., Kurdyak, P., Guttmann, A., & Vigod, S. (2019). Suicide and self-harm in recent immigrants in Ontario, Canada: A population-based study. *Canadian Journal of Psychiatry*, 64(11), 777-788. https://doi.org/10.1177/0706743719856851

[193] Saunders, et al. (2019). Suicide and self-harm in recent immigrants in Ontario, Canada: A population-based study.

[194] Forte, A., Trobia, F., Gualtieri, F., Lamis, D. A., Cardamone, G., Giallonardo, V., Fiorillo, A., Girardi, P., & Pompili, M. (2018). Suicide risk among immigrants and ethnic minorities: A literature overview. *International Journal of Environmental Research and Public Health*, 15(7), Article 1438. https://doi.org/10.3390/ijerph15071438

[195] World Health Organization. (2021). *Mental health and forced displacement* [Fact sheet]. *https://tinyurl.com/yckhefrw*

[196] American Psychiatric Association. (n.d.). *Mental health facts on refugees, asylum seekers, and survivors of forced displacement*. https://tinyurl.com/yj7xtxu9

[197] Olsen, R. (2012). *Suicide prevention and cultural sensitivity*. Centre for Suicide Prevention. https://tinyurl.com/3e4pkwhn

[198] Lipsicas, C. B., & Mäkinen, I. H. (2010). Immigration and suicidality in the young. *Canadian Journal of Psychiatry*, 55(5), 274-281. https://journals.sagepub.com/doi/pdf/10.1177/070674371005500502

[199] Hagaman, A. K., Sivilli, T. I., Ao, T., Blanton, C., Ellis, H., Lopes Cardozo, B., & Shetty, S. (2016). An investigation into suicides among Bhutanese refugees resettled in the United States between 2008 and 2011. *Journal of Immigrant and Minority Health*, 18, 819-827. https://doi.org/10.1007/s10903-015-0326-6

[200] Milner, A., Page, K., Spencer-Thomas, S., & LaMontagne, A. D. (2014). Workplace suicide prevention: A systematic review of published and unpublished activities. *Health Promotion International*, 30(1), 29-37. https://doi.org/10.1093/heapro/dau085

[201] Milner, A., Currier, D., LaMontagne, A. D., Spittal, M., & Pirkis, J. (2017). Psychosocial job stressors and thoughts about suicide among males: A cross-sectional study from the first wave of the Ten to Men cohort. *Public Health*, 147, 72-76. https://doi.org/10.1016/j.puhe.2017.02.003

[202] Mental Health Commission of Canada & Public Health Agency of Canada. (2018). *Research on suicide and its prevention: What the current evidence reveals and topics for future research*. https://tinyurl.com/3xakahz3

[203] Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. *University of Chicago Legal Forum*, 1989(1), Article 8, 139-167. https://chicagounbound.uchicago.edu/uclf/vol1989/iss1/8

Appendix

International strategies and plans

Jurisdiction	Title	Implementation date	Mentions data infrastructure	Mentions evidence-based best practices	Mentions safe and responsible reporting	Mentions online resource hub	Mentions community-based programs	Mentions training standards
Australia	*National Suicide Prevention Strategy*	2020	☑	☑	☑		☑	☑
Austria	*SUPRA (Suicide Prevention Austria)*	2012	☑	☑	☑			☑
England	*Preventing Suicide in England*	2012	☑	☑	☑		☑	☑
Finland	*Programme for Suicide Prevention*	2020	☑	☑	☑		☑	☑
Ireland	*Connecting for Life*	2015	☑	☑	☑		☑	☑
New Zealand	*Every Life Matters*	2019	☑	☑			☑	☑
Northern Ireland	*Protect Life 2*	2019	☑	☑	☑		☑	☑
Scotland	*Suicide Prevention Action Plan: Every Life Matters*	2018	☑	☑				☑
Switzerland	*National Action Plan for Suicide Prevention*	2016	☑	☑	☑		☑	☑
Sweden	*National Action Programme for Suicide Prevention*	2016	☑	☑				☑
United States	*National Strategy for Suicide Prevention*	2012	☑	☑	☑	☑	☑	☑
Wales	*Talk to Me 2*	2015		☑				☑

Provincial and territorial strategies and plans

Jurisdiction	Title	Implementation date	Mentions data infrastructure	Mentions evidence-based best practices	Mentions safe and responsible reporting	Mentions online resource hub	Mentions community-based programs	Mentions training standards
Quebec	*Rallumer l'espoir*	2022	☑	☑	☑	☑	☑	☑
Newfoundland and Labrador	*Our Path of Resilience*	2022	☑	☑			☑	☑
Nova Scotia	*Preventing and Reducing the Risk of Suicide*	2020	☑	☑			☑	☑
Nunavut	*Suicide Prevention Strategy*	2010		☑			☑	☑
	Resiliency Within	2016	☑	☑			☑	☑
	Inuusivut Anninaqtuq	2017	☑	☑			☑	☑
Prince Edward Island	*The Building Blocks of Hope*	2018	☑	☑	☑		☑	☑
Saskatchewan	*Pillars for Life*	2020	☑	☑	☑		☑	☑

Population-based strategies and plans

Population	Title	Implementation date	Mentions data infrastructure	Mentions evidence-based best practices	Mentions safe and responsible reporting	Mentions online resource hub	Mentions community-based programs	Mentions training standards
First Nations	*Saskatchewan First Nations Suicide Prevention Strategy*	2018		☑			☑	☑
Indigenous youth	*National Aboriginal Youth Suicide Prevention Strategy*	2013		☑			☑	☑
Inuit	*National Inuit Suicide Prevention Strategy*	2016		☑			☑	☑
Military	*Canadian Armed Forces and Veterans Affairs Canada Joint Suicide Prevention Strategy*	2017	☑	☑				☑
Post-secondary	*University of Alberta Suicide Prevention Framework*	2018		☑			☑	☑
	Mount Royal University Suicide Prevention Strategic Framework	2021		☑	☑		☑	☑
	University of Calgary Suicide awareness and prevention framework			☑				☑
Youth (Alberta)	*Building Strength, Inspiring Hope: A Provincial Action Plan for Youth Suicide Prevention*	2019	☑	☑		☑	☑	☑

Mental Health Commission of Canada
Commission de la santé mentale du Canada

Mental Health Commission of Canada, 2023
Suite 1210, 350 Albert Street
Ottawa, ON. K1R 1A4
Tel: 613.683.3755
Fax: 613.798.2989

@MHCC_ /theMHCC
/1MHCC @theMHCC
/Mental Health Commission of Canada
/theMHCC