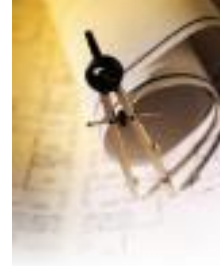




Canadian Association for Suicide Prevention
L'association canadienne pour la prévention du suicide

The CASP National Suicide Prevention Strategy



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1. Introduction to the Second Edition

The CASP Strategy was first published in 2004 by the Canadian Association for Suicide Prevention with input from many other organizations and individuals. While most industrialized countries have national strategies to reduce suicide, often aided by the leadership of Canadian experts involved in the development of the United Nations guidelines for the formulation and implementation of national suicide prevention strategies, Canada has not. In 2002, the Board members of CASP decided it was our duty as a national organization to take up the challenge and the lead in developing a National Strategy for Suicide Prevention. In 2004, the CASP Strategy for a Canadian National Suicide Prevention Strategy was released to all Canadians and all levels of government.

The CASP Strategy for a Canadian National Suicide Prevention Strategy has become the strategy for suicide prevention initiatives throughout Canada as seen in the development of provincial strategies in Nova Scotia and Alberta with ongoing projects in British Columbia, Manitoba, Ontario and New Brunswick. Significant support for our Strategy was provided in May 2006 when the Final Report of The Standing Senate Committee on Social Affairs, Science and Technology “*Out of the Shadows at Last*” recommended that “the federal government support the efforts of the Canadian Association for Suicide Prevention and other organizations working to develop a national suicide prevention strategy.”

In keeping with the advancements in the field of suicidology, our expertise, experience, and science, this edition will include some of the more recent knowledge and understanding in this emerging field, recognizing that as soon as new knowledge is spoken or printed, it oftentimes becomes designated as the “old news” of tomorrow.

One important vocabulary change throughout the document will be the inclusive terms: *Suicide-Related Behaviours* and *Suicide-Related Communications* (Silverman et al. 2007 – see reference list). *Suicide-Related Behaviours* include the broad spectrum of suicidal behaviours from self harm, with or without intent to die, to attempts to end one’s life and suicide. *Suicide-Related Communications* include two subsets, either a Suicide Plan or a Suicide Threat where there is no injurious outcome.

What is the Strategy?

This Strategy is a proposed national suicide prevention strategy for Canada. It is also a policy agenda, a national task list, a tool for identifying promising and best practices, and a roadmap to an integrated solution. As you will see, it covers every aspect of our concerns as a nation respecting suicide prevention, research, education, treatment, crisis intervention and bereavement support. As researchers, authors and suicide prevention leaders, we have tried to address issues, needed improvements, and emerging promising practices in a practical, achievable and humane manner. While we accept that any Pan-Canadian strategy will require public debate and national input, we have put forward our Strategy as a starting point, hoping to challenge, motivate and assist our lawmakers and governments to fulfill their leadership roles.

The CASP Strategy: A Three Year Effort and Beyond

2003 ~ Strategy, Research, Planning Sessions

- Strategic planning sessions to develop a framework and process strategy involving volunteer CASP Board members and a group of invited volunteer participants: clinicians, researchers, teachers, program administrators, consumers and survivors. In addition to professional designations, each member had the expertise of a personal loss through suicide, alongside other designations such as parents, brothers, sisters, children, family members, partners, friends, neighbours, patients, and professionals.

- We agreed that the Goal of the Strategy would be: *“To unite all communities, governments, organizations and resources across Canada with CASP and our stakeholders to work effectively together to prevent death by suicide and to assist, educate and comfort those who have been impacted by suicide-related behaviors.”*

1I. Acknowledgements

Members of the Board of Directors of the Canadian Association prepared the First Edition of the Strategy for Suicide Prevention with assistance from other organizations and individuals.

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2004 ~ Writing, Peer review, Editing

- Beginning in 2004, initial drafts are written by a team of four -- a psychiatrist, a psychologist, a social worker/researcher and a lawyer/addictionologist
- Submitted across Canada for peer review
- Fourteen formal revisions
- Second peer review
- First published edition of the CASP Strategy sent for review by all Canadians, members of the World Health Organization and the United Nations.
- Public announcement of the Strategy at the CASP Annual Convention in Edmonton, October 2004.

2005 ~ Developing a Business Implementation Plan, Budget and Timeline

- CASP Board makes presentations to introduce the Strategy and Business Implementation Plan across Canada believing that involvement and partnership with governments, agencies and citizens' initiatives is essential to the development and successful completion of an integrated solution for suicide prevention.
- CASP members make citizen presentations to the Kirby Commission
- CASP members make citizen presentations to the Canadian Mental Health Association
- CASP members make citizen presentations to the Canadian Alliance on Mental Illness and Mental Health

October 2005 CASP Annual Conference, CASP Business and Implementation Plan for 2006-2007

- Delivered to the Federal Minister of Health Honorable Ujjal Dosanjh who acknowledged the years of effort, the achievement of the CASP Strategy, promising that suicide prevention would be "one of the legs on the foundation of a national mental health strategy – the best in the world."

May, 2006: Suicide prevention on the national stage

- The Final Report of The Standing Senate Committee on Social Affairs, Science and Technology "Out of the Shadows at Last" recommends that "the federal government support the efforts of the Canadian Association for Suicide Prevention and other organizations working to develop a national suicide prevention strategy." (Recommendation 106; page 427)

2007~ Pushing Forward

At the provincial level, Alberta and Nova Scotia have used the CASP Strategy to complete their own provincial strategies, while in Nunavut, Manitoba, New Brunswick, British Columbia and Ontario communities of concerned citizens are currently using the CASP Strategy as the catalyst for working towards their provincial strategies. With the Québec Strategy already in place for many years, Canada as a whole is turning the corner.

2008-2009

At this five year anniversary of the original release of the Strategy, we can celebrate its success in creating a tool which has helped provinces and territories work towards suicide prevention strategies. In presenting our second edition, we acknowledge the help and guidance we have enjoyed and we use it to remind ourselves that the work must continue if Canada is to adopt its own national suicide prevention strategy.

Dr. Paul Links, a past CASP president, initiated this second edition project. We acknowledge his leadership and effort with the contributions of CASP Board members Bonny Ball, Yvonne Bergmans Marnin Heisel, Adrian Hill, Richard Ramsey and Tim Wall. The CASP Strategy remains the only national suicide prevention strategy in the world produced entirely by volunteers and without government funding. Our second edition editors were Yvonne Bergmans, Mary-Jo Bolton and Adrian Hill.

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III. Dedication

We are the Canadian Association for Suicide Prevention, its Executive and Board, its members, friends, and supporters. We are Canadians who want to reduce suicide and its impact in Canada. We want to end the silence. We want to ease the suffering, to heal our communities and our neighbours, as we have healed ourselves. We are survivors of loss. Among us, we have lost children, parents, family members, neighbours, friends, and patients. Some of us have attempted suicide ourselves. We want to end the silence and prevent others from experiencing such loss.

*Why would a small group of dedicated individuals believe that by working together
we can change the world?*

Because, throughout history, it is the only thing that ever has.

-Margaret Mead

CASP's National Suicide Prevention Strategy follows our study and research, our knowledge and expertise. More importantly, it reflects our experience, strength and hope. It is dedicated to the memory of those dear to us who have died by suicide, to my mother, to your child, parent, family member, friend, neighbour, colleague, clients, patients. We make this Dedication in the belief that we can heal ourselves and help our country and our communities to lessen the suffering and to prevent suicide – *Adrian Hill, Editor 2004*

1V. Introduction

A National Strategy for Canada

To unite all communities, governments, organizations and resources across Canada with CASP and our stakeholders to work effectively together to prevent death by suicide and to assist, educate and comfort those who have been impacted by suicide-related behaviours.

Suicide is most often the result of pain, hopelessness and despair. It is almost always preventable through caring, compassion, commitment and community.

Suicide in Canada

In the past three decades, more than 100,000 Canadians died by suicide. Every year in Canada, an average of 3,750 people die by suicide. These deaths included our children and our parents, our family members, our clients and patients, our friends and colleagues, our neighbours and people from all socioeconomic, age, gender, culture and ethnic groups. In addition, suicide-related behaviours are a major cause of emotional, financial and psychological burden on individuals, families, friends, communities and healthcare systems. No part of our society is immune. Suicide affects all of us. It remains among Canada's most serious public health issues.

For too long, discussion of suicide has involved secrecy, stigma and taboo. The stigma surrounding suicide is as prevalent among mental health professionals, organizations and institutions, as it is among the Canadian population. Through our silence, and fueled by our fears and ignorance, much suffering has resulted. We are now confronting the silence and we must continue to have the courage to do so – stand up to stigma, to confront that silence, to educate ourselves, and to move into action and to reach out to comfort the suffering.

Suicide is a complex problem involving biological, psychological, social and spiritual factors. No one perspective has the corner on truth, but taken together many suicides are preventable. We know that those at risk for suicide experience overwhelming emotional pain. They want and need help in reducing the pain so that they can go on to lead productive, fulfilling lives.

Tragically, when someone dies by suicide the pain is not gone; it is merely transferred to family, friends and community. The grief of those bereaved by suicide requires compassion, understanding and support to help minimize its impact.

The purpose of this document is to guide the development and adoption of a Canadian National Suicide Prevention Strategy. We ask that you take the time to read it, share it with others and join us in turning this strategy into a strategy for all Canadians.

This strategy begins with the guiding principles used in its construction. The goals and objectives of a national strategy are presented followed by the rationale for developing a national strategy.

V. Guiding Principles

Canada has a wealth of experience, knowledge and expertise to approach suicide as a public health issue and as a preventable problem. Realistic opportunities exist for saving many lives. With a national commitment and with a will expressed through a national strategy to reduce suicide and its impact, Canadians can move forward together.

Can we prevent suicide?

Experience teaches us that many suicide-related behaviours can be prevented. Suicide is the result of intolerable pain, fear, or despair overwhelming an individual's sense of hope. Suicide prevention, intervention and bereavement support is our responsibility as a people and as a nation of diverse communities.

The following principles were used to guide the development of this strategy:

1. Suicide prevention is everyone's responsibility.
2. Canadians respect our multicultural and diverse society and accept responsibility to support the dignity of human life.
3. Suicide is an interaction of biological, psychological, social and spiritual factors and can be influenced by societal attitudes and conditions.
4. Strategies must be humane, kindly, effective, caring and should be:
 - a) Evidence or experience based.
 - b) Active and informed.
 - c) Respectful of community and culture-based knowledge.
 - d) Inclusive of research, surveillance, evaluation, accountability and reporting.
 - e) Reflective of evolving knowledge and practices.
5. Many suicides are preventable by knowledgeable, caring, compassionate and committed communities.
6. We must have the courage to confront the stigma of suicide and the patience to address mental health literacy on both a national and local level.

VI. GOALS & OBJECTIVES

(A) Awareness and Understanding

Goal 1- Promote awareness in every part of Canada that suicide and suicide- related behaviour is our problem and is preventable.

Objectives:

- 1.1 Each province, territory, region and community will have a coordinated public awareness campaign that will reach the majority of the population and target special populations.
- 1.2 Enhance and expand upon the CASP Annual National Conference on Suicide Prevention designed to foster collaboration with stakeholders on prevention strategies across disciplines and with the public.
- 1.3 Convene national forums on special target populations and specific issues as needed (for example, physician education on risk assessment).
- 1.4 Support and enhance the number of public and private institutions and volunteer organizations active in suicide prevention.
- 1.5 Develop a national suicide prevention week to coincide with World Suicide Prevention Day.
- 1.6 Increase awareness and support for persons suffering from mental illnesses and substance use disorders, trauma and grief.
- 1.7 Participate in a national anti-stigma campaign.
- 1.8 Participate in Mental Health literacy initiatives.

Goal 2 – Develop broad-based support for suicide prevention, intervention and postvention.

Objectives:

- 2.1 Ensure a broad representation of government, private and public stakeholders in further development, adoption and implementation of the CASP Strategy.
- 2.2 Increase the number of employer and national professional, voluntary and other groups that integrate suicide prevention, intervention and postvention activities into their ongoing programs and efforts.
- 2.3 Identify and increase the number of advocacy activities for suicide prevention, intervention and postvention at community, provincial/territorial and national levels.
- 2.4 Facilitate the inclusion of the national suicide prevention strategy within the key initiatives of The Mental Health Commission of Canada.

Goal 3 – Develop and implement a strategy to reduce stigma, to be associated with all suicide prevention, intervention and bereavement activities.

Objectives:

- 3.1 Increase the proportion of the public that values mental, physical, social, spiritual and holistic health.

- 3.2 Improve public understanding that mental health, treatment for depression, other mood disorders and mental illnesses, substance abuse, trauma and suicide prevention services are fundamental and essential components of health care in the Canadian, Provincial and Territorial health care systems.
- 3.3 Improve public understanding that *breaking the silence surrounding suicide* increases realistic opportunities to save lives and to reduce suffering.
- 3.4 Support the launch of an anti-stigma campaign by The Mental Health Commission of Canada and work as an active partner in the campaign.
- 3.5 Encourage less stigmatizing language as recommended by The Alberta Mental Health Board (www.amhb.ab.ca) promoting the avoidance of stigma related terms such as “committed” or “completed” suicide; and, promoting the use of terms such as “died by suicide” and, “bereaved by suicide.”
- 3.6 Increase and improve training for all health care workers: including physicians, nurses, social workers, personal care workers, psychologists, psychotherapists, mental health and addictions workers, and personal counselors.

Goal 4 - Increase media knowledge regarding suicide.

Objectives:

- 4.1 Develop media guidelines regarding the reporting of suicide and training related to increasing knowledge and sensitivity.
- 4.2 Improve the reporting and portrayal of suicidal behaviour in all media.
- 4.3 Create national, provincial, territorial and community media awards for excellence in reporting.
- 4.4 Develop and distribute to each region a code of ethics for all media regarding suicide.

(B) Prevention, Intervention and Postvention

Goal 1: Develop, implement and sustain community-based suicide prevention, intervention and postvention programs, respecting diversity and culture at local, regional, and provincial/territorial levels.

Objectives:

- 1.1 Support the development of specific strategies by Inuit, First Nations, Métis and all Aboriginal peoples; for example, the National Aboriginal Youth Suicide Prevention Strategy.
- 1.2 Support the development of specific strategies for:
 - Persons suffering depression, other mood disorders, mental illness or with a history of suicide-related behaviour,
 - Gay, lesbian, bisexual, transgender, transsexual, intersexed and two-spirited persons.
- 1.3 Support the development of separate strategies for all high-risk groups.

- 1.4 Support the development of prevention strategies by the Government of Canada and by each province, territory, region and community in Canada.
- 1.5 Support the development of awareness and prevention strategies in settings for:
 - Youth, young adults, family, community service providers, employers,
 - School districts and private school associations, colleges and universities,
 - Correctional institutions,
 - In-home and community based services for seniors,
 - Persons with disabilities,
 - The military, police and emergency responders,
 - Mental health, medical personnel, and other health care providers.
- 1.6 Support the development of training and technical resource centres to build capacity for provinces, territories, regions, and communities to implement and evaluate suicide prevention programs.
- 1.7 Support the development of training in protective factors and in solution-focused approaches to suicide prevention
- 1.8 Develop a working agenda, timeline and target dates for implementation of these objectives by each community, region, province, territory and the Government of Canada.

Goal 2: Reduce the availability and lethality of suicide methods

Objectives:

- 2.1 Increase the proportion of primary care clinicians, other health care providers and health and safety officials who routinely assess the presence of lethal means including firearms, drugs, poisons and other means in the home, and who educate about actions to reduce associated risks.
- 2.2 Educate the public to reduce access to lethal means.
- 2.3 Support/advocate for the development and use of technology to reduce the lethality of means, for example, firearm locks, carbon monoxide shut-off controls, bridge barriers, subway stop barriers, medication containers.
- 2.4 Educate the public about the specific risk of harm and death by suicide any time there is a firearm in the home or otherwise available.
- 2.5 Advocate for necessary legislation to support these objectives at municipal, provincial and federal levels.

Goal 3: Increase training for recognition of risk factors, warning signs and at-risk behaviours and for provision of effective intervention and postvention, targeting key gatekeepers, volunteers and professionals.

Objectives:

- 3.1 Increase the number of professional groups committed to training and management of the current best practices and the most promising practices in suicide risk and identification and the promotion of protective factors, reasons for living and solution-focused approaches.

- 3.2 Increase the number of employers in the training and management of suicide risk and identification and promotion of protective factors.
- 3.3 Increase the training and management of suicide risk and of identification and the promotion of protective factors within schools and education systems, and for:
 - Youth, family, community service providers, employers,
 - School districts and private school associations, colleges and universities,
 - Correctional institutions,
 - In-home and community based services for seniors,
 - Persons with disabilities,
 - The military, police and emergency responders,
 - Mental health, medical personnel, and other health care providers.

Goal 4: Develop and promote effective clinical and professional practice (effective strategies, standards of care) to support clients, families and communities.

Objectives:

- 4.1 Increase the number of people who receive early diagnoses and mental health treatment and who pursue mental health aftercare or continuing care plans after being treated for suicide-related behaviours in hospital departments.
- 4.2 Support the development and use of guidelines for assessment and treatment of suicide-related behaviours among persons receiving care in primary health care settings, emergency departments, hospital wards and mental health and substance abuse treatment centers.
- 4.3 Support the development and use of guidelines for assessment and treatment of suicide-related behaviours across the age span including children, youth, adults and the elderly such as the Canadian Coalition for Seniors' Mental Health (CCSMH) National Guidelines: The Assessment of Suicide Risk and Prevention of Suicide.
- 4.4 Facilitate accurate and current understanding of suicide-related behaviours and communications in text books and other materials used in the training and continuing education of health care professionals
- 4.5 Support the development and use of guidelines for providing education and support to family members and significant others of persons receiving care for the treatment of mental health and substance abuse disorders.
- 4.6 Increase the number of outreach activities for those affected by suicide-related behaviour.
- 4.7 Promote the development of provincial and regional strategies for better service delivery and accessibility.
- 4.8 Support the development and use of guidelines for assessing trauma and promoting trauma informed services.
- 4.9 Support the development of training in solution focused approaches to suicide prevention

Goal 5: Improve access and integration with strong linkages between the continuum-of-care components/services/families.

Objectives:

- 5.1 Follow-up within twenty-four hours of discharge or other transition of care for everyone deemed to be high risk, or with severe mental illness or a history of suicide-related behaviour within the previous three months, and face-to-face contact within a maximum of seven days.
- 5.2 Develop individual care plans to specify action to be taken if a person is deemed to be high risk, or with severe mental illness or history of self-harm within the previous three months does not attend follow-up or aftercare or is unable to follow the care plan as originally designed.
- 5.3 Develop guidelines and protocols to actively seek out and respectfully utilize collaborative input from families and friends.
- 5.4 Review and reform mental health care legislation to facilitate appropriate involvement of caring family and community members in aftercare.
- 5.5 Support and provide assistance to The Mental Health Commission of Canada's goal of an integrated mental health system that places people living with mental illness at its centre.
- 5.6 Support and provide assistance to the Canadian Alliance on Mental Illness and Mental Health (CAMIMH), mental health literacy research and public education initiatives.

Goal 6: Prioritize intervention and service delivery for high-risk groups while respecting local, regional and provincial/territorial uniqueness.

Objectives:

- 6.1 Improve the diagnosis and effective treatment of persons with mental illness, mood disorders and substance abuse and addictions.
- 6.2 Develop and promote interventions and coordinated service delivery for persons with mental illness, mood disorders, substance abuse and addiction, and concurrent disorders.
- 6.3 Develop and promote interventions and coordinated service delivery for persons experiencing severe distress as gay, lesbian, bisexual, transgender, transsexual, intersexed and two-spirited persons.

Goal 7: Increase crisis intervention and support.

Objectives:

- 7.1 Increase the number and training of programs and service providers for those affected by suicide-related behaviors.
- 7.2 Enhance and increase crisis and support networks and certification standards appropriate to the needs of each community.
- 7.3 Establish a Canadian Certification Program for Crisis Intervention services.

- 7.4 Develop a national crisis line network to connect existing crisis lines and websites to provide service where none exists.
- 7.5 Connect all ‘accredited’ community-based Crisis Lines across Canada, using a single access/number system and web portal. In this ‘Accredited Network’ callers and/or people connecting through a virtual network are able to connect and receive emotional support, 24 hours a day, every day from highly trained volunteers, supported by professional Crisis Intervention staff.
- 7.6 Develop a national crisis resource database accessible to all crisis lines and crisis intervention services across all electronic and other media.
- 7.7 Develop and implement support structures for families living with suicidal people. Acknowledge their roles as caregivers and as contributing members of the care team.

Goal 8: Increase services and support to those bereaved by suicide or who have attempted suicide.

Objectives:

- 8.1 Increase the number of support services, both immediate and longer-term, to those impacted by a suicide.
- 8.2 Develop standards of competency and care for those who work with people bereaved by suicide.
- 8.3 Develop education modules for first responders regarding death notifications, funeral arrangements, community systems of support, and aftercare.
- 8.4 Develop guidelines and information packages for funeral directors, churches, schools, healthcare settings and other community resources to improve services, education and support to those bereaved by suicide.

Goal 9: Increase the number of primary prevention activities.

Objectives:

- 9.1 Increase the number and training and service providers of evidence-informed programs that promote resiliency and protective factors.
- 9.2 Increase connections and networking and improve cooperation and communication between suicide prevention, intervention and postvention programs, and services and associations that promote community wellness, public health and injury prevention.

(C) Knowledge Development and Transfer

Goal 1: Improve and expand surveillance systems.

Objectives:

- 1.1 Develop consistent standards and protocols for collecting information on suicide-related behaviour and suicide related communication.

- 1.2 Develop standards for coroners and police to assist in accurately determining and reporting on manner of death.

Goal 2: Promote & support the development of effective evaluation tools.

Objectives:

- 2.1 Increase the development and use of standardized assessment protocols for program evaluation.
- 2.2 Develop and enhance links and communication between survivors, community resources and researchers to facilitate knowledge transfer and knowledge uptake.

Goal 3: Promote and develop suicide-related research.

Objectives:

- 3.1 Increase the study and reporting of risk factors, warning signs and protective factors for individuals, families, communities and society.
- 3.2 Reinstitute the development of the national suicide research agenda by the Canadian Institutes of Health Research first established in February 2003 identifying six broad themes for ongoing investigation. [See Appendix 5]
- 3.3 Communicate with other suicide prevention agencies internationally with respect to best and promising practices and learning outcomes.

Goal 4: Increase opportunities for reporting.

Objectives:

- 4.1 Increase opportunities including scientific journals, conferences, workshops and training for dissemination of data and knowledge from surveillance, evaluation and research activities.
- 4.2 Develop a national suicide research database of information, data and resources available to appropriate agencies and entities.

(D) Funding and Support

Goal 1: Increase funding and support for all activities connected with the CASP National Suicide Prevention Strategy (2nd Edition).

Objectives:

- 1.1 Provision of appropriate and adequate financial resources by the public and private sectors, including all levels of government, organizations, institutions and enterprises, to fund the attainment of these goals and objectives in the CASP National Suicide Prevention Strategy within three years.
- 1.2 Enact the recommendation 106 from the Final Report of The Standing Senate Committee on Social Affairs, Science and Technology “Out of the Shadows at Last” ...
 - 1.2.1 106 – *“That the federal government support the efforts of the Canadian Association for Suicide Prevention and other organizations working to develop a national suicide prevention strategy”.*

- 1.3 Support advocacy at all levels to achieve all of the above goals and objectives.
- 1.4 Develop a working agenda, timeline and target dates for implementation of these objectives by the public and private sector, including all levels of government, organizations, institutions and enterprises.
- 1.5 Give priority to initiatives and strategies that most closely follow the Guidelines, Goals and Objectives in this CASP Strategy.

Goal 2: Ensure access to appropriate and adequate health, wellness and recovery services for all Canadians in keeping with the *Canada Health Act*.

Appendix #1

Rationale for the Development of the Strategy

The World Health Organization's (WHO) first report on violence and health, published in October 2002, indicates that suicide is the single greatest cause of violent death around the globe; more deaths annually than all war casualties and homicides combined. It states that suicide is one of the leading causes of death worldwide and therefore is an important public health problem.³ Of the 82 countries reporting suicide statistics to the WHO, Canada ranks 26th putting it in the top third of countries with the highest rates. Canada's national government has been aware of suicide as a serious community issue for close to two decades, having published a leading-edge national suicide task force report in 1987 and comprehensive update in 1994. Suicide-related behaviour is an action, not an illness, which can have a fatal outcome. It doesn't result from a single cause. Suicide-related behaviour (resulting in fatal and non-fatal outcomes) is the result of an interaction of complex biopsychosocial factors that include mental health issues and other conditions of risk such as social isolation, biological vulnerability, trauma, stress, family violence, illness, and substance abuse; an interaction that Aboriginal communities have long understood as involving a constellation of personal and wider community issues.

The tragic and complex nature of suicide has traumatic and rippling consequences for individuals and those around them. The death of one person affects parents, children, siblings, and grandparents, in addition to relatives, friends, teachers, co-workers and others known to the individual. Although descriptive accounts are available, neither Canadian nor international research has focused sufficiently on the impact of suicide on the well-being of those left behind.

Suicide is generally seen as a preventable action. If its impact on Canadians is to be reduced, there is a need for:

- a.) A better understanding of the nature of suicide and suicide-related behaviours,
- b.) A national strategy designed to mobilize policies and services and,
- c.) Education about public attitudes toward suicide and its prevention.

A national strategy requires a broad array of individuals and organizations, public and private, to join in the common cause of prevention through the coordination and development of appropriate services in communities throughout the country.

Why Canada Should Implement a National Strategy for Suicide Prevention?

We must do better. Working together we will do better. While many Canadians, in many areas and in many settings, have accomplished a great deal, no vehicle exists to express our collective will to build, to share and to improve our efforts utilizing our cumulative experience and expertise.

1. Canada's suicide rate is higher than a number of other industrialized countries.

Canada's suicide rate per 100,000 is in the middle of G8 countries (Canada, France, Germany, Italy Japan, Russian Federation, United Kingdom, United States) reporting suicide statistics to the World Health Organization (WHO). The Canadian rate is higher than Italy, the United Kingdom and the United States¹. There has been a constant upward trend in suicide rates since the 1950s, increasing 75% from a decade average of 7.3 in the 1950s to 12.8 in the 1990s. The rate increased significantly from the 1960s to the 1970s but remained relatively stable throughout the 1980s and 1990s. Midway through the first decade of the 2000s, there has been an encouraging 9% decrease, but the overall change between 1950 and now is still a distressing 60% increase. The impact of this increase is particularly noted in our adolescent and young adult populations (15-24 years). In 2000, only two G8 countries, Japan and the Russian Federation, had higher youth rates than Canada. Canada's male youth rate is second to Russia and third highest for females after Russia and Japan. Our youth male rates are almost 20% higher than the United States and over 90% higher than the United Kingdom. Overall, more young Canadians die by suicide than by disease or by most other forms of injury. At the beginning of the 21st century, Canada's suicide rate was an alarming 45% higher than rates for motor vehicle collision deaths. Male youth rates were 4% higher. Only female youth had higher motor vehicle death rates.²

2. Over 3,500 Canadians die by suicide every year.

Although Statistics Canada has collected suicide data since 1924, the information was incomplete until 1956 when territorial data was included. Up to 1950, female rates varied from a high of 7.0 to a low of 4.8, very similar to current rates. Male rates ranged between a high of 24.0 in the late 1920s to a low of under 15.0 during the Second World War. The early years of the 21st century has seen the rates approaching 20 again.³

Since 1950, the Canadian population has grown from under 14 million to over 33 million in 2007, an increase of 138%. The numbers of suicides each year have more than tripled (238%) from just over 1,000 to over 3600 in 2004. Canada continues to experience more than 10 suicide deaths every day, a daily statistic that has plagued our country for more than 15 years. The age-standardized rates increased from a decade average of 8.5 in the 1950s to 12.8 in the 1990s, an increase of almost 32%. The most significant increase was in the 1960s that saw the annual numbers almost double between 1959 and 1969. The number of suicides reached a peak of 4,000 in 1999. Since then there has been a modest and encouraging decrease of 9% up to 2004.⁴

Suicide rates for First Nations, Inuit and Metis people in Canada are a serious concern but comprehensive information to fully understand their origins remains limited. The First Nations rate in 2000 was 24.0, twice the general population rate. In Inuit regions between 1999 and 2003, the average rate across regions was 135.0; ten times the general population rate. However, even with elevated rates compared to the general population, wide variations are noted in several studies. In British Columbia over an 8 year period (1993-2000), rates ranged from 0.0 – 120.0 across several communities with 12% of the communities accounting for 90% of all suicides. Overall one cannot ignore the facts that suicide rates among Aboriginal people are at least three times the rate of the general population.⁵

Suicide is a serious community health concern as indicated by the potential years of life lost from suicide. At the turn of the century, suicide was ranked third after cancer and heart disease across all ages in potential years of life lost for men. For women, suicide was fourth after cancer, heart diseases, and motor vehicle traffic collisions. By 2000, suicide was ranked second (725) behind unintentional injuries (1,036) for the greatest number of potential years of life lost per 100,000 for males. For females, suicide (179) was fourth behind unintentional injuries (375 years), lung cancer (344 years) and breast cancer (339 years). Among First Nations people, the potential years of life lost was higher than all cancers combined and 50 percent higher than potential years lost to all circulatory diseases. First Nations populations lost three times as many potential years of life to suicide as did Canadians overall. For First Nations people (on-reserve) suicide (1,495 years) ranked second after unintentional injuries (3,218 years) for

the greatest number of potential years of life lost per 100,000. In the same year in Nunavut, where Inuit people make up 85% of the population, suicide ranked first for the greatest number of potential years of life lost per 100,000 (3,619.1 years), followed by unintentional injuries (2,827 years).

3. Suicide is a leading cause of death for Canadians between ages 15 and 54 years.

In 2000, suicide was the leading cause of death for Canadian males aged 15 to 54 years, considerably higher than motor vehicle collision deaths. Only in the younger age group, 15 to 24 years were motor vehicle deaths slightly higher. At the turn of the century, suicide was the leading cause of male deaths in two age groups: 25-29 years and 40-44 years. For women, it was the leading cause of death in the 30-34 year age group. Tragically among young First Nations people, suicide was the leading cause of death for an even younger group, children and adolescents between 10 and 19 years, accounting for 38% of all deaths for that age group. The tragedy of this loss is noted in the fact that it is even higher than the 30% killed in motor vehicle collisions.

4. Suicide versus motor vehicle collision deaths among Canadian youth aged 15-24 years

The motor vehicle collision death rate for youth in 2000 was 15.2 from close to 640 deaths.⁶ Suicides were just behind motor vehicle collision injuries at 12.8 from 540 deaths as a leading cause of death for young Canadians. Most disturbing is evidence that shows motor vehicle collision deaths declining over several years while youth suicide rates have been increasing.

5. Suicide is the third leading cause of death among adults in their primary parental years from ages 25-49 years

Suicide follows cancers and diseases of the circulatory system as one of the major causes of death in this age group and is the second leading cause of death for males. One of the primary factors that enable people to manage the stress evident in daily life is a stable home relationship. The suicide of a family member is one of the most significant stressors a family can face. Adults from the ages of 25 to 49 are in their primary years of parental responsibility and the suicide rates of males of this age are among the highest of any age group. Suicide is also the third leading cause of death among females in this age group.

6. Over 350,000 Canadians deliberately harm themselves every year

Research from general population surveys show that the rates of suicide related behaviours not resulting in a fatal outcome, may be up to 100 times higher than rates of suicide. Although it is difficult to arrive at accurate national figures for non-fatal suicide related behaviours, national trauma registry reported 23,000 hospitalizations due to non-fatal suicide related behaviours in 2001-2002.⁵ The age-adjusted rate was 76.0 per 100,000, six times higher than the national suicide rate. Females represented 62% of all hospitalizations. Two age groups had the highest hospitalization rates: 15-19 years for females and 35-39 years for males. Contrary to common perceptions, male hospitalizations were higher than female admissions for nearly all age groups 20 years or older. Beyond reported attempts and hospitalizations, suicide-related communication also increases the magnitude of suicide risk. Canada's most recent national community health survey reported 3.7% of those over 15 years had thought of suicide in the past 12 months.⁷

7. Males are more likely to die by suicide but females are more likely to survive a suicide attempt.

Since the 1950s, Canada's suicide rates for males have been at least three times higher than for females, reaching a four times higher peak in the 1990s and dropping back to a 3.5 times higher ratio in 2001 due to a lower number of male deaths (2869) and a slight increase in female deaths (819). The rates for males increased steadily from a low of 12.8 in the mid 1950s to as high as 18.0 in the 1960s, rising again in the 1970s to as high as 22.0. A further steady increase was evident in the 1980s to a high of 23.0 in 1983 followed by a decrease to 19.7 by 1990. There was another increase to 21.0 by 1999 followed by an encouraging decrease to 17.3 by 2004.⁸ Males are most likely to use hanging and firearms in their suicide acts, resulting in fewer opportunities for rescue.

Females are also at high risk for suicide actions but tend to use less immediate lethal methods in their suicide attempts and are thus more likely to survive. They are more likely to use drugs, poisons and gases in their resulting

in better chances to prevent death with effective medical intervention. The female suicide rate was 4.0 per 100,000 in 1950, increasing to a high of 7.8 in the 1970s and declining steadily since then to a low of 5.4 in 2004.⁹

8. Close to 2.5 million Canadians are affected by suicide-related behaviours each year.

Using a conservative estimate of six individuals personally affected by suicide-related behaviours, close to 2.5 million Canadians are affected annually. Suicide-related behaviours affect us all, families, friends, classmates, co-workers and ourselves. Most survivors are affected in their social networks by judgmental attitudes or cultural or religious taboos toward suicide.

9. Several studies (Canada and US) have estimated the cost of suicide to society.

The estimated cost of a suicide ranges from \$433,000 to \$4,131,000 per individual depending on potential years of life lost, income level and effects on survivors. A major Canadian study completed in New Brunswick estimated the average direct and indirect cost per suicide at \$850,000¹⁰

The estimated cost of non-fatal suicide related behaviours ranges from \$33,000 to \$308,000 per individual depending on the hospital services, rehabilitation required, family disruption and support required following the attempt. Psychological distress and ongoing mental health problems may result in long term treatment and care for the suicidal individual and family members. Suicide-related behaviour in one family member may result in other family members choosing similar responses to distress in the future.

10. Suicide can be prevented — but prevention requires a comprehensive strategy guided by federal policy and implemented with full federal participation.

The conditions evident in the Canadian population which lead to suicide-related behaviours are also manifested in other social problems such as violence against others, substance abuse, delinquency, employment disruption, poverty and family breakdown. A national strategy that contributes to the reduction of suicide may also contribute to the reduction of many other social problems.

Footnotes:

¹ World Health Organization. *Table 1: Numbers and Rates of Registered Deaths*. Retrieved from: http://www.who.int/whosis/database/mort/table1_process.cfm

² World Health Organization. *Table 1: Numbers and Rates of Registered Deaths*. Retrieved from: http://www.who.int/whosis/database/mort/table1_process.cfm

³ Statistics Canada. (n.d.). *Suicides Canada 1950-1994*. Ottawa, ON.

⁴ Statistics Canada. (2006) (2007). *Mortality, Summary List of Causes, 2000, 2001, 2002, 2003, 2004*. Ottawa, ON: Author.

⁵ Kirmayer, L. Brass, G. Holton, T. Simpson, C. Tait, C. (2007). *Suicide Among Aboriginal People in Canada*. Ottawa: Aboriginal Healing Foundation.

⁶ CIHR (2004). Hospitalizations due to suicide attempts and self-inflicted injury in Canada, 2001-2002. *National Trauma Registry Bulletin*. Toronto: Canadian Institute for Health Information.

⁷ Canadian Community Health Survey. Retrieved from: <http://www.statcan.ca/english/freepub/82-617-XIE/index.htm>

⁸ Statistics Canada. (2007). *Mortality, Summary List of Causes, 2004*. Ottawa, ON.

⁹ Statistics Canada. (2007). *Mortality, Summary List of Causes, 2004*. Ottawa, ON.

¹⁰ Clayton, D., & Barceló, A. (1999). The cost of suicide mortality in New Brunswick, 1996. *Chronic Diseases in Canada*, 20(2), 89-95.

Appendix #2

Current Suicide Prevention Initiatives in Canada

Canada-Wide

In 2004, the Prime Minister acknowledged the problem of suicide among Canada's aboriginal youth and pledged multi-year funding to help support a National Aboriginal Youth Suicide Prevention Strategy (NAYPS), focusing on risk reduction and promotion of protective factors across primary through tertiary levels of prevention and via knowledge development. Funding was provided in 2006-2007 from the First Nations Inuit Health Branch to develop a document entitled *Acting on What We Know: Preventing Youth Suicide in First Nations*. Work is underway to further enhance the NAYPS. See <http://www.honouringlife.ca/> for more information.

In May of 2006, the Canadian Coalition for Seniors' Mental Health (CCSMH) released a document entitled *National Guidelines for Seniors' Mental Health: The Assessment of Suicide Risk and Prevention of Suicide*, with federal funding from the Public Health Agency of Canada and the Canadian Institutes of Health Research, along with some industry funding. The CCSMH has continued the development of a late-life suicide knowledge translation toolkit for health and mental healthcare providers working with older adults and their families, funded in part by the Public Health Agency of Canada. See www.ccsmh.ca for more information and for free downloads.

As of January 2009, all Canadian nursing homes and hospitals seeking accreditation will be required to develop a suicide prevention program within their institutions in order to be accredited. .

Atlantic Canada

New Brunswick

The Mental Health Commission offers suicide intervention training for caregivers in English and French. A Provincial Suicidologist has recently been appointed.

In September of 2007 a document entitled **Connecting to Life: Provincial Suicide Prevention Program** was published by the Department of Health of the Government of New Brunswick. See <http://www.gnb.ca/0055/index-e.asp> for more information or go to <http://www.gnb.ca/0055/pdf/4768e-compressed.pdf> to download the document.

Newfoundland and Labrador

Suicide intervention training by independent trainers is provided. In 2007, a funding announcement was made providing funding for administration of youth suicide prevention initiatives through the Federation of Newfoundland Indians (FNI). In the 2006 budget, the government provided funding for suicide prevention initiatives under the Suicide Prevention Grants Program of the Department of Labrador and Aboriginal Affairs. See <http://www.releases.gov.nl.ca/releases/2007/laa/0320n01.htm> for more information.

Nova Scotia

There is now a province-wide network linked through a local newsletter, *Suicide Alert*, an annual symposium, *NS Symposium on Suicide*, and a leadership/coordinating committee, the *N.S. Community Network to Address Suicide*. This inter-agency type of coordination, while a relatively new and unstructured arrangement, is province-wide. In November of 2006, the Provincial Strategic Framework Development Committee released a document entitled **Nova Scotia Strategic Framework to Address Suicide** to help integrate effective approaches to address the problem of suicide in that province (available for download at <http://www.gov.ns.ca/ohp/injuryPrevention/SuicideFramework.pdf>). See <http://www.gov.ns.ca/hpp/injuryPrevention.html> for more information. The province had previously released the **Nova Scotia Injury Prevention Strategy: Report and Recommendations** (available for download at http://www.injurypreventionstrategy.ca/downloads/NS_IP_strategy.pdf).

Prince Edward Island

Community crisis services and independent suicide intervention training is being provided. An interagency **Provincial Suicide Prevention Committee** is working to reduce the suicide rate and lessen the impact of suicide in PEI. For more information, see the local CMHA website.

Others

Suicide intervention training by independent trainers along with crisis and distress centres in many communities in Atlantic Canada. There is no standardized training program or established minimum standards for staff or volunteers.

Central Canada

Québec

Quebec has 1) an established provincial policy with designated funding, 2) an established network of community crisis/distress centres, 3) annual conferences and awareness week activities, 4) independent suicide intervention training and 5) a government funded suicide prevention research centre. Repertoire of available resources produced by the **Conseil permanent de la jeunesse** is available. In 1998 the government of Québec released **Québec's Strategy for Preventing Suicide: Help for Life (Stratégie Québécoise D'Action Face Au Suicide: S'entraider pour la vie)** focusing on the 1997-2002 period (French and English-language copies currently available for download at <http://publications.msss.gouv.qc.ca/acrobat/f/documentation/1997/97-237-a.pdf>). The government has since released **Plan d'action en santé mentale 2005-2010: La force des liens** addressing the provincial mental health system.

Ontario

The province has independent suicide intervention and bereavement training and an established network of crisis/distress centres. Some regional suicide prevention organizations and initiatives such as the **Hamilton Suicide Prevention Council**, the **London Middlesex Suicide Prevention Council**, the **Northern Ontario Suicide Prevention Network**, the **Ottawa-Carleton Regional Inter-Agency Suicide Prevention Committee**, The **Arthur Sommer Rotenberg Research Chair** at the University of Toronto (established through private funding) and the **Toronto Council on Suicide Prevention**. The recently established, unfunded, **Ontario Suicide Prevention Network** is working to improve education, networking and sharing of suicide prevention resources. At present, two regional suicide prevention strategies exist in the province of Ontario, both released in 2006. The Niagara Suicide Prevention Coalition released the **Niagara Region Suicide Prevention Strategy** (see <http://www.cmhaniagara.ca/documents/NSPCStrategyFinal.pdf>). The Waterloo Region Suicide Prevention Council (<http://www.wrspc.ca/>) released **The Waterloo Region Suicide Prevention Strategy** (see http://www.wrspc.ca/pdf/Suicide_Prevention_Strategy_Final_Report_April_2006.pdf).

Western Canada

Manitoba

The province has suicide prevention training and resources with responsible mental health staff in government and regional responsibility for direct services through Regional Health Authorities; however, without designated funding for suicide prevention services. Independent trainers and crisis/distress centres provide services. In 2003, the Winnipeg Regional Health Authority released a document entitled **Discussion Paper for the Development of a Suicide Prevention Strategy for the Winnipeg Health Region** outlining a description of the problem of suicide,

available suicide prevention strategies to date, and calling for the development of a regional suicide prevention plan (currently available for download at http://www.wrha.mb.ca/community/mentalhealth/files/Suicide_Prevent_Feb04.pdf). In 2006 a multi-sectoral working group consisting of representation from Regional Health Authorities, self-help groups, consumers, family members, First Nations and Metis communities produced a Framework for Suicide Prevention Planning in Manitoba. In 2008, the department of Manitoba Health and Healthy Living appointed a Provincial Suicide Prevention Coordinator.

Saskatchewan

Government coordinated Adolescent Suicide Awareness Program (ASAP) since 1992 with a designated youth suicide prevention facilitator in each health district and a part time provincial coordinator providing suicide prevention, early identification, crisis intervention, specialized assessment, treatment and consultation, post-intervention and trauma response, bereavement and trauma counseling, and policy development. Corporate funded youth suicide prevention program (Friends For Life) was established but currently winding down with the end of funding. Independent trainers and crisis/distress centres work throughout the province.

Alberta

The province has had provincial programs since 1981 with internationally recognized components, but initially with no formal provincial policy. Active components included The **Suicide Information & Education Centre (SIEC)** is the only provincially funded suicide specific resource centre in Canada and the **Suicide Prevention Training Programs (SPTP)** was the first provincially funded program to develop, deliver and coordinate gatekeeper and caregiver training in suicide intervention, postvention and awareness. Independent crisis/ distress centres provide service. In 2005, the Alberta Mental Health Board (AMHB) released ***A Call to Action: The Alberta Suicide Prevention Strategy*** establishing a provincial suicide prevention strategy (currently available for download at http://www.amhb.ab.ca/Publications/reports/Documents/AMHB_SPS_mainMar06.pdf); for more information see www.amhb.ab.ca. Given the high rates of suicide among aboriginal youths, the government of Alberta has responded to requests for assistance by aboriginal Chiefs and Councils and helped create ***The Aboriginal Youth Suicide Prevention Strategy*** to raise awareness and enhance suicide prevention through knowledge exchange and project funding; for more information see <http://www.acicr.ualberta.ca/AYSPS.htm>.

British Columbia

The Suicide Prevention, Intervention and Postvention (PIP) Initiative for BC began in 2008 and is working towards developing and promoting a Framework and Planning Template for local, regional and provincial initiatives addressing suicide PIP across the lifespan. The Framework will provide objectives, actions and a logic model around

stakeholder determined PIP priorities. The Planning Template will help guide programs through development, implementation, improvement and evaluation of PIP services. Targeted completion is September 2009.

Other BC initiatives include:

- Since 2004, as a part of a network of five AAS accredited crisis lines in BC, the 1-800 SUICIDE prevention service has been providing free and confidential 24/7 telephone support to British Columbians.
- Suicide Attempt Follow-up, Education and Research (SAFER) has trained professionals working to reduce suicide risk for those in crisis, provide assistance to families and friends, aid those bereaved by suicide and deliver education, training and consultation for suicide prevention, intervention and postvention.
- Since 2005, The Aboriginal Suicide and Critical Incident Response Team (ASCIRT) has partnered with communities, providing knowledge and skills for each community to develop their own response to critical incidents and suicide. Aboriginal facilitators (community-based human service professionals who serve in 19 of 29 communities supported by the Inter Tribal Health Authority) conduct community suicide prevention, intervention and postvention workshops, youth workshops and critical incident response.

The North

Nunavut

Between 1999 and 2007, approximately 40% of the 553 reportable deaths investigated by the Coroner's Office in Nunavut have involved suicidal deaths of young men. In response to this shocking situation, in 2007, the Government of Nunavut released a document entitled ***Annirusuktugut: A Suicide Intervention and Prevention Strategy for the Government of Nunavut*** (see <http://www.gov.nu.ca/annirusuktugut/jun29a.pdf>).

Yukon Territory

The province has independent suicide intervention training with some government departments supporting staff training

Northwest Territories

A cooperative government/foundation suicide intervention training initiative is in the final stages of training for trainers. The province has volunteer crisis/distress services in some communities and some independent training offered.

Canada Wide Crisis/Distress Resources

The Canadian Association for Suicide Prevention (CASP)

A non-profit association dedicated to reducing suicidal behaviour.

Choosing Life: Special Report on Suicide Among Aboriginal People -

The Royal Commission on Aboriginal Peoples Report on Suicide which contains many recommendations.

Corrections Services Canada

Suicide intervention training for staff and inmates, utilizing the LivingWorks suicide intervention program, is offered in the Atlantic, Ontario and Prairie regions.

Crisis/Distress Centres

Communities across Canada have established Distress/Crisis centres to address suicidal behaviour and other crisis situations. These are primarily operated by a large component of volunteers with few paid professional staff. Training is not standardized. There is no standardized training program or established minimum standards for staff or volunteers and standards are set individually by each agency. There are no universal Canadian standards or external accreditation and evaluation criteria on a national level. A number of distress centres have been certified by the American Association of Suicidology, but there is as yet no other Canadian certification standard.

Government of Canada

Established the **Task Force on Suicide in Canada** which resulted in the publication of the report ***Suicide In Canada, 1987*** and the ***Update in 1994***. Some suicide research has been funded, but no specific requests for proposals from the federal government for suicide research. National meetings have been hosted to discuss suicide prevention. Health Canada together with the Canadian Institutes of Health Research (CIHR) co-hosted a special workshop on **suicide-related research in February of 2003 in Montreal** (see <http://www.cihr-irsc.gc.ca/e/18918.html> and Appendix #5 for more information).

A background paper entitled **Suicide-Related Research in Canada: A Descriptive Overview** (White, 2003) was prepared for that workshop and later updated with the assistance of workshop participants (to download a copy of this document see <http://www.phac-aspc.gc.ca/publicat/mh-sm/suicide-research/index-eng.php>).

Kids Help Line

A toll-free professionally staffed crisis line to assist youth.

LivingWorks Education, Inc.

This public service corporation provides research and development services and training and support for national and international independent suicide intervention trainers.

LPAC ~ Legal Profession Assistance Conference of the Canadian Bar Association

LPAC's *1997 Lawyer Suicide Study*, (Hill, 1997) by Adrian Hill identified a rate of death by suicide among older male lawyers at a rate nearly six times Canada's national suicide rate. LPAC established a comprehensive suicide prevention and bereavement support program including education, training and web-based learning as well as professional counseling and peer support. The program has been copied around the world. The LPAC program has been the catalyst for this CASP Strategy project.

RCMP

The **Aboriginal Police Service** of the RCMP provides five-day suicide prevention conferences in aboriginal communities, managed and delivered by SPTP in Calgary. Aboriginal trainers are used and community members are trained to establish and operate their own suicide prevention services.

Suicide Information and Education Centre (SIEC)

The **Suicide Information and Education Centre** of the **Centre for Suicide Prevention** provides a collection, database search, document delivery service and provides suicide prevention information via the Internet, on CD-ROM, and through a variety of publications and serials. For more information see <http://www.suicideinfo.ca/>.

Suicide Prevention Training Programs (SPTP)

The **Suicide Prevention Training Programs** of the **Centre for Suicide Prevention** develops and delivers caregiver training through a variety of workshops ranging from two hours to five days. SPTP also manages a network of trainers offering caregiver training across Canada and worldwide. Workshops include Suicide Intervention, Suicide Bereavement, Awareness, Adolescent Suicide, Elderly Suicide, Surviving Suicide, Crisis Management and others.

Suicide in Canada, Leenaars et al., 1998

A compilation of articles by Canada's leading experts. This book makes a strong call for action from all segments of our population.

Canada and the United Nations Guidelines for Suicide Prevention

Why Canada

In 1991, the United Nations Centre for Social Development and Humanitarian Affairs made a general request for help to prepare a global review of recent innovations in the provision of social welfare services based on recommendations set forth in the *Guiding Principles for Developmental Social Welfare Policies and Programmes in the Near Future, 1987*.

A group of individuals from the University of Calgary, Faculty of Social Work and LivingWorks Education responded by focusing on Canadian innovations in suicide prevention. The Canadian reviewers were commended for drawing the UN's attention to the social welfare, as well as mental health, nature of the suicide problem. Canada, through the Alberta principals, was invited to organize, host and fund the UN's first inter-regional expert group meeting on suicide prevention. Recommendations were to include one expert from each of the major population regions of the world. In order to complete the task with the limited funds available the experts group was restricted to one Canadian presenter and two United States representatives along with representatives from 11 other countries worldwide. The UN objective was the formulation of national strategy guidelines for the prevention of suicide that could be circulated on a global scale.

Development

In 1992, **LivingWorks Education, Inc.** and the **Suicide Information and Education Centre** accepted the challenge of organizing the interregional expert meeting. They approached **Health Canada** and a wide variety of government and non-government agencies for financial assistance. The Department for Policy Coordination and Sustainable Development of the United Nations, the Division of Mental Health of the World Health Organization and the Calgary WHO Collaborating Centre for Research and Training in Mental Health supported this initiative. Strong fiscal support from within the province of Alberta and the commitment of the principal organizers dictated the location of the experts meeting. In June 1993, **Inter-Regional Experts Meetings** were held in Calgary and Banff, Alberta where a keynote address was presented and responses were heard from the **United Nations** and the **World Health Organization**. Thirteen national perspective papers were presented from countries representing all regions of the world. Participants at this five-day experts meeting drafted the guidelines for the formulation and implementation of national strategies for the prevention of suicide, which were published by the UN in 1996.

Timeline History — How did Canada get to where we are today?

1987

United Nations Guiding Principles for Developmental Social Welfare Policies and Programmes in the Near Future (UN, 1987)

1989

UN General Assembly reaffirms the Guiding Principles

1991

The UN General Assembly approved the Guiding Principles as a major framework for action in developmental social welfare at the local, national, regional and inter-regional levels to address:

- Widespread stress and anxiety causing increased incidence of individual dysfunction, including rising rates of suicide among young people.
- Decline in the capability of many families and communities to provide adequate care for their younger members.
- The absence of comprehensive national strategies to prevent and resolve severe dysfunctional conditions, including suicide.
- UN Centre for Social Development and Humanitarian Affairs requested help to prepare a global review of social welfare services and make recommendations on areas of concern set forth in the 1987 Guiding Principles.
- The Secretary General of the UN called on countries to formulate social policy strategies that would deal with prevention as well as care and rehabilitation.
- The UN invites LivingWorks and SIEC to organize and host inter-regional expert meeting on suicide prevention.

1993

A Calgary based group organized and conducted a five day Inter-Regional Expert Meeting to develop a policy guideline for national strategies on suicide prevention that could be adopted by countries from all regions of the world.

1996

Publication of the guidelines in the United Nations document - *Prevention of Suicide – Guidelines for the formulation and implementation of national strategies.*

1996

Publication of the book *Global Trends in Suicide Prevention - Toward the Development of National Strategies for Suicide Prevention*, edited by Canadians R.F. Ramsay, and B.L. Tanney.

1998

Health Canada commissioned and received a report outlining a four-stage process for the development of a national strategy for suicide prevention, which would include:

1. A study of the economic burden of distress and suicide in Canada.

2. Informal consultation among federal, provincial/territorial departments and major stakeholders on the feasibility of a national strategy.
3. The establishment of a coordinating body to guide the development.
4. The development and implementation of the strategy.

2003

CASP embarks on a strategy to be released at their CASP meeting in 2004.

2004

CASP releases **The CASP National Suicide Prevention Strategy** at the CASP annual conference, held in Edmonton, Alberta. The Strategy is highly lauded, and forms the basis for various provincial and community-level strategies across the nation (see above).

2005

CASP releases the **CASP Strategy Business and Implementation Plan** at the CASP annual conference, held in Ottawa, Ontario. Then Federal Health Minister Ujjal Dosanjh gives a keynote address, publicly supports CASP's leadership in suicide prevention in Canada and addresses the need for a Canadian Mental Health Strategy.

2006

In the Standing Senate Committee on Social Affairs, Science and Technology (commonly known as "The Kirby Commission") report **Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada** (document currently available for download in two parts at <http://www.parl.gc.ca/39/1/parlbus/commbus/senate/Com-e/SOCI-E/rep-e/pdf/rep02may06part1-e.pdf> and <http://www.parl.gc.ca/39/1/parlbus/commbus/senate/Com-e/SOCI-E/rep-e/pdf/rep02may06part2-e.pdf>), The Honourable Michael J.L. Kirby (Chair) and The Honourable Wilbert Joseph Keon (Deputy Chair) identify the critical need for suicide prevention efforts at a national level, and acknowledge the **CASP Strategy** as a framework for national suicide prevention efforts. The report specifically indicates "The Committee believes there is merit in advancing the Canadian Association for Suicide Prevention's initiative aimed at development of a national prevention strategy." (p.426), and recommended that the Canadian government "support the efforts of the Canadian Association for Suicide Prevention and other organizations working to develop a national suicide prevention strategy" (p.416) and encourage the Canadian Mental Health Commission (see below) to work with stakeholders to develop associated surveillance and research initiatives.

2007

Following recommendations made in **Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada**, Prime Minister Stephen Harper announces the creation of the **Mental**

Health Commission of Canada (see <http://www.mentalhealthcommission.ca/Pages/index.html> for more information), to help integrate the Canadian mental health system.

2008

CASP is in contact with the **Mental Health Commission of Canada**, and encourages that body to recognize suicide prevention as a critical component of any national mental health strategy, further acknowledging that suicide is both a mental health and a public health issue.

2009

CASP releases the second edition of the **CASP Strategy** in Brandon Manitoba, site of the CASP of the 2009 annual conference and symbolically, the geographic centre of Canada.

Appendix #3

National Strategy Guidelines in Other Countries

As of 2008

Australia

Australia initiated a four-year \$13 million budget for a *Here for Life Youth Suicide Prevention Initiative* in 1995/96. As part of the National Youth Suicide Prevention Strategy, one million dollars was allocated for research on youth suicide, leading to a workshop and reviews of the literature. These literature reviews were summarized in the 1999 document published by the Strategic Research Development Committee, the National Health and Medical Research Council, and the Mental Health Branch of the Commonwealth Department of Health and Aged Care entitled **National Youth Suicide Prevention Strategy: Setting the Evidence-Based Research Agenda for Australia (A literature review)** (see <http://www.nhmrc.gov.au/PUBLICATIONS/synopses/files/mh12.pdf>). Evaluation reports of this strategy are available online at <http://www.aifs.gov.au/institute/pubs/ysp/evaluation.html>. In 1999 the Federal Budget allocated \$39.2 million over four years to the *National Suicide Prevention Strategy* (NSPS) to extend suicide prevention strategies across the age spectrum, addressing the needs of all groups at risk of suicide or suicidal behaviour, including youth. The National Advisory Council on Suicide Prevention was established to advise on implementation of the funds. Of the total budget, 40% was allocated to projects of national relevance with the remaining funds for all States and Territories to allocate through an appropriate selection process. The 2007 Australian national strategy is being funded by the Australian Government's Department of Health and Ageing, and is entitled ***Living is for Everyone (LIFE): A Framework for Prevention of Suicide and Self-Harm in Australia*** (see <http://www.livingisforeveryone.com.au/LIFE-Framework.html> for more information and to download the framework). Various regional strategies exist as well. These include the Queensland Government's suicide prevention strategy (***Reducing Suicide: The Queensland Government Suicide Prevention Strategy 2003-2008***, available at http://www.health.qld.gov.au/mentalhealth/docs/qgps_report_apr06.pdf) and its companion document (***Reducing Suicide: Action Plan 2003: The Queensland Government Suicide***

Prevention Strategy 2003-2008, available at <http://www.health.qld.gov.au/mentalhealth/docs/20768.pdf>), the National Public Health Partnership's document **The National Aboriginal and Torres Strait Islander Safety Promotion Strategy** (available online at <http://www.nphp.gov.au/publications/sipp/atsi.pdf>), and the Loddon Mallee Region's *Connections: Suicide Prevention in the Loddon Mallee Region*.

Canada

In 2004, the Canadian Association for Suicide Prevention publishes the CASP Strategy, Canada's first National Suicide Prevention Strategy. A business and implementation plan was released in 2005. The second edition of the CASP Strategy is released in 2009.

Denmark

A Danish national suicide prevention strategy was first outlined in the 1998 Danish National Board of Health publication **Proposal for a National Programme for Prevention of Suicide and Suicide Attempt in Denmark**.

England

In 1994, the Department of Health established a target of reducing national suicide rates by at least 15% and the suicide rate for severely mentally ill people by at least 33% by the year 2000. In 2002 England released its national strategy for suicide prevention, which will be administered by the new National Institute of Mental Health.

Estonia

The Action Plan for Preventing Suicidal Behaviour in Estonia sets out strategies for suicide prevention among specific target groups, proposes creating a national centre with funding for coordination and development of suicide prevention initiatives, and incorporating surveillance and monitoring efforts. For more information, see a 2005 briefing from the WHO European Ministerial Conference on Mental Health ("Facing the Challenges, Building Solutions" available online at <http://www.euro.who.int/document/mnh/ebrief07.pdf>).

Finland

Finland was the first nation to develop a comprehensive national suicide prevention strategy. The National Board of Health formulated a 10-year strategy in 1986 to reduce their high suicide rates by 20 percent. Their rates increased during the first years of the project to a peak in 1990, followed by a reduction of 20% between 1991 and 1996, and an overall reduction of 9% from the 1986 base rate. It is the only national strategy to have a completed international peer evaluation.

Germany

In 2003, the German government created a comprehensive national strategy. **The German National Suicide Prevention Programme** (Nationales Suizidpräventionsprogramm für Deutschland) covers public education, crisis intervention, suicide prevention among children and adolescents, workplace initiatives, means restriction, treatment of associated mental health problems, training for professionals, and working with the media. For more information, see <http://suizidpraevention-deutschland.de/Home.html>.

Greenland

A proposal for a national suicide prevention strategy in Greenland was developed and presented to the Greenland Parliament in 2004. An abbreviated copy of this document is available for download at <http://www.peqqik.gl/upload/rapport - engelsk.pdf>

Japan

In 2002, the Japan Ministry of Health, Labour, and Welfare Special Committee on Prevention of Suicide released a report on national suicide prevention strategies, beginning work on implementation of the Japanese suicide prevention strategies (Ueda & Matsumoto, 2002). One such program (“Health Akita 21”), began in 2000, was a community-based suicide prevention program in Akita Prefecture in the Tohoku Region of Japan, employing a Health Promotion approach (Motohashi, Kaneko, & Sasaki, 2004). In 2007, Japan’s Cabinet approved measures to try to reduce that country’s suicide rate by 20% over the next decade.

Among the majority of the world’s suicides occur in Asia. To date, efforts are underway in China (see Phillips, Yang, Zhang, Wang, & Zhou., 2002), Hong Kong, and India to encourage the development of national suicide prevention strategies.

Ireland

In 2005, Ireland’s Health Service Executive, National Suicide Review Group, and Department of Health and Children released ***Reach Out: National Strategy for Action on Suicide Prevention 2005-2014*** (available for download at http://www.dohc.ie/publications/pdf/reach_out.pdf?direct=1). This work builds on the work of the National Task Force on Suicide (1998). Ireland also has a National Parasuicide Registry, and a National Health Promotion Strategy for 2000-2005 (see <http://www.dohc.ie/publications/pdf/hpstrat.pdf?direct=1>). More information is available at the website of the National Office for Suicide Prevention (<http://www.nosp.ie/>).

Northern Ireland

In 2006, the Minister for Health, Social Services, and Public Safety released a draft of Northern Ireland's national suicide prevention strategy for consultation (***Draft Suicide Prevention Strategy: Protect Life-A Shared Vision*** see <http://www.dhsspsni.gov.uk/suicide-consultation-main-report.pdf>). Later that same year, the Health Minister launched the finalized strategy ***Protect Life-A Shared Vision-The Northern Ireland Suicide Prevention Strategy & Action Plan 2006-2011***, at the same time creating a pilot telephone helpline for North and West Belfast, and promising funding to support suicide prevention. As of 2008, Northern Ireland had a dedicated 24-hour helpline for people in crisis, a result of the national strategy.

Netherlands

In 1997, the Netherlands was identified as having a suicide prevention program which consisted of one or more targeted activities with no planned coordination between activities.

([http://www.health.gov.au/internet/main/publishing.nsf/Content/1D2B4E895BCD429ECA2572290027094D/\\$File/intprev.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/1D2B4E895BCD429ECA2572290027094D/$File/intprev.pdf)). In response to a policy advisory document on suicide prevention, in 2008, the Netherlands's Minister of Health, presented to Parliament an agenda for a new national policy on suicide prevention making recommendations that the Government take on a more prominent role in several areas in a national strategy. It is reported that Government adopted most recommendations. Efforts to develop a national strategy remain underway. <http://www.supportproject.eu/news/policynews/preventing-suicide-and-depression/suicide-prevention-new-national-policy.htm>

New Zealand (Youth)

The National Youth Suicide Prevention strategy was published in 1998. It has two parts: In Our Hands, which is the general population strategy and Kia Piki Te Ora o te Tatamariki (Strengthening Youth Wellbeing), which specifically targets Maori needs and issues. Since that time, the Ministry of Health released the 2006 document the ***New Zealand Suicide Prevention Strategy: 2006-2016*** building and expanding upon the youth strategy to provide a strategy for all New Zealanders (see [http://www.moh.govt.nz/moh.nsf/pagesmh/4904/\\$File/suicide-prevention-strategy-2006-2016.pdf](http://www.moh.govt.nz/moh.nsf/pagesmh/4904/$File/suicide-prevention-strategy-2006-2016.pdf)).

Norway

Norway established the National Plan for Suicide Prevention (1994-1999) under the direction of their National Board of Health. Annual funding of 6 million NOK (approx. \$1.2 Million CAD) was approved. The objectives of the plan were externally evaluated and largely achieved. The plan was extended as Measures Against Suicide (2000-2002) that includes a national training strategy under the direction of National Board of Health.

Scotland

"Choose life: A National Strategy and Action Plan to Prevent Suicide in Scotland" was published in December 2002 by the Scottish Executive. This document outlines the national and local strategy for suicide prevention in Scotland and raises issues such as public awareness, taking action to prevent problems arising in the first place, providing early support and intervention where problems do occur, developing a wider range of supports and services, improving training for front-line workers, and research and monitoring. To date, a number of Choose Life Local Action Plans have been developed for implementation of local plans for suicide prevention, various research and evaluation projects have been commissioned, and a Suicide Information Research and Evidence Network (SIREN) has been developed-this group co-sponsored the 2008 12th European Symposium on Suicide and Suicidal Behaviour (ESSSB12) in Glasgow. For more information on this strategy, see <http://www.chooselife.net/home/Home.asp>.

Slovenia

A suicide prevention strategy was proposed for Slovenia in 1995; however, to date it does not appear that such a strategy has been developed.

Sri Lanka

Operating for over 30 years, , the leading suicide prevention NGO in Sri Lanka has operated a befriending program. In 1997 Sri Lanka's Presidential Committee on Prevention of Suicide was the first of the developing countries to operationalize a national suicide prevention strategy and three years later, the Presidential Committee ceased to function, thus leading to questions around sustainability of the initiative. (Vijayakumar L., Pirkis, J. Whiteford, H. (2005).: Suicide in Developing Countries (3) Prevention Efforts. Crisis; Vol. 26(3):120–124. Still, efforts continue and in 2003, Sri Lanka produced media guidelines in the form of "Suicide Sensitive Journalism Handbook" http://www.cpalanka.org/research_papers/suicide_report.pdf. In November 2007, the Sri Lankan department of agriculture announced that alterations and elimination by 2010 of a toxic pesticide attributed to a significant number of deaths by suicide: <http://medicine.plosjournals.org/perlserv/?request=read-response&doi=10.1371/journal.pmed.0050058&ct=1#r2140> Although no nation-wide prevention strategy appears to be available, suicide prevention programs are in effect in Sri Lanka.

Sweden

In 1997 The Swedish National and Stockholm County Centre for Suicide Research and Prevention was designated a WHO Collaborating Centre in order to assist the WHO in initiating and evaluating suicide preventive research and programmes. The centre has a national responsibility for devising measures to prevent

suicide and is active in four main areas - research and development of suicide preventive methods, epidemiological surveillance, information and teaching.

United States

The US Senate and House passed resolutions (1998) that recognized suicide as a major public health problem. The process of developing a national strategy was grounded to the UN national strategy guidelines and spearheaded by the volunteer led Suicide Prevention Advocacy Network (SPAN) with the help of public and private supporters. The issue was championed by the Surgeon General with the release of a Call for Action report in 1999. The first-ever national suicide prevention strategy ***National Strategy for Suicide Prevention: Goals and Objectives for Action*** was published in 2001. Additional U.S. federal suicide prevention initiatives include formation of the Suicide Prevention Resource Center (SPRC), development and evaluation of a nationwide single-number accessible suicide prevention telephone line, and passing of the Garrett Lee Smith Memorial Act establishing funding for suicide prevention initiatives in Colleges and Universities.

Wales

In November 2008, Wales initiated the “Talk to me: A National Action Plan to Reduce Suicide and Self Harm in Wales 2008-2013” initiative. Full details of the initiative can be found at:
<http://new.wales.gov.uk/news/latest/081104actionplan/?lang=en>

Appendix #4

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Appendix #5

Health Canada's Canadian Institutes of Health Research ("CIHR"), Report on the Workshop on Suicide-Related Research in Canada, Montreal, February 7-8, 2003, identifies 6 Broad Themes for Ongoing Investigation, as follows:

In alphabetical, not priority order

1. Data Systems: Improvement and Expansion

The improvement and expansion of data systems depends on a strong classification system, reliability and the elimination of biases. Data should be comprehensive, e.g., include information on both completed suicides and suicidal behaviours.

2. Evidence-based Practices

Research on evidence-based practices includes the evaluation of interventions (ranging from clinical treatments, public education and professional/volunteer training to systems-level interventions, policy changes, and strategies for improving knowledge translation and uptake). The focus of evaluative studies can be broad, including the impact on practice and community responses. Research under this theme may also address the determination of what constitutes acceptable influence, and as such will likely use (and examine the use of)

methodologies that extend well beyond Random Clinical Trials to include various qualitative and quantitative approaches as well as indigenous knowledge. Also eligible would be studies of how suicide research and the development of evidence-based practices are influenced by current peer review and ethics review processes, and research into the nature of evaluation in this subject area, including its intent and utilization.

3. Mental Health Promotion

The Mental Health Promotion theme includes components such as actualization, advancement, the development and dissemination of culturally and community-appropriate information. It also covers community capacity, community-based initiatives and cultural continuity at multiple levels, e.g., individual/family/community/nations. Research topics include protective factors, risk factors and resiliency over the life span and address issues related to discrimination, care for the caregiver (the wounded healer), social competence, shame, stigma and the perception of mental illness. The focus is on a problem-solving approach that is based on efficacy and excellence and that acknowledges the need for growth and fulfillment of human potential. Positive psychology and the effects of social supports and isolation should also be considered under this theme.

4. Multidimensional Models for Understanding Suicide-Related Behaviours

Multidimensional models can be community and theory-driven, but must be based on theoretical models and multi-dimensional approaches. Models must (a) address more than one factor and (b) explore interactions among factors. There is a need to encourage (but not require) interdisciplinary themes. The focus must be broader than suicide, i.e., it should cover the spectrum of suicide-related behaviour. Priority should be given to projects where design, methodology and measurements cross various domains.

5. Spectrum of Suicide Behaviours, including Suicide Attempters

The spectrum of suicidal behaviours includes aborted, attempted and assisted suicide, attempts disguised as accidents, deliberate self-harm, euthanasia, the hastening of death through life-threatening or self-injurious behaviour, suicidal gestures, suicidal ideation and suicide threat. It includes non-fatal/sub-intentional attempts, premature death, and risk behaviour, screening identification. There is a need for mutually accepted operational definitions for terms such as parasuicide.

6. Suicide in Social and Cultural Contexts

The incidence of suicide in Canada varies dramatically as a function of institutional, regional, social, spiritual, cultural and political contexts. It is critical to develop new knowledge about how these contextual factors have an impact, not only on the incidence of suicide, but on determining what constitutes best practices in the prevention of suicide and in responding to suicide-related social and human problems.

The CIHR [Report on the Workshop on Suicide-Related Research in Canada](http://www.cihr-irsc.gc.ca/e/institutes/inmha/18918.html) can be found in its entirety at: <http://www.cihr-irsc.gc.ca/e/institutes/inmha/18918.html>

Appendix #6

Resources and CASP Contact Information

The Canadian Association for Suicide Prevention (CASP):

870 Portage Ave.
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Associate Executive Director: Mary Jo Bolton
Administrative Coordinator: Donna Reid

CASP President and Board Chair: Dammy Damstrom Albach
Editors: Yvonne Bergmans, Mary-Jo Bolton and Adrian Hill

The Suicide Information and Education Centre of the Centre for Suicide Prevention (SIEC):

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Fax: 1-403-245-0299
e-mail: siec@suicideinfo.ca
website: www.suicideinfo.ca

CASP welcomes your feedback and all information, research and data, suggestions and ideas to help improve, expand and strengthen the Canadian National Suicide Prevention Strategy.

All corrections, comments, and other feedback should be directed to the executive director of the Canadian Association for Suicide Prevention: Tim Wall.