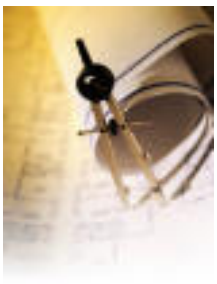
Canadian Association for Suicide Prevention
L'association canadienne pour la prévention du suicide

The CASP Blueprint for a Canadian National Suicide Prevention Strategy.



First Public Release, October, 2004

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I. Acknowledgements

This Blueprint was prepared by members of the Board of Directors of the Canadian Association for Suicide Prevention with assistance from other organizations and individuals.

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II. 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 member, neighbours, friends, patients. 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.

This CASP Blueprint for a Canadian 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. 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.

III. 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 suicidal behaviours.

Suicide is the triumph of pain, fear and loss over hope.

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. These deaths include our children and our parents, our family members, our friends, our neighbours and people from all socioeconomic, age, gender, culture and ethnic groups. 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. Through our silence, and fueled by our fears, ignorance has resulted in much suffering. Now is the time to confront the silence. We must all be willing to learn. We must all be willing to educate ourselves and become ready to move into action to prevent suicide and 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 they provide much knowledge. We know that those at risk for suicide experience overwhelming emotional pain. They do not necessarily want to die, but do want 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, but merely transferred to family, friends and community. The grief of those bereaved by suicide requires compassion, understanding and support to help minimize its impact. Many countries have developed or are developing national strategies to reduce suicide and minimize its impact. It is now Canada's turn.

The writers of this Blueprint anticipate cooperation, enthusiasm and funding from all levels of government and from all segments of Canadian society. We expect our federal government to take a leading national role, to apply its own *Health Canada's Healthy Living Strategy* and initiate the successful implementation of this *CASP Blueprint for a Canadian National Suicide Prevention Strategy*.

This blueprint 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. This blueprint has been developed through the Canadian Association for Suicide Prevention / L'association canadienne pour la prévention du suicide. 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 blueprint into a strategy for all Canadians.

IV. 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.

Communities in Crisis

Every year in Canada, approximately 4,000 people die by suicide. It remains a leading cause of death for men, women and young people. In every family and in each community, the aftermath of a death by suicide is as painful and tragic as it is profound and far-reaching.

Can we prevent suicide?

Experience teaches us that many suicides can be prevented. Suicide is the triumph of pain, fear, hopelessness and despair over hope. Suicide is almost always preventable by knowledgeable, caring, compassionate and committed communities. Most developed nations in the world have established suicide prevention strategies, often utilizing Canadian expertise to guide the development and implementation of those strategies. Now is the time for Canadians to join with all levels of government to create a national suicide prevention strategy. 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 blueprint:

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-based.
    - **b)** Active and informed.
    - **c)** Respectful of community and culture-based knowledge.
    - **d)** Inclusive of research, surveillance, evaluation and reporting.
    - **e)** Reflective of evolving knowledge and practices.
5. Many suicides are preventable by knowledgeable, caring, compassionate and committed communities.

V. GOALS & OBJECTIVES

(A) Awareness and Understanding

Goal 1- Promote awareness in every part of Canada that suicide 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 Increase 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.

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

Objectives:

2.1 Ensure a broad representation of government, private and public stakeholders in further development, adoption and implementation of the CASP Blueprint.

2.2 Increase the number of national professional, voluntary and other groups that integrate suicide prevention activities into their ongoing programs and efforts.

2.3 Identify and increase the number of advocacy activities for suicide prevention at community, provincial/territorial and national levels.

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 illness, substance abuse, 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.

Goal 4 - Increase media knowledge regarding suicide.

Objectives:

4.1 Develop media news packages and training to increase knowledge and sensitivity regarding suicide.

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 and Intervention

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

Objectives:

1.1 The development of separate strategies by Inuit, First Nations, Métis and all Aboriginal peoples.

1.2 The development of separate strategies for:

- persons suffering depression, other mood disorders, mental illness or with a history of suicidal behaviour or multiple suicidal acts,
- Gay, lesbian, bisexual, transgender, transsexual, intersexed and two-spirited persons.

1.3 The development of separate strategies for other high-risk groups.

1.4 The development of implemented prevention strategies by the Government of Canada, and by each province, territory, region and community in Canada.

1.5 The development of 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 response,
- mental health, medical personnel, and other health care providers.

1.6 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 The development of 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, 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.

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

Objectives:

3.1 Increase the number of professional groups in the training and management of suicide risk and identification and promotion of protective factors.

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 response,
- 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 treated for self-destructive behaviours in hospital departments who pursue a follow-up mental health aftercare or continuing care plan.

4.2 Develop guidelines for assessment of suicidal behaviour among persons receiving care in primary health care settings, emergency departments and mental health and substance abuse treatment centres.

4.3 Develop guidelines for assessment of suicidal behaviour across the age span including children, youth, adults and the elderly.

4.4 Develop 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.

4.5 Increase the number of outreach activities for those affected by suicidal behaviour.

4.6 Promote the development of provincial and regional strategies for service delivery and accessibility.

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 history of self-harm 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.

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 and mood disorders.

6.2 Develop and promote interventions and coordinated service delivery for persons with mental illness, mood disorders, substance abuse and addiction, and dual diagnosis 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 suicidal behaviour.

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 facilities.

7.4 Develop a national crisis line network to connect existing crisis lines and to provide service where none exists.

7.5 Connect all 'accredited' community-based Crisis Lines across Canada, to one three-digit access system (N11). In this 'Accredited Network' callers are able to connect and receive emotional support, 24 hours a day, everyday from highly trained volunteers, supported by professional Crisis Intervention staff.

7.6 Develop a national crisis resource data base accessible to all crisis lines and crisis intervention facilities.

7.7 Develop and implement support structures for families living with suicidal people. Acknowledge their roles both as caregivers and as contributing members of the care team.

Goal 8: Increase services and support to those bereaved by 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 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 programs that promote resiliency and protective factors.

9.2 Increase connections and networking and improve cooperation and communication between suicide prevention and intervention programs, and services and associations to those programs 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 deaths, non-fatal attempts and ideation.

1.2 Develop standards for coroners to assist in accurately determining and reporting on *cause 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 Adopt the recommendation from the Canadian Institutes of Health Research (February, 2003) on the national suicide research agenda, identifying six broad themes for ongoing investigation. [See Appendix 4]

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.

(D) Funding and Support

Goal 1: Increase funding and support for all activities connected with the CASP Blueprint for a Canadian National Suicide Prevention Strategy.

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 Blueprint for a Canadian National Suicide Prevention Strategy within three years.

1.2 Support advocacy at all levels to achieve all the above goals and objectives.

1.3 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.

1.4 Give priority to initiatives and strategies that most closely follow the Guidelines, Goals and Objectives in this CASP Blueprint.

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 CASP Blueprint

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. 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. Suicidal behavior is an action, not an illness, which has a fatal outcome. It doesn't result from a single cause. Suicidal actions (resulting in fatal and non-fatal outcomes) should be viewed in the context of mental health issues and other conditions of risk - such as social isolation, biological vulnerability, trauma and stress, family violence, illness, and substance abuse - that interact in complex biopsychosocial ways. Aboriginal communities, in particular, understand that the problem is not just individual but involves a constellation of personal and wider community issues.

The tragic and complex nature of a suicide action has traumatic and rippling consequences, both for individuals and for 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, the causes of which lie in some combination of biological, psychosocial and environmental factors. There is a need for better understanding of the nature of suicide and for a national strategy designed to mobilize policies and services and to affect public attitudes toward suicide and its prevention if the impact on Canadians is to be reduced. 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 through the country.

Why Canada Should Implement a National Blueprint for Suicide Prevention?

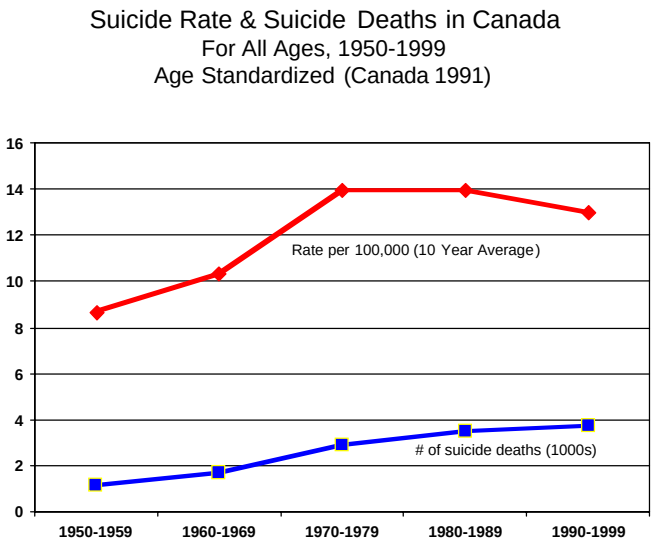
Because, we have to do better. Working together we will do better. While much has been accomplished by many Canadians, in many areas and in many settings, no vehicle exists to express our collective will to build, to share and to improve our efforts utilizing our cumulative experience and expertise.

1. The suicide rate in Canada is higher than in many industrialized countries.

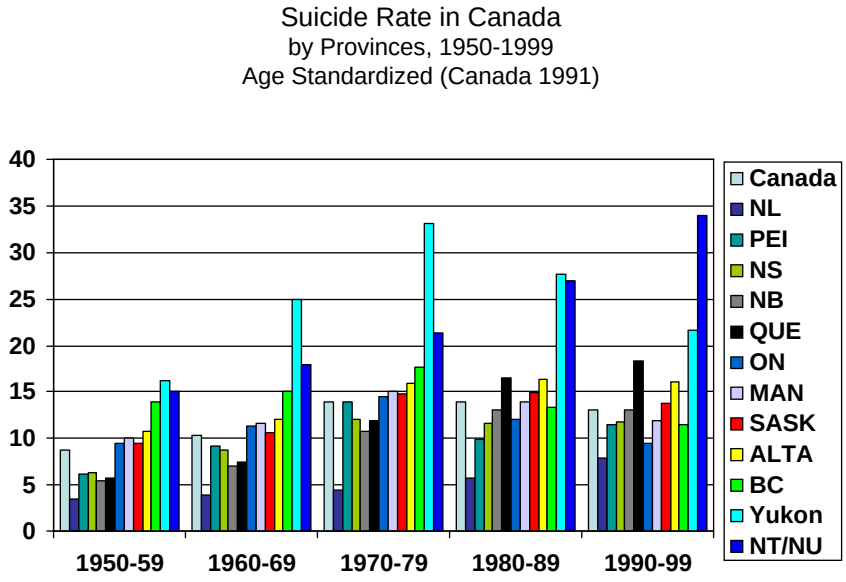
The Canadian suicide rate is near the middle of all countries and in the top third of the highest rate countries reporting to the WHO. The Canadian suicide death rate per 100,000 of population has increased 73% from an average of 7.4 in the 1950's to an average of 12.9 throughout the 1990's. The rate increased significantly from the 1960's to the 1970's but has remained relatively stable throughout the 1980's and 1990's. WHO reports show that the suicide rate for Canadian youth is the third highest in the industrialized world. More young Canadians die by suicide than by disease or by most other forms of injury.

2. Over 4,000 Canadians die by suicide every year.

The Canadian population has shown a steady increase from less than 14 million in 1950 to just over 30 million in 1999, an increase of 122%. The numbers of suicide deaths each year have more than tripled in the same period from just over 1,000 to over 4,000, while the population-adjusted rates of suicide have increased from 8.9 per 100,000 in 1950 to 13.13 in 1999, an increase of almost 50%. The most significant 10-year average increase was from the 1960s to the 1970s, which stabilized through the 1980s and showed the beginning of a downward trend in the 1990s; a trend that needs to be continued and sustained.



More than 10 Canadians kill themselves every day, and with inconsistent mortality reporting standards across Canada's provinces, there are well over 4,000 suicide deaths each year representing 2% of all deaths by Canadians. Canada loses on average 11 people a day to suicide, a figure that has been tragically predictable throughout the 1990s and into the early 2000s.



Statistics Canada suicide data go back to 1924 but were incomplete until 1956 when territorial data was included. Female suicide rates from 1924 to 1950 varied from a high of 7 to a low of 4.8 per 100,000, very similar to the current rates. Male suicide rates from 1924 to 1950 ranged from a high of 24 in the late 1920s to a low of under 15 during the Second World War. By the end of the 1990s, they were again approaching the 20 per 100,000 level.

The rates of suicide for First Nations and Inuit people are a serious concern of tragic proportions. In 1997, age-standardized rates available from Saskatchewan, Manitoba and British Columbia show a suicide rate almost three times higher than the total Canadian population. The suicide rates in Inuit regions range from two to six times the national average. The rates have been as high as 82 (per 100,000) in Nunavik, 30 in Labrador and 77 in Nunavut compared to 13 per 100,000 in all of Canada.

3. Over 400,000 Canadians deliberately harm themselves every year.

Research shows that the rates of deliberate self-harming behaviours, including serious suicide attempts, may be 100 times higher than rates of suicide deaths. The large number of people engaging in self-harming actions may be one result of the increased levels of stress and resulting mental health problems evident in our current society (Bland, Newman, Dyck, 1994; Kerkhof et al, 1994). Although it is difficult to arrive at accurate national figures for attempted suicide, a review of hospital discharge records provides another look at the magnitude of the problem. In

1998/99 a total of 22, 887 hospital discharges were related to suicide and intentional self-inflicted injury, close to 6 times the number of suicide deaths. Approximately 9% had been discharged in that year for one previous attempt and among these repeated attempts; approximately 23% had been discharged on at least three occasions following a suicide attempt. Recent (2002) national health survey information indicates that 3.7% of the Canadian population over 15 years has thought of suicide in the past 12 months.

4. Over 2,800,000 Canadians are affected by suicidal behaviour every year.

Using a conservative estimate of seven individuals personally affected by every suicide death and act of intentional self-harm, over 2.8 million Canadians are affected annually.

Suicide and acts of self-harm affect all of us, families, friends, classmates and co-workers. They strain our health care system and increase the level of stress in society.

5. Suicide is a leading cause of death for Canadians between ages 10 and 49.

In 1995, suicide was the leading cause of death for Canadian males aged 10 to 49. Cancer, motor vehicle collisions and HIV/AIDS were the next most common causes of death. At the end of the 1990s, it was the leading cause of death for men between 25 and 29 years and 40 to 44 years, and for women between 30 and 34 years. For young people between 10 and 24 years, suicide was the second leading cause of death for both males and females, surpassed only by motor vehicle collision deaths. For young First Nations people, suicide was the leading cause of death for youth between 10 and 19 years, accounting for 38% of all deaths for that age group, and higher than the 30% killed in motor vehicle collisions.

As we enter a new century, suicide is ranked third after cancer and heart disease across all ages in potential years of life lost for men; for women, it is fourth after cancer, heart diseases, and motor vehicle traffic collisions. 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 in 1999, the potential years of life lost was higher than all cancers combined and 50 percent higher than potential years lost to all circulatory disease. 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 (2,827years).

The age group from 25 to 50 years is the primary parental group in Canada. Members of this age group exhibit some of the highest rates of suicidal behaviour. Family disruption due to suicide can lead to a wide range of social and financial problems, which in turn result in more deaths and antisocial behaviours.

6. Suicide is the second leading cause of death among Canadian youth aged 10-24.

Fatal injuries from suicidal behaviour closely follow motor vehicle collision injuries as the most likely cause of death for young Canadians. While the numbers of MVC deaths have been falling for several years, youth suicide rates in the 10-19 year range have been increasing.

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 per 100,000. 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 and ending at 21.0 in 1999. 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 immediately 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 suicide acts 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 5.3 in 1999. Although females have some tendency to utilize more lethal and less reversible methods in recent years, they are more likely to take advantage of community suicide prevention services and to ask for help even after initiating a suicide attempt. Males are less likely to ask for help from any source at any time.

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

Suicide follows cancer 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 which 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 suicide rates of males of this age are among the highest of any age group. Suicide is the third leading cause of death among females in this age group

9. Suicide deaths and attempts cost the Canadian economy over $14.7 billion annually.

Several Canadian and US studies have estimated the cost of death due to AIDS, gunshot wounds and suicide. The estimated cost of a suicide death ranges from $433,000 to $4,131,000 per individual depending on potential years of life lost, income level and effects on survivors. One study completed in New Brunswick estimated the average direct and indirect cost per suicide at $850,000.

The estimated cost of attempted suicide ranges from $33,000 to $308,000 per individual depending on the hospital services and rehabilitation required and the 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. Suicidal 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 suicidal actions 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.

Appendix #2

Current Suicide Prevention Initiatives in Canada

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.

Newfoundland

Suicide intervention training by independent trainers.

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 loose arrangement, is province-wide.

Prince Edward Island

Community crisis services and independent suicide intervention training.

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

Quebec

The only funded provincial suicide prevention association in Canada. Established provincial policy with designated funding. Established network of community crisis/distress centres. Annual conferences and awareness week activities. Independent suicide intervention training. Government funded suicide prevention research centre. Repertoire of available resources produced by the **Conseil permament de la jeunesse.**

Ontario

Independent suicide intervention and bereavement training. Established network of crisis/distress centres. Some regional suicide prevention organizations and initiatives such as the **Hamilton Suicide Prevention Council,** the **Toronto Council on Suicide Prevention**, the **Ottawa-Carleton Regional Inter-Agency Suicide Prevention Committee**, and **The Arthur Sommer Rotenberg Research Chair** at the University of Toronto (established through private funding). The recently established, unfunded, **Ontario Suicide Prevention Network** is working to improve education, networking and sharing of suicide prevention resources.

Western Canada

Manitoba

Suicide prevention training and resources responsibility with mental health staff in government and regional responsibility for direct services through Regional Health Authorities without designated funding for suicide prevention services. Independent trainers and crisis/distress centres provide services.

Saskatchewan

Government coordinated Adolescent Suicide Awareness Program (ASAP) with a designated youth suicide prevention facilitator in each health district and a part time provincial coordinator. Corporate funded youth suicide prevention program (Friends For Life) currently winding down with the end of funding. Independent trainers and crisis/distress centres work throughout the province.

Alberta

Provincial programs since 1981 with internationally recognized components but no formal provincial policy. Active components include: Coordinated Community Outreach, Information and Training (The Alberta Model), but little funded research. 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. Some staff training at Solicitor General and Child Welfare agencies. Intervention training in some school systems.

British Columbia

The Ministry of Health funds the **BC Suicide Prevention Program** which is administered through the University of British Columbia to provide leadership for the province in the area of youth suicide prevention. Encourages community consultation and support, education and skill development, information and research, and provincial coordination and monitoring. Assists and supports the development of community suicide prevention services and coordinates government funded **Community Wide Suicide Prevention Pilot Projects**. Developed a manual of ***Best Practices in Youth Suicide Prevention.***

The North

Yukon Territory

Independent suicide intervention training with some government departments supporting staff training

Northwest Territories

A cooperative government/foundation suicide intervention training initiative in final stages of training for trainers. 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 small number of distress centres have been certified by the American Association of Suicidology, but there is 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. National meetings have been hosted to discuss suicide prevention. Co-hosted a special workshop on **suicide-related research in 2003**.

Kids Help Line

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

LivingWorks Education, Inc.

A public service corporation providing 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,* by Dr. Adrian Hill, LSM, Ph.D, Juris.D., ICADC, 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 counselling and peer support. The LPAC program has been the catalyst for this CASP Blueprint project.

RCMP

The **Aboriginal Police Service** of the RCMP provide 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.

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.

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.

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. This initiative was supported by 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**. 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.

History — How did we 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 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 blueprint strategy to be released at CASP meeting in 2004.

Appendix #3

National Strategy Guidelines in Other Countries

2003/04

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.

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.

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.

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.

Australia

Australia initiated a four-year $13 million budget for a *Here For Life Youth Suicide Prevention Initiative* in 1995/96. 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.

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.

United States

The US Senate and House passed resolutions (I998) 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 was published in 2001 and implementation steps are now underway.

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.

Canada

In 2004, the Canadian Association for Suicide Prevention publishes the CASP Blueprint, Canada's first National Suicide Prevention Strategy.

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 measurement cross different 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, 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 can be found

in its entirety at:

http://www.cihr-irsc.gc.ca/e/institutes/inmha/18918.shtml

Appendix #6

Resources and CASP Contact Information

The Canadian Association for Suicide Prevention (CASP):

301 – 11456 Jasper Avenue
Edmonton, AB, Canada
T5K 0M1

Tel: 780. 482.0198
Fax: 780. 488.1495
e-mail: casp@suicideprevention.ca
website: www.suicideprevention.ca

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

Centre for Suicide Prevention
Suite 320, 1202 Centre Street SE
Calgary AB, Canada
T2G 5A5

Tel: 403.245.3900
Fax: 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 CASP Blueprint for a Canadian National Suicide Prevention Strategy.

All corrections, comments, and other feedback should be directed to the Blueprint Editor:

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