# SUICIDE RESPONSE PLANS: A COMPARATIVE CROSS-JURISDICTIONAL ANALYSIS

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# STRATÉGIES D'INTERVENTION FACE AU SUICIDE : ANALYSE COMPARATIVE PANGOUVERNEMENTALE

Prepared for the
Mental Health Task Force
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## Executive Summary

Suicide is the second most frequent single cause of death among Canadian children and youth. Since the mid-1980's the occurrence rates among those between ten and nineteen years of age have increased significantly, marked by a dramatic spike in suicides by Aboriginal and northern adolescents. Nearly one-third of Aboriginal youth who die, do so at their own hand. People in the Territory of Nunavut, in particular, have witnessed a rising loss of young lives. Given the ascendance of suicide in rural and remote parts of the country, the Mental Health Task Force of the Centre of Excellence for Children and Adolescents With Special Needs undertook a review of suicide response planning in Canada (which varies by province or territory) that considers these policies in a comparative international context. The country's research and policy community interested in suicide issues is currently engaged in a lively debate about the need for a national intervention strategy. The intent was to produce a comprehensive, systematic policy document which will inform that debate and, more important, provide for policy formulation specific to children and youth.

Information on existing policies, rates, trends and programs were compiled through a review of documents available from Canada's respective provincial and territorial governments, as well as non-governmental sources. Similar material was obtained for Australia, New Zealand, Norway, Sweden, England and the United States. Key informant interviews were done with individuals in policy decision-making roles at relevant ministries across the country, as well as with university-based researchers. This information was augmented by a review of literature evaluating the effectiveness of response planning.

Obviously response plans are shaped by the complex nature of suicide as a phenomenon. So the report starts with a discussion of the factors associated with suicide and how these combine to compound the risk for individuals and groups. Characteristics thought to predispose certain young people to act, such as mental disorders like depression, are considered along with situational triggering stressors such as parental breakups. As well, there are pressures common to their time of life related to drug use, social competition, and interpersonal difficulties. Aboriginal youth often have an additional burden resulting from socio-economic disadvantage, discrimination and cultural dislocation.

The report compiles detailed information on suicide planning from the eight Canadian jurisdictions which have policies and/or programs in place: Alberta, British Columbia, Manitoba, New Brunswick, the Northwest Territories, Ontario, Quebec, and Saskatchewan. These vary in scope; there are comprehensive integrated initiatives in a few regions, but just generally facilitative policies or narrowly targeted programs elsewhere. The diverse approach found across Canada is compared with that of countries, such as Australia, New Zealand and Norway, which have adopted national strategies to confront suicide. The discussion considers cross-cutting themes common to these frameworks, as well as elements that are situationally unique.

Effective response policies share certain features. They are holistic in approach, addressing

all of the bio-psycho-social aspects of suicide. They are also comprehensive in terms of both the recipient and provider groups involved, instead of focussing on a narrow target population or relying on a dominant discipline model. Rather than creating new services, they co-ordinate delivery of care from among the existing health resources in a community. Moreover, good strategies include *before* as well as *after-the-fact* interventions, building resiliency among youth as a protective factor against risk increasing change or loss in their lives. Ideally, the approaches are transferrable, so they can be adapted and applied in various settings. Policy frameworks must allow for local input and control, however. For example, to be culturally appropriate for Aboriginal youth, the interventions must be based on processes identified by their communities. Finally, evaluation must be incorporated into the design of response plans in ways that provide continual feedback. The monitoring and regular updating of information facilitates identification of trends and helps to enable adjustments in existing policies.

A large number of discrete components that contribute to comprehensive suicide response planning are discussed. Several of these are of a concrete nature; for example limiting access to firearms and drugs or other common means of committing suicide. Others are more amorphous, albeit vital, like establishing system-wide protocols between the network of agencies serving a given geographic area, to ensure that crisis events are met with a co-ordinated and timely response. The barriers to effective intervention are also considered. These fall into four broad areas. First, a lack of *knowledge*, for example about suicide warning signs, or appreciation of the pain suffered by depressed youth. Second, *attitudes*, like the fear that talking about suicide will encourage its occurrence, may impede efforts to deal with critical situations. Third, there may be a lack of *skills* in knowing how to respond to attempters. And, fourth, real or perceived lack of *access* to services can be a major barrier, especially in the case of rural youth. For purposes of a national strategy, the barriers to effective response planning include the following: shifting political agendas; governments' willingness to spend on short-term "quick fix"crisis management, but not invest in long-term solutions; the lack of unity among stakeholders; and competition between advocates of various social causes for attention and scarce resources.

Recognizing the essential role of research and evaluation in the formulation and implementation of good suicide response plans – whether local, regional or national -- the report outlines unique methodological and ethical issues that must be considered. For example, although suicide rates are alarmingly high, for research purposes they are low, making scientifically rigorous studies difficult to mount. Acknowledging these impediments, argument is made for the study of key questions that bear on suicide policy formulation.

## Sommaire exécutif

Le suicide constitue la deuxième cause de décès chez les enfants et les jeunes canadiens. Depuis le milieu des années 80, le taux de suicide chez les jeunes de dix à dix-neuf ans a considérablement augmenté, et on note une hausse alarmante des suicides chez les adolescents autochtones et du Nord. Près du tiers des jeunes autochtones décèdent par suicide. La population du Nunavut a particulièrement été éprouvée par une augmentation des pertes de vie chez les jeunes. Compte tenu de la hausse des suicides dans les régions rurales et éloignées du pays, le groupe de travail sur la santé mentale du Centre d'excellence pour les enfants et adolescents ayant des besoins spéciaux a commencé à étudier la planification, au Canada, des interventions face au suicide (qui varie selon la province ou le territoire) en tenant compte de ces stratégies dans un cadre comparatif international. La collectivité canadienne de recherche et de stratégies qui s'intéresse aux questions touchant le suicide mène actuellement des débats animés sur le besoin de mettre en place une stratégie d'intervention nationale. Ces débats ont pour objectif d'élaborer un document stratégique systématique détaillé qui fera connaître ces débats et, plus important, jettera les fondements permettant de formuler une stratégie spécialement adaptée aux enfants et adolescents.

L'information relative aux stratégies actuelles, taux de suicide, tendances et programmes a été compilée en analysant les documents disponibles provenant des gouvernements provinciaux et territoriaux du Canada, ainsi que de sources non gouvernementales. Du matériel similaire provenait également de l'Australie, la Nouvelle-Zélande, la Norvège, la Suède, l'Angleterre et les États-Unis. Des personnes jouant un rôle décisionnel stratégique dans différents ministères pertinents à travers le pays, ainsi que des chercheurs universitaires ont aussi été interrogés. Cette information est étayée d'une analyse de la documentation évaluant l'efficacité de la planification des interventions.

De toute évidence, les stratégies d'intervention sont modelées par la nature complexe du suicide en tant que phénomène. Le rapport débute donc par une discussion sur les facteurs associés au suicide et comment leur combinaison forme le risque chez les individus et les groupes. On a tenu compte des caractéristiques susceptibles de prédisposer certains jeunes à passer aux actes, notamment les troubles mentaux comme la dépression, ainsi que des facteurs circonstanciels de stress déclencheurs tels que la séparation des parents. Il existe également des pressions communes au moment de la vie reliés à l'usage de drogues, la compétition sociale et les difficultés interpersonnelles. Les jeunes autochtones présentent souvent un fardeau additionnel résultant de difficultés socioéconomiques, de discrimination et de dislocation culturelle.

Le présent rapport comporte une information détaillée sur la planification face au suicide provenant de huit territoires canadiens ayant en place des stratégies et (ou) des programmes : l'Alberta, la Colombie-Britannique, le Manitoba, le Nouveau-Brunswick, les Territoires du Nord-Ouest, l'Ontario, le Québec, et la Saskatchewan. Leur portée varie; on retrouve de vastes initiatives intégrées dans quelques régions, mais surtout des stratégies générales facilitantes ou des programmes étroitement ciblés. La démarche diversifiée au Canada a été comparée à celle de quatre autres pays comme l'Australie, la Nouvelle-Zélande et la Norvège, qui ont adopté des stratégies nationales pour

faire face au suicide. La discussion s'est penchée sur des thèmes transversaux communs à ces cadres, de même que sur des éléments uniques sur le plan circonstanciel.

Les stratégies d'intervention efficaces partagent certains aspects. Elles font appel à une démarche holistique et abordent tous les aspects biopsychosociaux du suicide. Elles sont également complètes en fonction tant du groupe bénéficiaire que du groupe pourvoyeur, au lieu de se concentrer uniquement sur une mince population cible ou de compter sur un modèle disciplinaire dominant. Plutôt que de créer de nouveaux services, elles coordonnent la délivrance de soins à partir des ressources de santé déjà en place au sein de la collectivité. Les bonnes stratégies incluent par ailleurs des interventions *avant* et *après le fait*, ce qui renforce le ressort psychologique comme facteur protecteur contre les changements ou les pertes qui surviennent pendant la vie des jeunes et qui augmentent leur risque. Idéalement, les démarches sont transférables, de sorte qu'elles peuvent être adaptées et appliquées à divers milieux. Les cadres stratégiques doivent cependant permettre la participation locale et le contrôle. Par exemple, les interventions appropriées sur le plan culturel pour les jeunes autochtones doivent être fondées sur des procédés identifiés par leurs collectivités. Enfin, l'évaluation doit être intégrée à la conception des plans d'intervention de façon à fournir une rétroaction continue. Le suivi et la mise à jour régulière de l'information facilite l'identification des tendances et aide à favoriser les ajustements des stratégies en place.

Un grand nombre de composantes discrètes qui contribuent à une planification détaillée d'intervention face au suicide sont abordées. Plusieurs d'entre elles sont de nature concrète; par exemple limiter l'accès aux armes à feu et aux drogues, ainsi qu'à d'autres moyens couramment utilisés pour commettre un suicide. Quoique vitales, d'autres sont plus amorphes, comme l'établissement de protocoles à l'échelle du système entre les agences desservant une région géographique donnée, afin d'assurer une intervention coordonnée et ponctuelle en situation de crise. On a également tenu compte des obstacles à une intervention efficace. Ceux-ci se divisent en quatre grands secteurs. D'abord, un manque de *connaissance*, par exemple au sujet des signes précurseurs de suicide ou de l'évaluation de la douleur ressentie par les jeunes déprimés. Deuxièmement, les *attitudes*, notamment la peur de parler du suicide, qui encourage son incidence et peut nuire aux efforts visant à traiter les situations critiques. Troisièmement, il peut exister un manque *d'aptitudes* à savoir comment réagir face aux jeunes ayant fait une tentative de suicide. Et quatrièmement, le manque réel ou perçu d'*accès* aux services peut constituer un obstacle majeur, surtout dans le cas des jeunes en milieu rural. Aux fins d'une stratégie nationale, les obstacles à la planification efficace des interventions comprend les points suivants: programmes politiques changeants; volonté des gouvernements de dépenser pour une gestion palliative à court terme des situations de crise, sans investir dans des solutions à long terme; manque d'unité parmi les intervenants;et compétition entre les partisans de diverses causes sociales pour attirer l'attention sur eux et le manque de ressources.

Reconnaissant le rôle essentiel de la recherche et de l'évaluation pour la formulation et la mise en place de bonnes stratégies d'intervention face au suicide – que ce soit à l'échelle locale, régionale ou nationale –le rapport met en évidence des questions méthodologiques et éthiques uniques dont on doit tenir compte. Par exemple, bien que le taux de suicide soit alarmant, il est néanmoins faible aux fins de la recherche, ce qui rend plus difficile la réalisation d'études

scientifiquement rigoureuses. En reconnaissant ces obstacles, on justifie l'étude de questions clés ayant un impact sur la formulation d'une stratégie face au suicide.

## Introduction

Next only to unintentional injuries, suicide is the most common cause of death among Canadian children and youth 10 to 19 years old.[1] Since the 1980's the incidence of self-inflicted death by young people has increased significantly, with overall occurrence rates now higher than those found in countries, like the United States and Australia, to which comparisons are often made.[2] Certain segments of this sub-population are at greatest risk: those who are male, between 15 and 19 years of age, of Aboriginal heritage and who live in the far north. The approximate ratios for completed suicides of males to females is 4:1, in the older youth age group 5:1, and for Aboriginals 6:1,[3] with Inuit youth in Nunavut being the single most vulnerable group.

Given the prevalence of suicidal behaviour, especially among the young, strong arguments have been made for Canada to develop a national suicide strategy, as other advanced industrial nations have done. However, the country's research and policy community interested in suicide do not all see this as feasible or, indeed, necessary. When in a recent international newsletter a prominent researcher lamented what he perceived as inactivity on the issue by the federal government,[4] others responded by reminding him of a significant hurdle that would have to be jumped in order to establish a pan-Canadian suicide strategy. Section 92(7) of the Constitution Act (1867) gives the provinces jurisdiction in matters pertaining to health. Consequently, adoption of a national strategy would require complex inter-governmental negotiations, which would take time and be difficult. Moreover, they argued, this approach is not necessary. Quebec, for example, has show it is possible to put a comprehensive plan in place at a provincial or territorial level that is the equal of the national initiatives found in other countries. Faced with Canada's constitutional realities,

expanding and strengthening provincial/territorial policies and programs will result in the best, fastest improvement in suicide prevention and intervention.

The impediments to creating a national policy for the population in general, do not apply to most Aboriginal Canadians, however.[5] Health care for Aboriginal people, on reserve in the case of the provinces and throughout the three northern territories, is a shared responsibility of the federal government, the territorial governments, local Aboriginal governments, and, for some services, the provinces. Therefore Health Canada, through the First Nations and Inuit Health Branch (FNIHB), can take a lead by establishing national strategies to deal with specific issues, enabling both the territorial and community levels of government to implement them in ways that respond to local needs and preferences. There are several areas where this approach has been taken, like the National Tobacco Strategy and the Aboriginal Diabetes Initiative. These frameworks provide sustained funding for health promotion, prevention, and intervention activities.

To date, FNIHB has not been given a clear mental health services mandate, although the branch provides funding for crisis intervention and counselling through the Non-Insured Health Benefits Program, as well as other programs with a mental health component (ie. Building Healthy Communities and the Brighter Futures Initiative). But lacking a mandate, the branch has not developed comprehensive mental health policies or programs for their client population. To remedy this, in 2002 an advisory group on suicide prevention, appointed jointly by the National Chief of the Assembly of First Nations and the Minister of Health, recommended that "Health Canada initiate and support the creation of a comprehensive national First Nations mental health strategy (including a mandate, policies and programs) that integrates approaches to suicides, psychiatric disorders and other critical mental, physical, emotional and spiritual problems in First Nations communities."[6]

Recognizing the different stances on the creation of a national suicide strategy, for Aboriginals and non-Aboriginals alike, the Mental Health Task Force of the Centre of Excellence for Children and Adolescents With Special Needs undertook a review of suicide response planning in Canada that considers these policies in a comparative international context. The intent was to produce a document that will inform discussion and, hopefully, contribute to policy formulation specific to the well-being of children and youth.

Information on existing policies, rates, trends and programs were compiled through a review of documents available from Canada's federal, provincial and territorial governments, as well as non-governmental sources. Similar material was obtained for Australia, New Zealand, Norway, Sweden, England and the United States. Key informant interviews were done with individuals in policy decision-making roles at relevant ministries across the country, as well as with university-based researchers. This information was augmented by a review of the literature evaluating the effectiveness of suicide response planning. In writing this report the authors chose to use position papers and other policy documents in preference to the scientific literature as the principal reference source, reasoning that the former best show the ideas upon which suicide response plans are based.

**Suicide: Occurrence and Cause**

Obviously response plans are shaped by the complex nature of suicide as a phenomenon. Grounded on rates of occurrence and trends, such plans must respond to risk factors and take into account the knowledge and resources available. The statistical elements are relatively easy to document. Overall, Canada has experienced increased suicidal behaviour in the post-war period, with five provinces experiencing triple digit increases.[7] For example, Newfoundland, although it has the lowest rate in Canada, has seen a 261 per cent increase over the last five decades; Quebec, with

one of the highest rates in the 1950's, witnessed a 280 per cent increase. A few provinces have seen their numbers go down. Ontario, Manitoba and British Columbia can all point to significant decreases during the 1980's and 1990's, while Saskatchewan had a small reduction in the latter decade. The Yukon Territory has also had a major drop in the 1990's although the actual numbers are small and fluctuate from year to year, so may not constitute a meaningful trend. From rates lower than several provinces during the 1950's, the Northwest Territories has suffered dramatic increases, with the situation worst in the communities of the eastern part (now Nunavut), where annual rates went from 48.7 per 100,000 in the mid-1980's to 85.5 per 100,000 in the mid-1990's.[8]

Age and gender specific rates vary over time, as well. Among children and youth, the groups of primary interest here, the rates have increased in recent years, with estimates of young attempters as high as 100,000 per annum.[9] Of course, response plans have to reflect age differences, with distinctions "made between the factors that play on children, young people, adults and the elderly."[10] Across the age range, between the genders the pattern of change is significantly different. The rate among males, 11.9 per 100,000 in the 1950's, had climbed to 21.5 by 1995; over the same period the female incidence moved from 3.3 to 5.4 per 100,000.

Suicide results from the interaction of numerous factors; but at the level of the individual it is difficult to predict.[11] "The individual, his history, his immediate environment, his social setting all make up a web almost impossible to untangle."[12] For purposes of response planning in Finland, "suicide is conceptualized as a result of an individual life process that has accumulated the damaging effects of several kinds of problems as predisposing or precipitating factors."[13] While causes may be found throughout the fabric of society[14] and peoples' lives, understanding how they inter-relate is fundamental.[15] For example, Isaacs notes the "need to distinguish between the historic experiences

and general characteristics of individuals that place them at higher risk of suicide (distal risk factors) and the more immediate risk factors or triggers (proximal risk factors), such as family breakup or other stressful life event."[16]

If identifying factors that place particular individuals at risk is difficult, isolating generally found risk factors is not. These are well documented. For example, previous attempts are frequently a precursor of death by suicide.[17] Indeed, in Australia attempters are a primary target group for prevention activities.[18] The literature notes that susceptibility models must take into account both elements of nature and nurture to explain why, for instance, death at their own hand often repeats within families.[19] "This tendency is both genetically inherited and partially acquired during childhood,"[20] according to Swedish experts. Some causes are pathological in nature. Suicide is prevalent among people with diagnosed psychiatric conditions, especially depression and bipolar disorder.[21] [22] [23] [24] Other forms of mental health deviation that precipitate self-destructive acts include impulsive and/or aggressive tendencies toward violence.[25] New Zealand studies suggest that as many as one-third of attempters suffer from conduct disorders and antisocial behaviour disorders.[26] The risk is heightened when a mental condition co-exists with alcohol or other substance abuse.[27] [28] "High rates of psychiatric illness and the presence of co-morbid disorders primarily characterize young people at highest risk of suicide."[29] Many causes are situational. For instance, where individuals have suffered a major loss, whether of a romantic relationship, through the death of a significant person in their life, or their job.[30] [31] Similarly, those suffering debilitating physical illnesses are prone to see suicide as a remedy to their suffering.[32] In other cases, a sense of social isolation[33] prompts people to act. Ultimately, feelings of hopelessness[34] result in personal tragedies and hard statistics.

Religious and traditional cultural beliefs[35] as well as media coverage of suicide by popular cultural celebrities[36] are identified as triggers for youth suicide. The persuasive effect of friends' suicidal behaviour also motivates some individuals. The phenomenon of suicide clusters among groups of young people underscores the contagious influence of their peers on teenagers.[37] Adolescents' attitudes about the issue are critical. A British Columbia study found: "compared to youth from the United States, Canadian youth saw suicide as an acceptable and normal response to problems and felt that suicide was more of a private matter."[38] At the same time, other studies conclude that teenagers may not seek needed help because of the stigma associated with mental health problems, or if treatment is difficult to access.[39]

Certain life experiences are differentially associated with suicidal behaviour. At higher risk are children and adolescents who were born into families which are poor,[40] [41] where parent-child relations are impaired, [42] or meaningful parental contact is lost due to separation and divorce.[43] Recent work has also underscored the vulnerability of gay and lesbian youth.[44] In some instances, singular events precipitate a crisis – an incident of sexual abuse, for example – but on-going challenges are more common. Coggan & Patterson found New Zealand youth "felt that a build up of a series of crises rather than one major issue contributed to suicidal ideation and behaviour."[45] They identified a lengthy list of pressures faced by teenagers. Some of these are broadly shared and common to their time of life, like social competition and peer pressure to use drugs. But many of the pressures are unique to individuals; difficulties linked to their sexuality, relationship problems, dissatisfaction with their body image, and parental expectations that they will excel at school. A stressor for some in this New Zealand sample, was the fact that they found themselves straddling between two cultural traditions, Maori and European.

The disjuncture associated with existing in more than one culture plagues Aboriginal youth worldwide; it is one of several suicide risk factors that are unique to indigenous populations. A sense of cultural alienation,[46] mixed with historical, social and economic dislocation,[47] is toxic for individuals. "The loss of traditional lifestyle has been linked to anomie, powerlessness, and youth suicide in Aboriginal cultures throughout North America, Australia, and the world."[48] The situation of Canada's Aboriginal youth is not significantly different, marked as it often is by poverty, lack of education, and limited opportunities. Moreover, many are burdened by unresolved grief around cultural suppression, cross-cultural adoptions and racial discrimination.[49] Among the Inuit, where wide-scale contact with Euro-Canadian culture is a phenomenon of the post-war period, each of the three living generations has been born into a radically different world. The sense of cultural division is inextricably linked to age; the rapidity of change creating immense barriers to inter-generational communication between children, their parents and their grandparents. More generally, the relationship between cultural maintenance and suicide in Aboriginal populations depends upon the degree of group integration and the extent of outside contact: "tribes whose beliefs and values promoted an interdependent and cohesive community, and who had limited contact with the dominant culture, demonstrated the lowest rates of suicide. When contact occurred, those communities that managed to maintain a strong interdependent and cohesive community maintained low suicide rates."[50]

**Suicide Response Planning: Canadian Measures**

In the policy arena, the Canadian government has wrestled with the issue of suicide for more than three decades. Leenaars[51] traced the public policy response from the 1970 *White Paper* that identified suicide as a major mental health problem, through decriminalization (1972), and stricter

gun control (1978), to the establishment of a National Task Force on Suicide (1980) and The Royal Commission on Aboriginal Peoples (1995), both of which produced significant documents on the topic. As noted earlier, however, the federal government's mandate to provide direct health services is limited. Since the provincial and territorial government's have primacy in setting health policies, differences from one to another with respect to suicide response planning are to be expected. Eight Canadian jurisdictions have policies and/or programs in place: Alberta, British Columbia, Manitoba, New Brunswick, the Northwest Territories, Ontario, Quebec, and Saskatchewan. These vary in scope; there are comprehensive integrated initiatives in a few regions, but just generally facilitative policies or narrowly targeted programs elsewhere.

Most of the focus is on education and early intervention training, although Tanney[52] notes there is often little coordination within the bureaucracy of a given jurisdiction. Nor are these initiatives well funded. Nelson *et. al.*[53] calculate that approximately 0.1 per cent of provincial mental health budgets are spent for prevention programs overall, with suicide being only one – albeit a significant area of interest. It should be noted that non-governmental bodies play a major part in our response to suicide, with the Canadian Mental Health Association at the forefront in Alberta, New Brunswick, the Northwest Territories and Ontario, the *Association québécoise de suicidologie* in Quebec, and the Canadian Association of Suicide Prevention acting nationally. At the frontline are community initiatives in prevention (e.g. the Suicide Information and Education Centre in Calgary), intervention (e.g.. Kamatsiaqtut: Baffin Island Crisis Line) and postvention (e.g. SAFER: Suicide Attempt, Follow-up, Education and Research Program in Vancouver).[54]

Four Canadian provinces and one territory are considered to have reasonably well-developed, comprehensive strategies in place to respond to suicide: Alberta, British Columbia, New Brunswick,

the Northwest Territories and Quebec. These plans differ in their particulars and approach, but little in their overall objectives. Rather than describing each in detail, for present purposes it is sufficient to summarize one of the most inclusive plans, that of Quebec, and then highlight features of policies and programs in other provinces.

Introduced in 1998, the Quebec strategy sought to transform existing services into an integrated network that would respond to needs in a holistic fashion. "The expertise and skills required to help suicidal individuals and their relatives are available. But we must encourage linkages among the various partners in the community and institutional sectors and promote avenues and agreements that foster complementarity in our actions and interventions."[55] Consolidation of essential services and, importantly, ending the isolation of caseworkers, depends on developing protocols for intervention, service agreements between institutions, reference guides and clinical supports for caseworkers. To improve services also requires augmenting the assessment and intervention skills of front-line professionals to deal with suicidal individuals, those around them or those in mourning as a result of a self-inflicted death.

The Quebec plan set out a series of initiatives to address particular objectives. These include the development and evaluation of highly integrated prevention and intervention projects targeting groups at high risk (e.g. males in prison, teenaged girls and previous attempters). Specific to youth, are programs to increase clients' personal efficacy and social skills, and to develop peer group suicide prevention expertise. The plan also incorporates several broader objectives. For example, it seeks to reduce access to the means through which people take their own lives (firearms, dangerous sites, medication and carbon monoxide). As well, it seeks to counteract the trivialization that results from sensational coverage of suicide occurrences, by emphasizing a sense of community,

responsibility and the value of life. Finally, the plan sets forth a priorized research agenda: evaluation of initiatives across the service spectrum; research on risk-group specific interventions and other aspects of the problem; and, basic research on suicide etiology and epidemiology. Responsibilities for implementation are clearly set out, divided between the ministère de la Santé et des Services sociaux, regional boards and local organizations and institutions.

The following paragraphs briefly highlight the strategies of other provinces. In New Brunswick, suicide response strategies are fundamentally community-based, although organized province-wide on a standardized conceptual and implementation model. At the system's heart are the local community mental health centres, which are involved in mental health promotion as well as suicide prevention, intervention and postvention, acting in concert with hospitals, police forces, and other agencies. Thirteen Community Suicide Prevention Committees are in place to provide advise to the centres, but also to liaise and coordinate at a regional level and provide advice to the Provincial Suicide Prevention Committee and, through it, the provincial government's Mental Health Services Division.[56]

The focus in the Northwest Territories is on community-level education. In response to a spike in suicides during the 1980's, the territorial government, in collaboration with the Canadian Mental Health Association, the Dene Cultural Institute and other agencies, developed the Northwest Territories Suicide Prevention Training program. It is designed to increase the capacity of community caregivers and natural community helpers to recognize and cope with those at risk of harming themselves. The fifteen week program, offered in communities to between 15 and 20 carefully screened participants, starts with an extended module on grieving and healing. Because of the high levels of suicide in the Northwest Territories, almost everyone has experienced some

personal loss. This component helps them to come to terms with that loss and to apply their understanding of it to help others. The grieving and healing module rated highly in evaluations of the program. There is considerable demand for knowledge about suicide in the territories' communities. To meet this demand in a cost effective way, a four week train-the-trainer module was added to the program to teach those who have completed the first phase and have a willingness and aptitude how to teach other community members the program's core content.

Alberta's case underscores the vagaries that a shifting policy environment can introduce. The province is often cited as the leader in developing a comprehensive suicide response plan, providing the model on which British Columbia, New Brunswick, the Northwest Territories and other jurisdictions have based their strategies. However, when interviewed, key decision makers within Alberta's mental health care system characterized this view as "outdated." They felt that the leadership mantle had been shrugged off in the early 1990's and that the province had done little to improve services or address residual gaps. They noted, for example, that services continue to vary from one region to another. Restructuring of mental health services in the province, on-going at the time of the interviews, had delayed a planned evaluation of suicide prevention programs.

In 1999, seven communities in British Columbia launched several year-long "before -the-fact" intervention projects using health promotion and early risk identification models. Earlier work had identified fifteen best practices to prevent youth suicides.[57] These demonstration projects had two objectives – to begin the process of putting best practices into action and, through research, to find answers to the question: what works, where? Of the fifteen best practices, eight were tested. Several of these were designed to enhance personal and community strengths thought to protect against suicide, through generic skill building, peer helping, youth participation and community

development. Others addressed factors predisposing or contributing to suicide, through suicide awareness education, school and community gatekeeper training, and establishing system-wide protocols. Evaluation of the projects showed that investing relatively small sums of money can have relatively high impact, and that there is potential to adapt strategies to suit other contexts. It also reinforced the importance of integrated planning to address common risk and protective factors. The evaluation also suggested that the government can contribute by fostering communication between communities to encourage information sharing and create a forum for public discussion. In addition, "(r)esearch is needed that can encompass many communities and community approaches at one time, and allow long-term examination of the impacts of suicide prevention programming on the number of suicides and rates of suicide behaviours in the province."[58]

Created in 1992 by Child and Youth Mental Health Services, the Saskatchewan Suicide Prevention Program is designed to assist health districts in coping with the youth suicide issue.[59] The program is generally facilitative in nature, working with mental health staff in districts across the province to provide suicide prevention, early identification, crisis intervention, treatment and consultation, bereavement and trauma counselling. The program also helps communities to develop their capacity to respond to youth at risk in various ways, including by educating professionals and non-professionals in critical skills.

The populous province of Ontario has been criticized for its lack of a comprehensive suicide response plan.[60] In fact there is just one program in place in the province, albeit one of major importance. Kids Help Phone is a national toll-free telephone and internet counselling and referral service that provides bilingual 24 hour-a-day coverage, every day of the year. Approximately 1,000 telephone calls are answered daily by professional counsellors who provide anonymous and

confidential help to children and youth facing a myriad range of problems, including suicide. The internet site gets about 200,000 hits a year. This vital program receives no on-going government funding; it's nine million dollar budget is raised mainly through corporate and individual donations.

**Suicide Response Planning: International Comparisons**

A number of countries have adopted national suicide response plans, prompted by high occurrence rates among segments of their respective populations. These vary from the detailed, comprehensive, relatively prescriptive Australian and American plans to the more selectively targeted English and Norwegian approaches. But they share in common a goal of reducing the number of suicides and suicide attempts. Indeed, Sweden made this their explicit goal when committing to the World Health Organization's "Health for all in the year 2000" targets.[61] England attached a number to their objective: to lower the suicide rate at least 15 per cent by the year 2000. Despite the differences in their particulars, when the plans of six countries – Australia, England, New Zealand, Norway, Sweden and the United States – are compared, common themes appear. These essentials may be subsumed under the three broad headings put forward in 1999 by the U.S. Surgeon General's *Call to Action to Prevent Suicide*: awareness, intervention and research.[62]

Public awareness is fundamental to establishing and achieving acceptance of suicide response plans. People need to realize that suicide is a largely preventable public health problem, which the community must take collective responsibility to combat. This "whole community" approach is a priority in the Australian plan and integral to those of New Zealand, Sweden and the United States. General engagement on the issue requires that members of the public know about and, if necessary, can direct others to supportive services in their communities. It may also necessitate changing

widely-held attitudes. For example, removing the stigma that is often attached to those who seek mental health treatment is an explicit objective of the American and Australian plans.

Intervention, as used here, is inclusive of activities across the spectrum of care. Effective intervention plans are characterized (e.g. in New Zealand and Norway) by co-ordinated efforts on the part of health and social service agencies, done in collaboration with the responsible governmental offices. Further, all countries' strategies recognize that the causes of suicidal behaviour are multiple and so, too, must be the remedies. This includes taking account of the unique aspects of the population at risk; the Australian, New Zealand and American plans give priority to establishing programs that are culturally relevant for their respective Aboriginal populations, while Norway's delivery system is designed to accommodate the country's dispersed settlement pattern. Programs should reinforce protective factors in a society (Australia and New Zealand), but also attempt to ameliorate adverse social conditions (Sweden). Initiatives targeting various populations at risk must be developed for adult and juvenile offenders (Australia), drug users (Sweden), and the clinically depressed (England), as well as young people everywhere.

Improving the skills of health and social service workers, so that they recognize the signs of mental health deviations often associated with suicidal behaviour and refer or treat clients appropriately, is a core intervention element (the United States, Australia, New Zealand, and Norway). Moreover, training should cut across disciplinary bounds, effectively creating response teams made up of individuals with a number of areas of expertise (Sweden and Norway). In the American case, the suggested list of human service professionals extends to include clergy, teachers, and correctional workers.[63]

One element common across national response plans is controlling the access suicidal individuals have to the various means of self-harm. Despite their divergent policies with respect to lethality in certain forms (e.g. gun control), the United States, Australia, England, Norway, and Sweden have all made this a central tenet of their plans. Another element (Australia, England , and the United States) addresses the presentation of suicide by the media and entertainment industries. The American plan summarizes the rationale for this clearly: "Cluster suicide and suicide contagion have been documented, and studies have shown that both news reports and fictional accounts of suicide in movies and on television can lead to increase in suicide."[64] A further element supports family members and others bereaved by suicide (New Zealand).

The Australian, New Zealand, Norwegian, and American plans all advocate for a robust agenda of research to advance understanding of suicide as a phenomenon. For example, there are calls for more work on the interaction between protective factors and those inducing risk, clinical treatments, risk-group specific interventions and comparative program evaluations. Epidemiological studies are of fundamental importance; this requires what the American plan refers to as "surveillance," the systematic and on-going collection of data. Commitment to evidence-based planning is borne out in requirements that monitoring and evaluation be a built-in part of intervention programs.

**Suicide Response Planning: Components**

As these Canadian and international policies and programs show, a large number of discrete components contribute to a comprehensive suicide response plan. Several of these are of a concrete nature; others are more amorphous, albeit vital to success. The former include the maintenance of drop-in centres, support groups or telephone hotlines for vulnerable youth,[65] as well as efforts to

restrict access to firearms, drugs, or high places commonly used to commit suicide.[66] There is a two-fold rationale for *means* denial. First, the suicidal act may be delayed long enough for the impulse to pass. And, second, prevented access to the most lethal means, individuals' attempts at self-harm may be less life threatening. "When there is ready availability of methods of suicide which are rapidly and irrevocably fatal, then some people who only intend to make an impulsive suicide gesture may inadvertently become a completed suicide."[67] Other acts that are concrete in nature improve the "gatekeeping" functions performed by health professionals to ensure that people in distress receive timely help. Examples would include routine screening within high risk populations,[68] and specific assessment and treatment of parasuicides. "There is increasing awareness of the high prevalence of deliberate self-harm and risk-taking behaviours . . . [that are] often the precursors to suicide attempts."[69] Moreover, the likelihood of repeated, more lethal acts spikes dramatically in the months after an unsuccessful attempt.

Broader initiatives to minimize irritants, triggers or contributing factors in the social environment must be part of a comprehensive plan. For example, programs to develop parenting skills in families at risk, which are intended to strengthen the formation of child-parent bonds, are a proven prophylactic against suicide.[70] Similarly, efforts to build resilience among vulnerable youth by providing generic life skills programs that emphasize creative problem solving, effective coping and confidence in interpersonal relationships – all of which increase the sense of competence and self-esteem.[71] But attention must be paid to the context in which young people function, also. The social climate in the schools they attend is often a major influence on their lives. Recent headline suicides by youth bullied at schools in several provinces underscore the importance of careful scrutiny by school authorities, parents and students of what is happening in the classrooms, halls and

on the playgrounds. Only then can carefully planned action be taken to improve the well-being of all students.[72]

It might be argued that news headlines in cases where teens have fallen victim to bullies are beneficial because they focus attention on the tragic consequences of taken-for-granted events. However, media coverage may have negative consequences as well. For instance, it was believed that intense national coverage of Aboriginal youth suicides in northern Ontario during the 1990's had a contagious effect, encouraging risk-taking behaviour by youth seeking attention.[73] As part of a general response plan, the media needs to be educated about suicide and urged to report occurrences in a responsible manner.[74]

Finally, there must be system-wide protocol between the network of agencies that serve a given geographic area, to ensure that those at risk do not fall through the cracks created by agency mandates. They must receive coordinated attention in a timely and effective manner – without duplication of services – from assessment through treatment to follow-up care.[75] The protocol should be part of the respective agencies policies, the written guidelines that direct management of client care under each organization's mandate.[76]

**Suicide Response Planning: Barriers**

There are significant barriers to successful implementation that must be taken into account when developing comprehensive, jurisdiction-wide response plans. These fall into four broad categories: *knowledge, attitudes, skills* and *access*. First is the knowledge deficit that may exist among decision-makers who do not fully comprehend the pain of depression and suicidal thoughts,[77] or lack awareness of the services in place.[78] The former is the greater impediment; those with in-depth understanding of individuals' suffering are more likely to push an agenda of programs and

enabling policies through the bureaucratic maze. Second, both societal and individual attitudes can stand in the way. In some cases widely shared attitudes change with the ebb and flow of events; a pressing issue can quickly fade and be forgotten. As public interest declines, so does the willingness to invest in remedies.[79] In other cases, societal attitudes are entrenched; for certain cultural groups, suicide and the need to provide or seek help is an anathema.[80] Individuals acting on personally held fears can limit the nature and scope of interventions offered. "Discussion of suicide is often met with anxiety and fear by community members."[81] In some Aboriginal communities this fear translates into a prohibition by leaders against talking about suicide, let alone taking action to combat its occurrence.[82] Consideration of services also depends on previous experiences; negative encounters with the health care system can make potential clients unreceptive to similar or the same services.[83]

A significant barrier to implementing effective programs is a lack of skills on the part of health professionals and others when faced with crisis situations. Not knowing, for example, how to respond when youth talk about suicide.[84] Or, caregivers may be able to act within their own professional bounds, but not understand the role of others with whom they should be formulating a collaborative response.[85] In some instances, the lack of insight is quite profound.[86] Insensitivity on the part of health professionals can translate into a question of accessibility. In one study youth complain that some psychologists and psychiatrists are too impersonal[87] – affectively and, thus, effectively unavailable. For rural and northern youth, however, difficulties accessing services are usually tied to a scarcity of providers and the travel necessary to reach them. Clients must wait for routine mental health appointments and then arrange transportation to keep them.[88]

For purposes of forming a national strategy, there are a number of barriers which might be characterized as *political* in nature. Of necessity, government priorities change continuously in response to the pressing issues of the day. And budgets are adjusted accordingly. Youth suicide is a high priority – at times. But it falls off the governments radar at other times. When tragic events create a sense of urgency, governments tend to make "quick fix" crisis management decisions, rather than dealing with the issue in a planned, inclusive way.[89] This lack of sustained interest within a shifting policy agenda, poses particular problems for those interested in formulating a comprehensive strategy. Timing is of critical importance, yet difficult to control because of the lead time required to develop public policies. What is more, despite the complexity of the issues, the models put forward must be conceptually simple, with clear mechanisms, outcomes and priorities.[90]

There is intense competition between advocates of various social causes for attention and scarce resources.[91] A major challenge in the process of policy formulation is achieving a unified position among stakeholders. Often concerned practitioners, decision-makers and academics disagree about what should be done to prevent sucide. However, they must reach consensus about one coherent strategy, if they hope for endorsement by government.

**Suicide Response Planning: Evaluation**

The importance of research and evaluation in the formulation and implementation of good suicide response plans is well-recognized.[92] [93] Yet few programs have undergone rigorous study.[94] [95] Where evaluation has been done, the "studies were methodological inadequate or they have used non-comparable outcome measures, or were difficult to interpret conclusively."[96] In the absence of strong evidence, reservations remain about the effectiveness of suicide prevention or intervention programs in reducing occurrence rates.[97] However, after examining the results from various studies,

Goldney concludes: ". . .far from being pessimistic about our capacity to prevent suicide, there is an increasing number of studies which confirm that it is possible."[98] Likewise, the British Columbia Ministry of Children and Family argues, "there is a clear foundation of knowledge from which we can proceed."[99] Nonetheless, comparative evaluation of programs is difficult because they differ so much in terms of objective, content, delivery and dosage (frequency/duration).[100] With specific reference to school-based suicide prevention programs, a recent review published by the Alberta Heritage Foundation for Medical Research underscored the difficulties in making comparisons and concluded that there was insufficient information on which to either support or not support curriculum-based school programs.[101]

The nature of the phenomenon itself poses substantial research challenges. For example, although suicide rates are alarmingly high, for research purposes they are low, making scientifically rigorous studies difficult to carry out. "The very fact that suicide has such a low base rate makes it virtually impossible, at the very least with conventionally available resources, to mount such huge studies (randomized controlled trials) even if it was ethically possible to do so."[102]

Nevertheless, there is an agenda of research that must be done in a Canadian context to provide evidence of best practices specific to suicide prevention, intervention and postvention. The Canadian Task Force on Preventive Health Care identified a number of areas requiring work, including, but not limited to, evaluation of: family physicians' ability to identify suicide risk; educational programs designed to increase physicians' skills in this area; and the effectiveness of programs identifying those at high risk, together with intervention and follow-up steps.[103] The task force and others[104] note the paucity of Canadian data. They also point out that evidence can not be imported from other countries and applied with confidence, using as an example the fact that school

demographics here differ from those in the United States, making it difficult to generalize from evaluations of American school-based suicide awareness programs.

**Suicide Response Planning: Hallmarks of Effectiveness**

To be effective, suicide strategies must respond to behaviour at various points on a trajectory of lethality – from risk to threat, attempt to completion. So, in other words, they have to include programs aimed at prevention, as well as intervention and postvention for victims. Those charged with developing an integrated approach need a clear understanding of the population at risk and the causative factors, informed by a well-founded theoretical base. Having the required pieces in place is not sufficient, however. Program adequacy depends on a number of factors; for example, the "dosage,"[105] or ratio of exposure frequency to duration, is of critical importance.

The Suicide Prevention Information and Resource Centre of British Columbia identified elements that should be taken into account at the planning stage in developing a provincial level strategy. Although their focus was prevention, the prescribed considerations apply equally to intervention and postvention programs. The key is to operationalize a service framework that clearly and specifically outlines implementation steps.[106] To do this, a number of questions have to be answered:

- What type and level of evidence is required to formulate a policy?
- What are the key information links?
- What services currently exist?
- What are the gaps in these services?
- What tangential projects are needed?
- What will constitute a comprehensive program of services?
- What means will be used to evaluate the program?

Obviously, this is a highly specialized policy area. Consequently, the centre stresses the importance of employing experts with relevant Canadian experience to develop jurisdiction-specific frameworks, and to continue to rely on expert opinion throughout the actualization and evaluation of the resulting policies and practices.

Certain characteristics of good response plans are consistently identified in the literature. One key is the use of multiple approaches to address a given challenge, rather than relying on "one answer for all who ask" [107] [108] Alternately described as *holistic* or *comprehensive*, such strategies take into account the biological, psychological and social dimensions of suicide and address the needs of individuals, their families and communities.[109] Writing about school based programs, Metha, Weber & Webb advocate for components that focus on overall health: physical, mental, social and emotional.[110] Clinical actions may be needed for individuals, but these should be combined with co-ordinated efforts to reach a larger audience. "Reducing the rates of suicide and self-harm among youth requires the concerted and coordinated efforts of both the broad-based prevention system (before-the-fact interventions) and the more specialized, individual-focussed treatment system (after-the-fact interventions)"[111] Taylor, Kingdom & Jenkins note the need for multi-faceted "comprehensiveness with regard to the range of groups at whom interventions are aimed, the range of disciplines or agencies implementing interventions and the range of intervention."[112]

With specific reference to prevention, it is argued that programs for children and youth should be goal oriented,[113] and consider not only risks, but also protective factors that may exist.[114] Indeed, an emphasis on personal resiliency is a hallmark of effective programs. "The bottom line is that we need to balance our risk-focussed efforts in suicide prevention with an equal emphasis on the

promotion of resilient outcomes in young people and the creation of competence-enhancing environments."[115] By reinforcing their strengths and sense of competence, as well as developing their ability to think in terms of consequences, they are better able to cope with challenging life situations.

Despite the gravity of youth suicide in Canada, limited human and fiscal resources dictate what is done about the issue. Initiatives that link to the existing health care and educational system in a community are most successful.[116] [117] That having been said, shortfalls within those systems need to be remedied. For example, a British Columbia source advocates improved education about symptoms for physicians who are the system's gatekeepers, noting that about one-half of those who die at their own hand were seen by a general practitioner in the preceding four weeks.[118] Improving physicians' skills in recognizing symptoms and providing care is a central tenet in a care-based approach to suicide prevention.[119]

Because of the incidence of suicide among Aboriginal youth, response plans must incorporate strategies that are informed by the values, beliefs and concerns of First Nation, Inuit and Métis Canadians. In this regard, it is important to recognize the diversity of Aboriginal traditions. One example of over-generalization is the assumption that the medicine wheel is the conceptual basis for all Aboriginal people's understanding of health, despite the fact that it is a foreign concept to many groups. The key is finding the cultural elements that affirm, celebrate and cherish life.[120] It is equally vital to understand that each community has a unique mix of strengths and challenges. Too often those responsible for developing service delivery policies assume that Aboriginal communities are alike. They are not. Some are traditional and resistant to changes while others embrace new developments. Some witness continuous internal political friction, while others are stable and well

managed.. Some suffer from rampant alcohol and drug abuse, while others are stringently "dry" communities. Some are highly religious, others not. To be successful, response plans must accommodate local circumstances, as well as the interests and concerns of all stakeholders: the clients, the providers, and the planners.[121] [122] [123]

Evaluation is widely seen as a constituent part of any successful plan.[124] Not only should formative assessments be done of on-going programs, evaluation needs to be incorporated into the design for new programs in ways that provide continual feedback. The monitoring and regular updating of information facilitates identification of trends and helps enable adjustments in existing policies and programs. Given the importance attached to having suicide policies and programs that are well-grounded in everyday experience, participatory action research models that actively involve community members are recommended as part of an overall evaluation framework.[125]

In 2001, the Mental Health Evaluation and Community Consultation Unit at the University of British Columbia identified best practices specific to youth suicide prevention programs.[126] Although focussed on prevention, the potential applications in terms of intervention/postvention are evident. The practices, themselves, reflect the foregoing hallmarks of effective programming with some additions. Highly visible and meaningful initiatives can be generated by adhering to the following practices.

- Train local people to train others in their communities;
- While respecting local approaches, explore adaptation of models developed in other contexts;
- Link initiatives to create a complimentary, systematic approach;
- Focus on leadership models that enable collaboration, but allow for distributed responsibility;
- Generate a comprehensive evaluation of initiatives as a basis for a best practices inventory;
- Adopt standardized measures that will allow accurate monitoring of suicidal behaviour; and
- Link communities to one another around the issue.

Government has a lead role to play in implementing such practices, whether at a provincial/territorial or national level.[127]

**Suicide Response Planning: Toward A Uniform Approach in Canada**

Many young Canadians are at high risk of taking their own lives – whether induced by biological, psychological or social conditions. All of them are equal in their need of supportive services – but not all have equal access to the services that they need. Often their fate depends upon where they happen to live. It is obvious that Canada should develop a uniform approach to suicide – so every child and adolescent at risk has similar chances to survive and thrive.

At present there are eight different provincial or territorial suicide strategies in place across the country and, in the case of five, no jurisdiction-wide plans at all. The strategies that exist vary considerably in nature and scope. However, the fact that general responsibility for delivering health care is in the hands of the provincial or territorial governments does not preclude moving toward a more uniform approach. The elements that make up a comprehensive, inclusive suicide response plan are well known and many models exist, both internationally and here in Canada. To achieve comparable levels of care for all children and youth, the provinces and territories have simply to make this issue a priority – and then to learn from one another.

Aboriginal youth are at particular risk of self-inflicted death. After years of staggering statistics, given the federal government's constitutional responsibility for their health and well being, it seems surprising that an Aboriginal mental health plan has not been adopted. Lacking such a strategy, when faced with continuous episodes of suicidal behaviour, the government has responded by attempting crisis management, providing critical resources on a short-term basis. This translates into a crisis perpetuating recipe. While it may ameliorate the pressures of the moment, it does not

address the causes of suicide, or offer opportunities for prevention. Indeed, even follow-up care may not be provided. The government must heed the call of it's own Advisory Group on Suicide Prevention and create a comprehensive national mental health strategy for Canada's Aboriginal people. In sum, concerted federal/provincial/territorial action is needed to protect our children and youth from self-harm.

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