

# Suicide Policy in Canada: Lessons From History

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## ABSTRACT

In Canada, suicide has transitioned from being a criminal activity with much associated stigma, to being a public health concern that needs to be managed by governments and clinicians in a culturally sensitive manner. In Canada and worldwide, the social attitudes toward and legal interpretation of suicide have been dynamic. Much has been proposed in the development of suicide policy in Canada, however Canada is unique in that it remains one of the only industrialized countries without a national suicide prevention strategy. The current article provides a critical review of the history of suicide in Canada, as well as an appraisal of Canadian suicide prevention policies and key government and political milestones that have impacted suicide policy. Current activity regarding a national suicide prevention strategy in Canada is discussed, as well as potential options for clinician involvement.

**Key words:** Suicide; policy; history

La traduction du résumé se trouve à la fin de l'article.

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Every year, nearly 4,000 Canadians die by suicide.<sup>1</sup> It has been estimated that direct and indirect costs of each suicide total almost \$850,000, with a Canadian annual total of over \$2.4 billion.<sup>2</sup> After a peak in 1978, suicide rates in Canada have remained relatively stable, decreasing slightly over time.<sup>3</sup> In 2010, the suicide rate in Canada was approximately 12 per 100,000,<sup>4</sup> as compared to 14.8 per 100,000 in 1978.<sup>5</sup> While overall rates appear stable, sex differences exist with younger females dying by suicide at greater rates than in the past, and younger male suicide rates having stabilized.<sup>6</sup> Suicide rates vary among groups, with rates higher in some populations. Suicide rates among First Nations are between 3 and 6 times those of the general population.<sup>7</sup> Suicide is also elevated among youth, and is one of the top 3 causes of death among 15 to 34 year olds.<sup>8,9</sup>

Suicide is acknowledged as a significant public health issue, yet national policies remain largely undeveloped. According to Miljan (2008), health policy occurs in five stages: 1) defining the policy problem, 2) formulating policy, 3) decision making, 4) policy implementation, and 5) policy evaluation.<sup>10</sup> While non-partisan support from all major Canadian political parties exists for a Bill supporting a national suicide prevention strategy (NSPS),<sup>11</sup> Canada is just entering the decision stage, presuming this stage will lead to policy implementation. In the meantime, the Canadian Association for Suicide Prevention (CASP), established in 1985 to represent professionals and non-professionals, has been leading the development of a national strategy. In 2007, CASP released a blueprint for a NSPS.<sup>12</sup> More than 6 years later, government policy is still early in development.

This brief introduction illustrates that evidence-based approaches can inform new suicide policy but new policy can be informed by past initiatives. By engaging a historical review, policy-makers can learn from past successes and failures, particularly in relation to the stigmatization related to suicide. This paper illustrates the merit of such an approach by 1) documenting the emergence of

suicide policy in Canada, and 2) highlighting key milestones as we move closer to realizing a NSPS. To add further context to understanding this approach, the unique features of the Canadian health care system are discussed, as well as the potential role for clinician-informed policy-making as an important future direction.

## The emergence of suicide policy in Canada

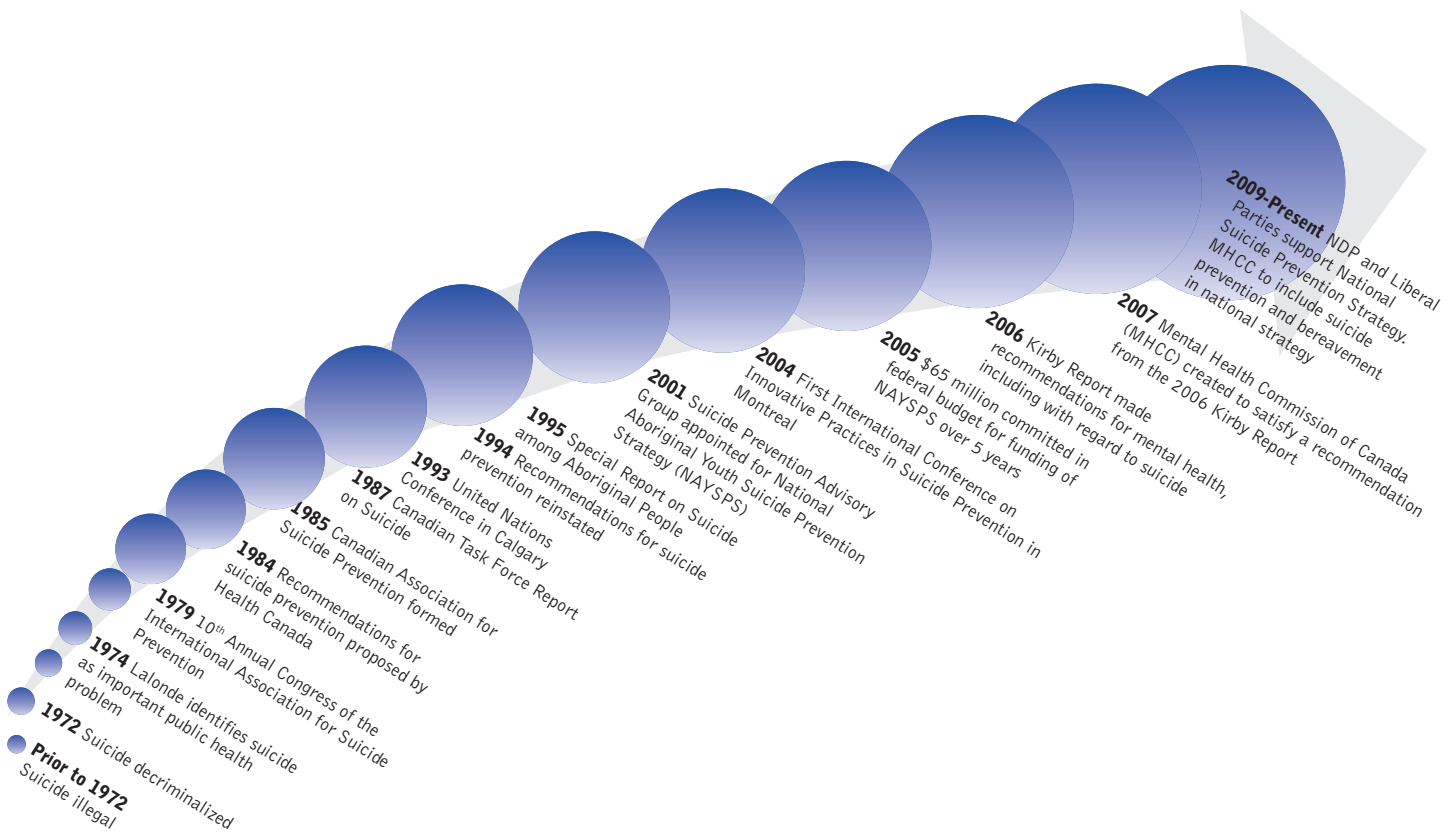
In Canada and worldwide, social attitudes toward and legal interpretation of suicide have been dynamic. Prior to 1972, the act of attempting suicide was a criminal activity punishable by law, thereby making suicide policy a federal jurisdictional matter. In 1972, suicide was decriminalized.<sup>13</sup> Subsequently, suicide was described as a health issue, with policy-makers pressuring the national and provincial governments to respond to suicide through prevention and health promotion policies.<sup>14</sup> In 1974, the Lalonde Report (see Figure 1), a key health promotion document, acknowledged suicide as a health issue and made transparent the stigma experienced by suicide survivors or individuals bereaved by suicide. Although governments were pressured, the development of a NSPS was hampered by constitutional concerns, including provincial governance over health. As well, the social stigma of suicide as a criminal act

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**Figure 1.** Historical timeline of suicide policy in Canada

Data abstracted from various Canadian policy documents<sup>13,14,16,17,27,30,31</sup>

remained, as illustrated by the ongoing use of the phrase “committing suicide”. Many argue that this term reinforces the view that suicide is still viewed as a heinous activity, implying judgement and further compounding the stigmatization of suicide.<sup>15</sup>

Over the course of the 10 years following the Lalonde Report, Health and Welfare Canada established the National Task Force on Suicide in Canada and in 1987 produced a national report.<sup>16</sup> This report included such recommendations as the need for 1) epidemiological evidence to identify at-risk groups, 2) evaluations of suicide prevention programs, intervention and postvention (support for individuals bereaved by suicide), and 3) federal, provincial/territorial and regional suicide policy guidelines. Because of lack of action on the report’s proposed recommendations for suicide prevention, these recommendations were put forward once again in 1994.<sup>17</sup>

Although federal reports have identified suicide as a health issue, barriers to the development of suicide policy have been constitutional in nature. Provincial governments have jurisdiction over health, which means that health policies and programs must occur at the provincial level, limiting the federal government to leveraging knowledge to influence policy and program uptake at the provincial level. Consequently, a NSPS does not exist. Instead, there is a range of provincial initiatives targeting various aspects of suicide prevention. In Manitoba, there is the Reclaiming Hope provincial youth suicide prevention strategy,<sup>18</sup> and a Suicide Prevention Strategy Network, which makes recommendations for policy change. Within each health authority, there are also regional committees that target suicide risk along the age continuum, with a special emphasis on youth and First Nations populations. Many

provinces and territories have also developed excellent strategies and multilevel approaches, each varying in their breadth and scope. These strategies can be found through the Mental Health Commission of Canada Knowledge Exchange Centre.<sup>19</sup> While similarities and differences exist among these strategies, some areas of focus include (and are not limited to): suicide prevention models based on theory and delivered by regional health authorities (New Brunswick);<sup>20</sup> approaches that aim to strengthen the continuum of mental health services, support research on suicide and the effectiveness of suicide prevention initiatives, as well as improve opportunities for early childhood development (Nunavut);<sup>21</sup> use of population health and health promotion approaches and multi-level supports (Nova Scotia);<sup>22</sup> health promotion and suicide postvention activities that occur largely at the community level (Quebec);<sup>23</sup> as well as strategies that aim to improve suicide-related surveillance systems (Alberta).<sup>24</sup> While this is not a comprehensive list of all provincial/territorial strategies, nor does it imply that the mentioned programs are only available in the province specified, it is clear that a national strategy would allow the integration and consistency of programs across Canada.

While policy and program development rests with the provinces, there are exceptions where both policy formation and implementation are a federal matter. For instance, the federal crown has a fiduciary relationship with and obligation to First Nations peoples, and this relationship and obligation has implications for the development and conduct of government policy in matters that involve First Nations peoples. The scope of obligations, and very nature of associated policy, however, can vary with individual circumstances.<sup>25</sup>

For instance, as part of the Royal Commission of Aboriginal Peoples in 1995, the high suicide rates among Aboriginal Peoples were investigated.<sup>26</sup> In 2001, in the wake of this report, a Suicide Prevention Advisory Group was appointed to review research and make recommendations for a National Aboriginal Youth Suicide Prevention Strategy (NAYSPS).<sup>27</sup> In 2005, the federal government committed \$65 million over a 5-year period to support the NAYSPS.<sup>28</sup> This strategy focused on suicide prevention, suicide postvention, and cultural considerations for Inuit youth, First Nations youth living on reserve, and Aboriginal youth living off reserve.

In 2006, the federal government commissioned the Kirby Report to examine mental health and the role of the federal and provincial governments in improving outcomes.<sup>29</sup> This report highlighted suicide as a priority area and the need for federal, provincial/territorial and stakeholder collaboration in the development of a NSPS, including suicide postvention.<sup>30</sup> Also emphasized was the need for a national suicide research agenda and studies on suicide risk and protective factors. The federal government responded and created the Mental Health Commission of Canada (MHCC), which is developing a mental health strategy and reducing stigma associated with mental illness, as illustrated by the Opening Minds campaign.<sup>31</sup> Included in its goals and objectives is suicide prevention.<sup>32</sup>

### Historical lessons

Since 1972, while there has been increased awareness as well as targeted provincial suicide prevention initiatives and action by the federal government, we are still early in policy development. From this review, it is apparent that stigmatization and jurisdictional issues continue to act as barriers to the creation and uptake of policy. While the development of First Nations suicide prevention strategies illustrates growth, it is limited to First Nation communities. Formation of the MHCC was a major milestone, as is political support for a NSPS. Nevertheless, suicide policy in Canada is relatively underdeveloped as compared to countries with a NSPS, such as the USA, Australia, Denmark, England, Estonia, Finland, Germany, Greenland, Japan, Ireland, Northern Ireland, the Netherlands, New Zealand, Norway, Scotland, Sri Lanka and Sweden.<sup>33</sup> Although constitutionally rooted powers have impeded the development of a NSPS in Canada, other nations have transcended jurisdictional barriers. For example, Australia has a federal-national suicide prevention framework with implementation extended to state and territory governments through the Council of Australian Governments.<sup>34</sup> The Council includes representation from the federal government, six state governments, two mainland territories, and the Australian Local Government Association.<sup>34</sup> The Council, chaired by the Australian Prime Minister, discusses and coordinates government activities across the various government levels. One milestone they achieved was placing suicide bereavement under their national strategy, and developing standards and guidelines for suicide bereavement support groups. Although their survivors support group model is based on down- and midstream approaches (i.e., individuals seeking support are already at risk for poor health outcomes), the model allows for standardization across states and territories, resulting in equal standards of care. In Canada, this approach, which could build out from the First Ministers Conference, could result in discussions and coordinated activities to integrate resources, decrease duplication, and improve efficiency.

Benefits of a NSPS are likely vast, as demonstrated by a recent link between reduced suicide rates and mental health services associated with “Suicide and Homicide by People with Mental Illness”, a strategy that monitored suicide in the United Kingdom.<sup>35</sup>

In Canada, there is potential to act on such innovations, given recent national political activity supporting a NSPS.<sup>36,37</sup> A national policy, at multiple levels and across jurisdictions, could address suicide and associated structural barriers. Indeed, a NSPS could result in the integration of redundant provincial suicide prevention frameworks, consistency and equality in postvention approaches, and uniform guidelines and regulations for suicide supports. In Manitoba, for instance, there are several suicide prevention frameworks, each addressing similar areas, which could be integrated.<sup>38</sup> Implementing a NSPS is therefore an opportunity for provincial and federal governments to jointly and uniformly address suicide prevention and postvention, and other recommendations in the *Report of the National Task Force on Suicide in Canada*.<sup>16</sup>

### Clinician advocacy in policy

The engagement of clinicians as advocates illustrates the various ways clinical knowledge can impact and inform suicide policies. For instance, support for a NSPS has come from special interest groups such as the Canadian Psychiatric Association (CPA) and CASP, as noted. CPA has advocated for the creation of media guidelines for suicide reporting aimed at reducing suicide contagion and associated stigma.<sup>39</sup> CASP has advocated for policy development at all government levels, as well as producing and sharing information on suicide interventions and research.<sup>40</sup> In 2004, CASP President Dr. Paul Links called again for federal leadership in developing a NSPS, and argued that all levels of government be involved to reduce suicide rates.<sup>41</sup>

Clinicians engaged in research and/or incorporating evidence in their daily practice can impact policy. For example, in Australia, clinicians have informed health policies in the area of nursing and midwifery, resulting in not only the creation of clinician-informed policy, but also the maximization of clinician investment in the final policy.<sup>42</sup> Clinical expertise can help generate patient risk profiles, identifying individuals at risk for suicide, or poor health outcomes following suicide bereavement. Clinical involvement can also encourage clinicians’ investment in the suicide policy well after its development, leading to improved uptake at multiple levels. An example of a clinician-informed care protocol is the addition of complicated grief- and bereavement-related depression diagnoses in the upcoming Diagnostic and Statistical Manual of Mental Disorders (DSM-V).<sup>43</sup>

### Emerging areas requiring guidance

Emerging areas of suicide policy requiring further investigation include: benefits and limitations of a NSPS within constituted roles; guidelines and regulation of suicide postvention activities; role of help-seeking barriers to suicide prevention and postvention care; policy-making role of clinicians; and investigations into effective suicide prevention approaches, as well as who should have input into the design and testing of these interventions. Ongoing evaluation is also required to refine policy and identify effective interventions. While clinical input is important in determining effective interventions for at-risk populations, finding ways to expand clinician involvement is essential for implementation and uptake of suicide policy.

In summary, suicide has transitioned from being a criminal activity in Canada with much associated stigma, to being a public health concern with some movement to address stigma. Informing the development of a NSPS using a reflective approach has merit in that it makes transparent the history of policy creation, implementation and uptake. From this review, it is clear that more research is required in suicide prevention and postvention programs and to refine appropriate care for all individuals impacted by suicide. As well, clinical advocacy and input has been and is critical in developing and implementing a national suicide policy.

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## RÉSUMÉ

Le suicide, qui était autrefois une activité criminelle à caractère infamant, est devenu au Canada un problème de santé publique qui doit être géré par les gouvernements et les cliniciens d'une manière adaptée aux différences culturelles. Au Canada et ailleurs dans le monde, on constate des changements dans les attitudes sociales face au suicide et dans les interprétations juridiques du suicide. Beaucoup de choses ont été proposées en vue d'élaborer une politique sur le suicide au Canada, mais le Canada est un cas particulier, car il demeure l'un des seuls pays industrialisés à ne pas avoir de stratégie nationale de prévention du suicide. Notre article fait l'examen critique de l'histoire du suicide au Canada et évalue les politiques canadiennes de prévention du suicide et les grands jalons gouvernementaux et politiques qui ont eu un impact. Nous présentons les efforts actuels pour mettre au point une stratégie nationale de prévention du suicide au Canada, ainsi que les moyens possibles pour les cliniciens de s'impliquer.

**Mots clés :** suicide; politique; histoire