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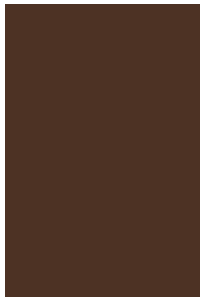

WORKING TOGETHER TO **PREVENT SUICIDE** IN CANADA

THE FEDERAL FRAMEWORK FOR **SUICIDE PREVENTION**

Canada

ACKNOWLEDGEMENTS

This Federal Framework for Suicide Prevention was developed in recognition of those lost by suicide and the many Canadians who continue to struggle with thoughts of suicide.

The Framework recognizes those who are affected by suicide, those who have survived suicide loss and those who have survived a suicide attempt and who are healing. It is built on the tremendous dedication of those who work in suicide prevention, intervention and postvention and those who are working to foster healthy and supportive environments for all Canadians.

If you or someone you care about needs help, please contact a call centre in Canada near you: ***http://suicideprevention.ca/need-help/*** *or 911*

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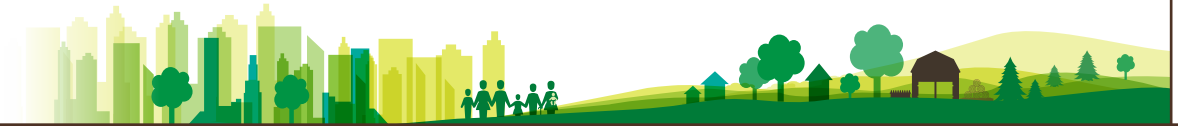


INTRODUCTION

Suicide is a significant cause of premature death in Canada. It affects people of all ages and backgrounds across all Canadian regions. An average of more than ten Canadians died by suicide each day in 2012.[1] Deaths by suicide have devastating and immeasurable impact and leave families, friends, classmates, coworkers and communities struggling with grief and searching for solutions.

Of the nearly 4,000 Canadians who die every year by suicide, more than 90 percent were living with a mental illness.[2] However, not all people who die by suicide have been diagnosed with a mental illness and most people living with a mental illness do not attempt suicide. Suicide also affects certain segments of the population disproportionately, such as some First Nations communities and all Inuit regions where suicide rates can be five to twenty times higher than the national average.[3] [See Annex A for more information about suicide in Canada.]

Suicide is a complex issue involving biological, psychological, social, cultural, spiritual, economic and other factors, as well as the physical environment in which people live.[4] These factors can interact and lead a person to have thoughts of suicide or suicide-related behaviour and the stigma associated with suicide and mental illness may discourage many people from seeking the help they need.[5] Stressful experiences, such as exposure to trauma, the death of a loved one, a job loss, a change in physical health or relationships and individual characteristics and behaviours are also associated with suicide.[6] [See Annex B for more information on the risk and protective factors associated with suicide.]

Suicide is not necessarily the wish to die but a need to end emotional pain.[7] People experiencing thoughts of suicide or suicide-related behaviour may feel hopeless or overwhelmed and see no other option.[5]

Despite the complexities related to suicide, there is hope. Suicide can be prevented when collective efforts are harnessed to instil hope and healing, raise awareness and promote mental health and well-being.

In accordance with ***An Act respecting a Federal Framework for Suicide Prevention*** which became law in December 2012,[8] the Government of Canada developed the Federal Framework for Suicide Prevention (the Framework) to align federal activities in suicide prevention, while complementing the important work underway in provinces and territories, Indigenous organizations,

non-governmental organizations and communities, as well as the private sector.

The Framework is not a national strategy nor does it replace existing strategies or frameworks implemented by provinces, territories, communities or Indigenous organizations. The Framework sets out the Government of Canada's strategic objectives, guiding principles and commitments in suicide prevention. It focuses on better connections among people, information and resources, as well as research and innovation in order to raise awareness, reduce stigma and prevent suicide.

The Framework contributes to the implementation of the ***Mental Health Strategy for Canada: Changing Directions, Changing Lives,***[9] which is focused on improving the mental health and well-being of all Canadians. It also aligns with the ***First Nations Mental Wellness Continuum Framework*** (the Continuum) which is designed to help partners work more effectively with federal, provincial and territorial programs within a comprehensive mental wellness system for First Nations.[10]

The Framework is informed by the ***World Health Organization's Preventing Suicide: A Global Imperative*** report,[5] which reinforces the value of a public health approach to suicide prevention. This approach includes both universal interventions, which strive to improve the health of the population as a whole, and tailored interventions for groups that experience higher rates of suicide and which strive to reduce health disparities between groups.

The public health approach focuses on prevention and draws on multi-disciplinary knowledge, perspectives and experience, including health sciences (such as medicine, nursing, psychiatry and epidemiology), sociology, psychology, criminology, education and economics to broadly understand suicide, identify factors that play a role in increasing or reducing risks for suicide and to improve collective action, research and best practices in suicide prevention. This is widely regarded as an approach that is likely to produce significant and sustained solutions in the prevention of suicide.[11] Overall, the Framework will help connect suicide prevention efforts across Canada and serve as the foundation for meaningful and lasting partnerships across sectors, organizations and jurisdictions to prevent suicide.

INFORMING THE FRAMEWORK

Since *An Act respecting a Federal Framework for Suicide Prevention* was enacted in 2012,[8] the federal government has undertaken considerable analysis to better understand suicide prevention.

The Public Health Agency of Canada gathered information through webinars and meetings with other government departments, non-governmental organizations, national Indigenous organizations, officials from provinces and territories and community stakeholders about current efforts to prevent suicide across Canada. The Public Health Agency of Canada also held an online public consultation to inform the development of the Framework. A total of 376 respondents (both organizations and individuals) participated in this consultation.

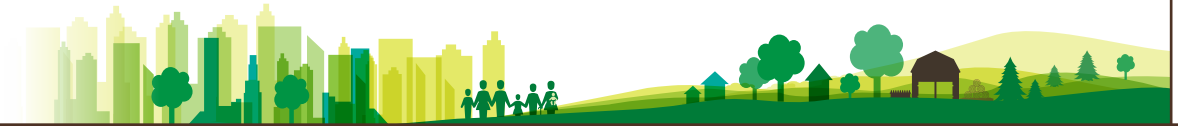
These discussions and consultations provided a broad range of information about many existing suicide prevention approaches and activities taking place across Canada. While excellent work is underway, these discussions highlighted that a number of challenges remain. Suicide prevention efforts and resources are fragmented across the country and among federal departments. As well, there is a need for better information and awareness to reduce stigma and improve programs and initiatives to prevent suicide.

Several key themes emerged from the online consultation:

- *Public perception as a barrier to suicide prevention*—Both the stigma of suicide and the fear of contagion when talking about suicide challenge efforts to raise awareness and disseminate information about suicide. Increased awareness of suicide in the general population to support open dialogue would help advance suicide prevention efforts.
- *The need for effective information dissemination and knowledge-sharing mechanisms, particularly at the community level*—Many respondents indicated that there is a lack of awareness of existing resources or that it is difficult to access tools, resources and guidelines for those seeking services to help themselves, friends or loved ones. Better access to support for those experiencing thoughts of suicide or suicide-related behaviour and for survivors grieving a loss due to suicide would be beneficial.

- *The need for a centralized, credible source of data and research information*—Suicide information, including data and research results, is fragmented, complex, sometimes costly and often difficult to access. Access to data and research about suicide, in a range of formats appropriate for diverse audiences could be enhanced.
- *The importance of learning from people affected by suicide*—The knowledge and lived experience of Canadians who have been affected by suicide should inform the development of guidelines and resources and should be included in prioritizing suicide prevention research. In addition, the perspectives of survivors of suicide loss and suicide attempt should inform dissemination strategies to ensure resources are reaching those who need them most.
- *The need to bring evidence into frontline practice, such as through partnerships between researchers and practitioners*—Priorities should be established for suicide prevention research, including both a traditional focus on risk and etiology as well as emerging science on protective factors and what works in which contexts and for whom. Enhancing knowledge exchange and transfer across sectors and effective collaborations could help result in better outcomes for those affected by suicide.

Those consulted strongly recommended a multi-sectoral approach to suicide prevention that includes populations who are at greatest risk for suicide. Traditional Indigenous knowledge and cultural relevance should inform best practices. Changing public perceptions through comprehensive and sustained public awareness campaigns, prioritizing research and its dissemination, sharing best practices and improving collaboration and coordination across sectors are critical in improving suicide prevention in Canada and will require a collaborative approach between all levels of government, across sectors and within communities across Canada.



FRAMEWORK OVERVIEW

PURPOSE

The Framework guides the Government of Canada's efforts in accordance with *An Act respecting a Federal Framework for Suicide Prevention.*[8]

VISION

A Canada where suicide is prevented and everyone lives with hope and resilience.

MISSION

Prevent suicide in Canada, through partnership, collaboration and innovation while respecting the diversity of cultures and communities that are touched by this issue.

STRATEGIC OBJECTIVES

The legislated elements of the *Act* are organized under three strategic objectives:

1. REDUCE STIGMA AND RAISE PUBLIC AWARENESS

- *Provide guidelines to improve public awareness and knowledge of suicide (Element 1).*

2. CONNECT CANADIANS, INFORMATION AND RESOURCES

- *Disseminate information about suicide and its prevention (Element 2);*
- *Make existing statistics about suicide and related risk factors publicly available (Element 3); and*
- *Promote collaboration and knowledge exchange across domains, sectors, regions and jurisdictions (Element 4).*

3. ACCELERATE THE USE OF RESEARCH AND INNOVATION IN SUICIDE PREVENTION

- *Define best practices for suicide prevention (Element 5); and*
- *Promote the use of research and evidence-based practices for suicide prevention (Element 6).*

THE FEDERAL FRAMEWORK FOR SUICIDE PREVENTION LEGISLATION

An Act Respecting a Federal Framework for Suicide Prevention received royal assent (became law) in December 2012. This Act builds on Bill C-300, a private member's bill introduced by Harold Albrecht, federal Member of Parliament. It emphasizes that suicide is a health and safety priority that is both a mental health *and* a public health issue.

As instructed by the Act, the Public Health Agency of Canada consulted with other federal departments, provinces and territories, non-governmental organizations and interested members of the general public to share information and align the elements of the Framework with existing suicide prevention efforts.

As the designated entity, the Public Health Agency of Canada is expected to report on progress related to the Framework by 2016 and every two years thereafter.

SIX LEGISLATED ELEMENTS FOR ACTION:

1. Provide guidelines to improve public awareness and knowledge of suicide.
2. Disseminate information about suicide and its prevention.
3. Make existing statistics about suicide and related risk factors publicly available.
4. Promote collaboration and knowledge exchange across domains, sectors, regions and jurisdictions.
5. Define best practices for suicide prevention.
6. Promote the use of research and evidence-based practices for suicide prevention.

GUIDING PRINCIPLES

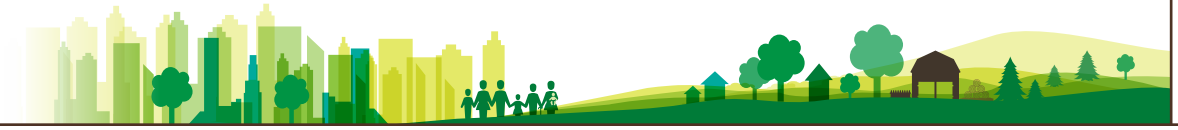
The following principles will guide the approach and actions undertaken to achieve the strategic objectives identified in this Framework.

BUILD HOPE AND RESILIENCE. PROMOTE MENTAL HEALTH AND WELL-BEING.

Suicide prevention should include actions to improve mental health and well-being and strengthen protective factors, such as improved resilience, effective problem solving, family cohesion, social connectedness, sense of meaning and belonging, positive attitudes and experiences, healthy relationships, positive cultural identity and restoring hope. Knowledge about the impact of trauma on people's lives and on their health will help ensure suicide prevention efforts foster safety, care, respect and empowerment for all.

COMPLEMENT CURRENT INITIATIVES IN SUICIDE PREVENTION.

Aligning federal activities, while complementing the important work underway in provinces and territories, Indigenous organizations, non-governmental organizations and communities as well as the private sector, will reduce duplication of effort.



BE INFORMED BY CURRENT RESEARCH AND BEST AVAILABLE EVIDENCE.

Applying the best available evidence from across Canada and internationally, including traditional and Indigenous knowledge and practices, and the experiences of survivors of suicide attempt and suicide loss, will contribute to our understanding of suicide and suicide prevention so that Canadians benefit from effective programs.

APPLY A PUBLIC HEALTH APPROACH.

Suicide prevention is a public health issue. By focusing on the population or community as a whole, protective factors (such as community cohesion, culturally appropriate and safe programs and services, particularly at the community level, safe and healthy environments, and resilience and coping skills) will be enhanced. Education, training and resources that are community-driven and culturally appropriate will help ensure that the distinct needs of individuals, families and communities are met. This approach also looks at suicide prevention in the context of social determinants that impact the health and quality of life for all Canadians.

LEVERAGE PARTNERSHIPS.

Improving coordination, collaboration and linkages across government departments and agencies, as well as among non-governmental organizations, Indigenous organizations, the private sector, provinces and territories, researchers, provincial coroners and medical examiners, communities, practitioners and those with lived experience (i.e., survivors of attempt and loss) is necessary. Suicide prevention approaches require multi-disciplinary and multi-sectoral collaborations that address a broad range of risk and protective factors. Partnerships leveraged in a safe and well-informed way will help ensure that suicide prevention efforts are effective and appropriate for diverse communities across Canada.

STRATEGIC OBJECTIVES AND FEDERAL COMMITMENTS

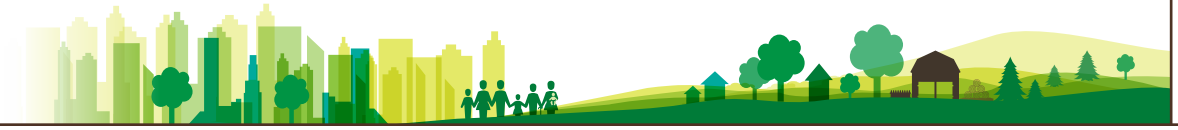
Under this Framework, the Government of Canada will take action towards three strategic objectives. With its partners, including national Indigenous organizations, the federal government will promote well-being, raise awareness and advance suicide prevention through connections, collaboration, research and best practices.

REDUCE STIGMA AND RAISE PUBLIC AWARENESS

The stigma associated with mental illness and with suicide-related thoughts and behaviour is a significant barrier for suicide prevention. Public awareness plays an important role in suicide prevention by changing attitudes, perceptions and behaviours. Prevention efforts that encourage hope, resilience and recovery can help reduce stigma, improve general knowledge about suicide and empower people to seek help and provide support to others when they need it most.

Suicide touches many Canadians. Some are living with thoughts of suicide or suicide-related behaviour such as self-harm. Some live with mental illness or are coming to terms with living with a mental illness. Some are in close relationships with someone at risk for suicide or have been directly affected by a suicide loss or suicide attempt. Some people may not recognize or acknowledge that they might need help or know how to get the support they need. Everyone benefits from greater knowledge and access to tools and services to prevent suicide.

Inappropriate messaging (e.g., offensive language, harmful content or graphic images and glorification in media or other portrayals) may have the negative and unintended consequence of normalizing, simplifying, glorifying or shaming suicide. This makes it more difficult for people to seek help or for others to provide assistance. Furthermore, details and language used to describe a death by suicide may further stigmatize and prevent healing for those grieving and coping with the loss of a loved one.



Communicating safely about suicide requires care and consideration. People need to feel safe and respected. Public messages need to focus on presenting the essential facts, being hopeful and encouraging people to seek or offer help. In some instances, safely sharing life experiences and stories may help people affected by suicide.

The Government of Canada will support collaboration among suicide prevention stakeholders, researchers and survivors of suicide loss and survivors of suicide attempt to provide guidance on the most effective, safe and appropriate ways to talk about suicide and its prevention with the goal of reducing stigma and raising awareness.

CONNECT CANADIANS, INFORMATION AND RESOURCES

Given the complexity of suicide, prevention must involve various disciplines and perspectives to ensure a comprehensive approach across Canada which optimizes existing and new efforts. Achievements under the Framework are contingent on effective collaboration and knowledge-sharing across domains, sectors, regions and jurisdictions to make current information easily accessible.

Enhanced collaboration will fill a gap in existing suicide prevention approaches by helping reduce fragmentation and ensuring a more integrated and proactive approach across the continuum of suicide prevention including suicide prevention, intervention during a crisis and postvention after an attempt or suicide loss.

The Government of Canada will develop resources about suicide and its prevention so that Canadians will have access to the information and other innovative services they need. A federal web presence on suicide data, information and helpful resources will be available to Canadians in both official languages. Furthermore, the Government of Canada will continue to work with partners to ensure that mechanisms are in place for sharing and exchanging information and evidence related to suicide prevention with researchers, communities, organizations and Canadians.

Federal departments will collaborate with external suicide prevention partners and stakeholders to share knowledge via various forums (e.g., in-person meetings, national conferences and online mechanisms), ensuring balanced representation and the participation of experts, non-governmental organizations, Indigenous organizations, survivors of suicide loss and survivors of suicide attempt and the private sector.

ACCELERATE THE USE OF RESEARCH AND INNOVATION IN SUICIDE PREVENTION

Effective suicide prevention depends on applying evidence from research and evaluation in prevention policy development, community outreach, mental health services, as well as family and community supports. Improved connections between researchers and research users, as well as access to plain language summaries of existing evidence, will facilitate the use of research findings.

The Government of Canada will help enhance the use of research by supporting mechanisms for dialogue on current evidence, including Indigenous knowledge sharing and application as well as implications for suicide prevention approaches. There is already a range of resources, networks and collaborations that contribute to this objective.

While there is a wide variety of suicide-related research being conducted across Canada, some knowledge gaps remain, such as research on factors that protect against suicide across the lifespan as well as research specific to some populations (including lesbian, gay, bisexual, trans, Two Spirit and queer/questioning populations; people with disabilities; newcomers and refugees; youth; seniors; Indigenous Peoples; and first responders). In addition, more analysis of the lived experience of suicide is needed, such as thoughts of suicide and suicide-related behaviour, the experiences of survivors of suicide attempt and the impact on survivors of suicide loss. There is a need to better understand research at the national, provincial, territorial and regional levels and to convene researchers and stakeholder groups to bring coherence to national research priorities that will meet the needs of communities, frontline providers and decision makers and facilitate knowledge uptake, particularly among populations that have higher rates of suicide.

This objective will be met by working in partnership with existing research networks and other relevant stakeholder groups and provinces and territories to create new opportunities for collaboration, including undertaking a systematic process to identify suicide prevention research priorities for Canada.

THE FEDERAL FRAMEWORK FOR SUICIDE PREVENTION: AT A GLANCE

VISION

A Canada where suicide is prevented and everyone lives with hope and resilience.

MISSION

Prevent suicide in Canada, through partnership, collaboration and innovation while respecting the diversity of cultures and communities that are touched by this issue.

PURPOSE

To guide the federal government's efforts in suicide prevention through implementation of *An Act respecting a Federal Framework for Suicide Prevention* (2012).

STRATEGIC OBJECTIVES

- Reduce stigma and raise public awareness.
- Connect Canadians, information, and resources.
- Accelerate the use of research and innovation in suicide prevention.

LEGISLATED ELEMENTS (SECTION 2 OF THE ACT)

- Provide guidelines to improve public awareness and knowledge of suicide.
- Disseminate information about suicide and its prevention.
- Make existing statistics about suicide and related risk factors publicly available.
- Promote collaboration and knowledge exchange across domains, sectors, regions and jurisdictions.
- Define best practices for suicide prevention.
- Promote the use of research and evidence-based practices for suicide prevention.

GUIDING PRINCIPLES

- Build hope and resiliency.
- Promote mental health and wellbeing.
- Complement current initiatives in suicide prevention.
- Be informed by current research and best available evidence.
- Apply a public health approach.
- Leverage partnerships.

FOUNDATION

Changing Directions, Changing Lives: A Mental Health Strategy for Canada

CURRENT SUICIDE PREVENTION EFFORTS IN CANADA

Effective suicide prevention requires a comprehensive approach that works across the continuum of prevention (as outlined in the diagram on p. 14). There are a number of common elements in suicide prevention approaches that have demonstrated effectiveness such as raising awareness, reducing stigma, enhancing access to mental health care services and restricting means.[5] At the same time, each of these elements should be considered within the local context and developed in partnership with affected populations. Because of this, suicide prevention requires an approach that brings together all levels of government and involves the health sector as well as education, employment, social welfare and justice sectors along with researchers and other stakeholders.[5] It requires a range of supports and interventions to reduce risk factors, enhance protective factors and meet the distinct needs of diverse groups[12,13] including tailored interventions for those groups who have a higher risk of suicide.

There is a great deal of work in suicide prevention happening across Canada.

At the national level, Canada's first mental health strategy, ***Changing Directions, Changing Lives: The Mental Health Strategy for Canada*** outlines a plan to improve mental health for all Canadians and newcomers, including refugees and includes suicide prevention as a priority.[9] ***The Blueprint for a National Suicide Prevention Strategy***, developed by the Canadian Association for Suicide Prevention, has helped inform suicide prevention work in Canada.[14]

Suicide Prevention Continuum

EARLY/PRIMARY PREVENTION (BEFORE SUICIDE RISK)

Prevention *works to build protective factors and promote mental health and well-being and reduce risk factors that could lead to suicide.*

Population

- Everyone

Types of Activities

Aimed at promoting mental health and well-being and building stronger, more resilient individuals and communities.

- Social/emotional learning programs in schools
- Mental health literacy programs
- Peer, family and (culturally-safe) community programs
- Stigma reduction and safe messaging campaigns
- Media guidelines
- Online resources and helpful information
- Training for gatekeepers and first responders

INTERVENTION

Intervention *works to address risk of suicide. It focuses on how best to respond early when someone has thoughts of suicide or suicide-related behaviours.*

Population

- Individuals in crisis, at high risk for suicide
- People seeking help for someone else
- Survivors of suicide attempt

Types of Activities

Aimed at intervening and preventing the onset of suicide.

- Crisis and distress line services (via telephone and Internet)
- Support and treatment
- Mental health services
- Emergency medical or social services
- Means restriction
- Employee assistance programs
- Training and counselling for gatekeepers, first responders and primary caregivers

SUPPORT FOR SURVIVORS (POSTVENTION)

Postvention *works to help support and heal those affected after the loss or experience of suicide, as well as providing follow-up education / prevention to reduce the risk of future crises.*

Population

- Survivors of suicide loss (e.g., family, friends, classmates, colleagues and communities of those lost)
- Survivors of suicide attempt

Types of Activities

Aimed at providing support and promoting mental health and well-being for those affected by suicide.

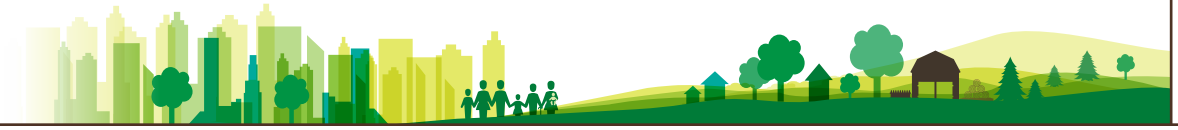
- Peer support (e.g., groups)
- Individual and family counselling
- Follow-up services (including new technologies to connect people with support)
- Online support groups and information
- Employee assistance programs
- Counselling and crisis interventions in schools, workplaces and communities to prevent suicide contagion
- Training and counselling for first responders

Internationally, the World Health Organization's report, ***Preventing Suicide: A Global Imperative***, encourages countries to pursue suicide prevention as a public health issue through approaches that address mental illness, promote mental health and well-being and build resilience in communities.[5]

At the local and regional levels, communities draw on a variety of approaches to improve mental health and reduce suicide and its impact (e.g., support programs in schools and community centres or public awareness initiatives). They also work with researchers to assess the effectiveness of promising multi-faceted approaches such as training for professionals, youth engagement, public awareness activities to address stigma and crisis line services (via telephones and Internet) to improve access to support and treatment. Together, they are increasing our understanding of the factors that lead Canadians to suicide and the factors that build resilience and protect against suicide risk, such as mental health and well-being.

Underpinning all suicide prevention efforts is the regular, systematic collection, analysis and dissemination of suicide-related surveillance data as well as the generation of evidence through research activities. Data and research results provide the basis of evidence needed to define the scope of the problem in Canada (e.g., the incidence of suicide); track changes in suicide rates; better understand risk and protective factors; inform policies and programs; and evaluate prevention efforts. Data and research should provide a comprehensive description of suicide and help community members, decision makers and planners develop and implement interventions that reach the right groups of people at the right time. They should also be grounded in ways that are meaningful to First Nations, Inuit and Métis.*

* For example, by respecting the First Nations Research Principles of OCAP (ownership, control, access and possession) to ensure that First Nations own, protect and control how their information is used. Respecting the First Nations Research Principles of OCAP ensures that First Nations control data collection processes in their communities. First Nations determine, under appropriate mandates and protocols, how access will be facilitated and respected for external researchers while also recognizing the important role of First Nations researchers and First Nations leadership in research.



A step towards improving collaboration across all sectors has been the creation of the National Collaborative for Suicide Prevention (the Collaborative). The Collaborative is jointly chaired by the Canadian Association for Suicide Prevention, the Mental Health Commission of Canada and the Public Health Agency of Canada. Its members include representatives from social and health-based organizations that are invested in the promotion of mental health and the prevention of mental illness and suicide across Canada, including the Assembly of First Nations and the Inuit Tapiriit Kanatami. Current federal membership also includes the Canadian Institutes of Health Research, Health Canada and the federally-funded Canadian Centre on Substance Abuse. The goal of the Collaborative is to increase the capacity for effective suicide prevention by connecting people, ideas and resources on a pan-Canadian level. The Collaborative is exploring opportunities to expand its membership to others working in suicide prevention.

No one jurisdiction has the sole responsibility for all that is needed to achieve a comprehensive approach to suicide prevention. Suicide prevention in Canada relies on a shared commitment and cooperation of effort along the continuum of suicide prevention. The Framework is meant to build on many efforts already underway and to improve collaboration among governments, while complementing the work of non-governmental organizations, Indigenous organizations and communities.

Federal Government

The Government of Canada undertakes activities to improve mental health and well-being and prevent suicide. It promotes and protects the health of Canadians in its role as a leader, partner, funder, convenor, information provider, regulator and service provider.

The federal government funds and provides a range of health care services including those related to mental health and suicide for serving members of the Canadian Armed Forces, Veterans, serving and former members of the Royal Canadian Mounted Police and the Correctional Service of Canada, Indigenous populations, newcomers including refugees and federally incarcerated individuals.

SERVING MEMBERS OF THE CANADIAN ARMED FORCES

Prior to 2010, the suicide rate among the male members of the Canadian Armed Forces was no higher than the general Canadian population (when standardized for age and sex). However, over the past five years, the overall suicide rate has slightly increased. The increase is related to suicide rates among young men serving within the Army command (as opposed to other units) and having worked in the combat arms occupations. This group was more likely to have been exposed to psychological trauma, especially related to the combat operations in Afghanistan.[15]

There is evidence that those diagnosed with post-traumatic stress disorder, including military personnel following combat trauma and first responders witnessing traumatic events face an increased risk of suicide-related behaviour, including thoughts of suicide, planning for suicide and attempting suicide.[16,17,18] The prevalence of post-traumatic stress disorder among active members of the Canadian Armed Forces has increased. The number of members who reported symptoms of post-traumatic stress disorder has nearly doubled from 2002 to 2013, from 2.8 percent to 5.3 percent, while rates of depression remained stable at about 8 percent,[19,20] which is higher than the rate of the general Canadian population.

The Canadian Armed Forces has a comprehensive health care system, which includes mental health as one of its priorities. The mental health program

includes education and health promotion, provision of clinical care and services and a research program to understand both the mental health burden within the population and ways to improve the care provided. The Canadian Armed Forces also conducts detailed investigations for each death by suicide providing vital details that ultimately lead to improvements in the quality of care and support for its personnel. The mental health program is guided by the ***Surgeon General's Mental Health Strategy: an Evolution of Excellence (2013)***[21] and is further informed by the recommendations from the ***Canadian Forces Expert Panel on Suicide Prevention (2010)***.[22]

CANADIAN ARMED FORCES VETERANS

The risk of suicide in male Canadian Armed Forces Veterans (former members) who enrolled in the Canadian Armed Forces between 1972 and 2006 was one and a half times higher than their counterparts in the general Canadian population.[23] Veterans released since 1998 have a higher prevalence of mood and anxiety disorders than the general Canadian population.[24,25] Furthermore, the combined number of serving and former Canadian Armed Forces personnel receiving service-related disability benefits from Veterans Affairs Canada for mental health conditions grew by an average of 12 percent per year from 2008 to 2013.[26]

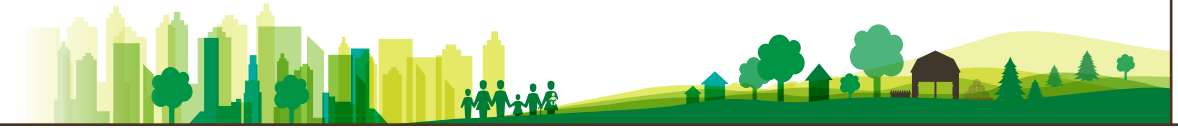
After release from service, Veterans receive mental health care from the publicly funded provincial/territorial health care systems. Veterans Affairs

Canada facilitates access to civilian health care and rehabilitation services for service-related health problems. Since 2000, in conjunction with the Canadian Armed Forces, Veterans Affairs Canada has substantially increased its capacity to provide mental health care for eligible Veterans. Veterans Affairs Canada provides case management for complex needs. In 2002, Veterans Affairs Canada began contracting a growing national network of Operational Stress Injury Clinics to provide specialized mental health care and establishing a national peer support program. The 2006 *Canadian Forces and Veterans Re-establishment and Compensation Act*[27] added an array of health care, rehabilitation and financial supports tailored to meet the needs of transitioning contemporary Canadian Armed Forces Veterans and established financial compensations for permanent disability, shifting focus from chronic health maintenance to the promotion of ability, well-being and independence.

INDIGENOUS POPULATIONS

As previously noted, suicide rates among some First Nations and Inuit populations in Canada are disproportionately higher than the Canadian population overall. Not all Indigenous communities experience higher suicide rates, although in all four Inuit regions in Canada, suicide rates are five to twenty times higher than the national average.[3] There is no historical evidence that earlier Inuit societies had particularly high rates of suicide. Suicide among Inuit in Canada began to rise in the 1960s, particularly among the first generation of young people who grew up in settled communities. The high rate of suicide has been linked with historic trauma, cultural losses and social upheavals that were the result of settlement and colonization. Research indicates an important link between suicide risk and trauma resulting from assimilative policies and the legacy of colonization in some communities. For example, the Indian residential school system, 'Sixties Scoop'[†] and the relocation of families and the loss of language, culture

† The term 'Sixties Scoop' refers to the Canadian practice, beginning in the 1960s, of apprehending children of Aboriginal people in Canada and either keeping them within Canada and placing them in Indian residential schools or placing them in the United States and western Europe where they were in foster care or adopted, usually into non-Aboriginal families.



and land has negatively affected several generations. The lasting impacts of these experiences include: marginalization; a loss of culture, community and family stability; as well as mental health and substance abuse issues, which can contribute to an individual's risk of suicide.[28]

Research has shown that communities where there is a strong emphasis on access to and participation in culture, as well as community ownership and other protective factors, have much lower rates of suicide, in fact sometimes none at all.[29] Protective factors that are particularly relevant for First Nations and Inuit communities include a strong sense of culture, traditional teachings, ties to the community, self-government (including autonomy over land, language, education and health) as well as access to essential services (police and fire) and housing.[30,31] Many collective efforts have been undertaken by communities to restore culture and foster healing, including traditional practices and knowledge. The social determinants of health, such as poverty, lack of adequate housing, food insecurity and under-education, are all associated factors that may impact the rate of Indigenous suicide.

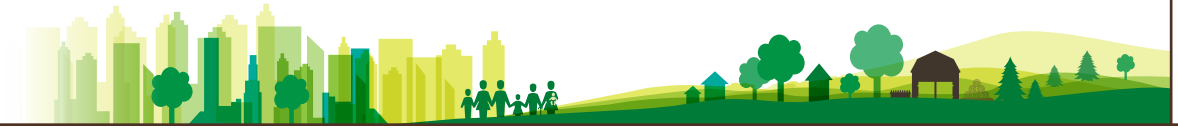
The federal government has taken steps to help increase protective and resilience factors within First Nations, Inuit and Métis communities. The implementation of the *Indian Residential Schools Settlement Agreement* began in 2007.[32] It strives to renew relationships between those who attended Indian residential schools, their families, communities and all Canadians. Recognizing that these processes have been painful for many former students and their families, it has promoted a greater understanding of the intergenerational impacts of the legacy of Indian residential schools and heightened the movement of reconciliation across the country. In 2008, the federal government issued a statement of apology to recognize the lasting consequences of Indian residential schools, including their impact on culture, heritage and language. Healing is an ongoing process for many Indigenous communities across Canada.

The ***National Aboriginal Youth Suicide Prevention Strategy*** (NAYSPS) program, led by Health Canada's First Nations and Inuit Health Branch and developed in partnership with Indigenous organizations supports community-based youth suicide prevention projects. In 2014–15, NAYSPS supported approximately 138 community-based projects in First Nations and Inuit communities across Canada. In a majority of regions, a request for proposals system is used, whereby communities can apply to access NAYSPS funding, based on regionally specific criteria. The program is based on primary, secondary and tertiary prevention,‡ as well as knowledge development to promote protective factors and reduce risk factors that contribute to youth suicide in First Nations and Inuit communities.

The Assembly of First Nations, Health Canada's First Nations and Inuit Health Branch and Indigenous mental health leaders have developed and launched the ***First Nations Mental Wellness Continuum Framework*** (the Continuum).[10] Developed in partnership with First Nations, it provides a coordinated, comprehensive approach to mental wellness programming that takes into account the important role of culture, traditions and language. It provides communities with the flexibility to realign programs to their unique circumstances, culture and history. In addition to helping communities build on their priorities, it also promotes opportunities for linkages between First Nations, provincial/territorial governments and the federal government.

Health Canada's First Nations and Inuit Health Branch is also working with the national Inuit organization, the Inuit Tapiriit Kanatami, which has released a **National Inuit Suicide Prevention Strategy**. The Strategy acts as a call to action to reduce the high rate of suicide among Inuit. It provides a common understanding of the context for suicide in Inuit communities and provides guidance to inform evidence-based suicide prevention approaches. In addition, the Inuit Tapiriit Kanatami is developing an Inuit Mental Wellness Continuum Framework, which will focus on enhancing mental wellness services and supports for Inuit communities.

‡ Primary or 'upstream' interventions prevent someone from ever reaching the point of considering suicide. Secondary preventions are those that recognize and assess an immediate risk of suicide. Tertiary interventions are also called 'postventions' and refer to the care, support and special treatment needs of those already displaying suicide-related behaviour.



NEWCOMERS (INCLUDING REFUGEES)

As a whole, first-generation immigrants are less likely to die by suicide than those born in Canada. This may be due to the 'selection effect' whereby immigrants to Canada are selected based on criteria related to physical and mental health, or due to an under-reporting of deaths by suicide.[33,34] While the overall rate is lower, there is variability between different groups and rates mirror those in the country of origin. Less is known about thoughts of suicide and suicide-related behaviour among immigrants to Canada and patterns of these behaviours can vary across generations and between different immigrant groups.[35] For immigrants, personal factors such as learning to speak their host country's language, ethnic pride and a positive attitude towards the new country's culture can serve as protective factors. In addition, social resources, such as family and ethnic community support, ties to culture and a warm welcome by the new country can lead to more positive mental health.[34]

There is less research on suicide rates in Canada's refugee population. Refugees are much more likely to face other risk factors for suicide-related behaviour, such as post-traumatic stress disorder as a result of being exposed to trauma and torture and/or coming from a country affected by war, socio-political conflict or disaster. For instance, some studies have shown that refugees resettled to western countries may be about ten times more likely to suffer from post-traumatic stress disorder than age-matched general populations in those countries.[36]

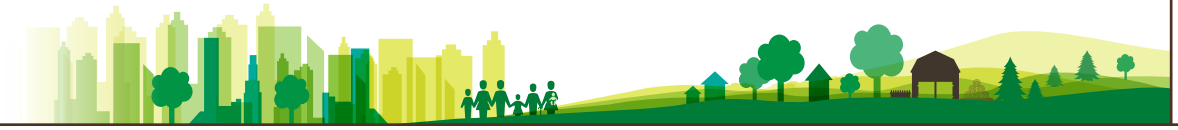
FEDERALLY INCARCERATED INDIVIDUALS

Incarceration may increase certain suicide risk factors, including social and cultural isolation and separation from loved ones. There are a number of other factors that are associated with an increased risk of suicide among federally incarcerated individuals, many of which are similar to the general population. These include having a mental health problem or a diagnosed mental illness, a prior suicide attempt, substance abuse issues, a history of self-harm, poor social and family supports, as well as a family history of suicide.[5] In addition, significant events and circumstances may lead to increased risk

for this population, including difficult relationships, the loss of a loved one, a major holiday, stress from separation and reunification, as well as changes in sentence administration (e.g., transfer to another institution, change in custody level and denial of conditional release or parole).

The chronic overrepresentation of Indigenous men and women (First Nations, Métis or Inuit) in the correctional system is well documented. Indigenous men and women comprise approximately 22 percent of the total federally sentenced population[§37,38] and yet comprise approximately four percent of the Canadian population.[39] Interventions that are based in Aboriginal culture and that take into account individual and social histories are important to meet the diverse mental health needs of the First Nations, Métis and Inuit federally incarcerated population.

§ Represents those federally sentenced both in prison and in the community (e.g., parole, conditional release etc.).



Partners and Stakeholders

Partnership and collaboration with other stakeholders, including provinces and territories, non-governmental organizations, Indigenous organizations, the private sector and communities are necessary to address suicide and its prevention. For example, the Government of Canada established the Mental Health Commission of Canada in 2007 to serve as a catalyst for improving the mental health system by bringing together leaders and organizations from across the country. In 2012, the Mental Health Commission of Canada released Canada's first mental health strategy, *Changing Directions, Changing Lives: The Mental Health Strategy for Canada*, which outlines a plan to improve mental health for all Canadians and includes suicide prevention as an integral focus.[9]

The Mental Health Commission of Canada informs policy development on suicide prevention by participating in various advisory committees that include representatives from federal, provincial and territorial governments and non-governmental organizations. It also works with its partners to increase dialogue about what is working in suicide prevention by facilitating knowledge-sharing about best practices and developing resources that support community-level suicide prevention activities.

In addition, the federal government provides funding to the Canadian Centre on Substance Abuse. Substance misuse is a significant risk factor for suicide.[6] The Canadian Centre on Substance Abuse aims to reduce the harm of alcohol and other drugs on society. This organization provides guidance and advice on addictions and substance use. The Canadian Centre on Substance Abuse is a member of the National Collaborative for Suicide Prevention.

The Framework will better coordinate existing federal activities and improve collaboration with other stakeholders to reduce stigma, share information and apply research to promote action to prevent suicide.

PROVINCES AND TERRITORIES

Provinces and territories are primarily responsible for providing direct health care services and supports, including those related to mental health and suicide, such as hospital services, crisis intervention, treatment and follow-up, as well as out-patient services. Provinces and territories are also primarily responsible for education and schools which can reach youth through suicide prevention programs as well as through gatekeepers (e.g., people who play a role in suicide prevention because of their primary contact with those potentially at risk).

Some jurisdictions have or will be implementing suicide prevention initiatives or strategies, including British Columbia, Alberta, Manitoba, Nova Scotia, Nunavut and Quebec.** Others address suicide within broader mental health or injury prevention strategies, such as New Brunswick, Newfoundland and Labrador, the Northwest Territories, Ontario, Prince Edward Island and Saskatchewan.

Suicide prevention approaches vary across the country. They may include mental health literacy, community and school-based prevention programs, 24-hour crisis lines, distress and intervention services or community-based support services and resources for bereaved families and individuals. Regional health authorities also play a key role in delivering mental health and related services in many jurisdictions. This can include mental health and public health services (e.g., health screening, health assessment, referral and early treatment), as well as the provision of aftercare and follow-up

** In 1998, Quebec implemented the first provincial suicide prevention strategy in Canada. Quebec's Strategy for Preventing Suicide: Help for Life comprises a multi-pronged approach that focuses on actions targeting youth, health care professionals and local communities. More recently, the Quebec Public Health Program 2003–2012 included comprehensive suicide prevention action.

A number of initiatives have been taken or are being developed in Quebec, including the following:

- The development and implementation of guides to good suicide prevention practices for managers and stakeholders in Quebec's regions;
- The development and dissemination of training and tools for stakeholders based on best practices;
- Activities with the media to encourage appropriate media coverage of suicides;
- The creation of a national data bank on suicides (project under way);
- The deployment of a network of suicide prevention sentinels in all regions of Quebec;
- The set up of a suicide prevention hotline; and,
- Activities to create awareness among the public and stakeholders of the risks involved in keeping medications and firearms at home and measures to restrict access to them.

services once an individual is discharged from hospital. Provincial coroners and medical examiners record important information that forms the basis for suicide surveillance in Canada.

The federal Framework will provide the foundation for collaboration and engagement with provinces and territories. It will complement existing strategies and initiatives by facilitating information sharing across regions and jurisdictions and by identifying promising practices to help meet the needs of communities throughout Canada.

INDIGENOUS ORGANIZATIONS

Suicide prevention has been identified as a priority by many Indigenous organizations and communities and significant work is underway to address this issue.

On January 28, 2015, the Assembly of First Nations announced the release of the ***First Nations Mental Wellness Continuum Framework*** (the Continuum), which was developed to improve mental wellness outcomes for First Nations.[10] The Continuum was developed in partnership with First Nations, Indigenous mental health leaders, Health Canada and other government departments. It is designed to support integration between federal, provincial and territorial programs within a comprehensive mental wellness system for First Nations. In addition, the Continuum will strengthen federal mental wellness programming and support culturally-safe delivery of services. It also provides guidance to communities to adapt, optimize and realign their mental wellness programs and services based on their own priorities. The Continuum uses a strengths-based approach to community development, which recognizes and builds on the assets in a community.

Inuit in Canada are working on preventing suicide and many communities have programs targeted towards youth that are land-based and use culture as a source of resilience. The national Inuit organization, Inuit Tapiriit Kanatami released the ***National Inuit Suicide Prevention Strategy*** in July 2016. This is a strategic national plan which includes guiding principles and national strategy priorities. It acts as a call to action aimed at reducing the alarming rates of suicide among Inuit. Inuit Tapiriit Kanatami is also working on an Inuit Mental Wellness Continuum Framework which highlights ongoing opportunities to strengthen integration and build on community strengths and resiliency to enhance mental wellness services and supports for Inuit in Canada.

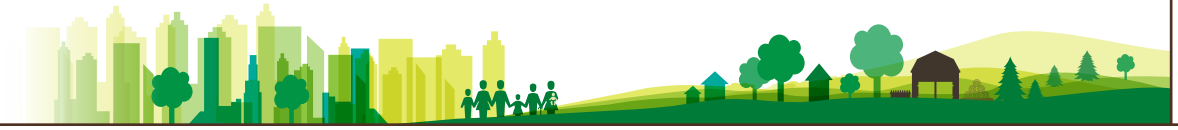
NON-GOVERNMENTAL ORGANIZATIONS

While Canadians look to their governments to provide leadership on public health issues, including suicide prevention, much of the work takes place at the community level through non-governmental organizations.

Non-governmental organizations, including the Canadian Association for Suicide Prevention, play a key role in providing information and resources to the public about suicide. Some non-governmental organizations conduct community-based research, support policy development, design and implement programs, deliver education and training, develop and distribute educational and awareness-raising materials and work with the media on suicide education and prevention. In many instances, these organizations and agencies serve as frontline agents in the provision of distress helpline services and crisis management as well as counselling. In addition, they often advocate on behalf of those most in need of social and health services and supports.

The ongoing role of non-governmental organizations in bringing together representatives from various sectors, such as schools, businesses, health, social services, justice and workplaces and reaching people in different settings is essential to all aspects of suicide prevention. This includes promoting the development of suicide prevention activities, focusing on collaborative work in the areas of research, education and training and supporting the development of services for Canadians who experience or are affected by thoughts of suicide and suicide-related behaviour, as well as their communities, families and friends.

Under the Framework, the Government of Canada will work with partners and stakeholders from a variety of sectors to improve collaborative efforts and share best practices. The Blueprint for a Canadian National Suicide Prevention Strategy, developed by the Canadian Association for Suicide Prevention encourages all segments of Canadian society and all levels of government to work together to prevent suicide and help those affected by suicide.[14] As noted in *Changing Directions, Changing Lives: The Mental Health Strategy for Canada* and the World Health Organization's *Preventing Suicide: A Global Imperative* report, effective suicide prevention requires collaboration between the public, private, non-governmental and voluntary sectors.[5,9]



EMPLOYERS

The workplace is an environment where many adults spend considerable time and employers play a major role in creating a healthier Canadian population. The economic and business costs of poor mental health in the workforce are significant and as such, employers are taking action to create safe and healthy working environments.

In recent years, companies and organizations have invested in the mental health of their employees through programs such as well-being and health promotion, education and training and the introduction of new policies, benefits and resources to support those facing mental health issues. In addition, some employers have established opportunities for their employees and consumers to support community-based projects that directly benefit people affected by mental illness (e.g., Canada Post's Foundation for Mental Health).

In addition, some major companies in the private sector are supporting mental health through public awareness campaigns (e.g., Bell Canada's Let's Talk Campaign) and by providing financial support for community programs and services across Canada. This sector can continue to bring its expertise and resources to increase public dialogue on suicide prevention, build partnerships and collaborations on suicide programming, interventions and research and develop or offer technological solutions and innovative ways to improve information sharing and reduce the stigma of suicide.

Moving forward, both the private and public sectors will continue to play critical roles in building and sustaining healthy workplaces and communities and preventing suicide. In particular, businesses and organizations can foster greater awareness and understanding, help to reduce stigma associated with mental illness and depression and encourage help-seeking behaviours among the working population. Leveraging practical and effective solutions (e.g., manager training, employee engagement activities and resources) and implementing the *National Standard of Canada for Psychological Health and Safety in the Workplace*[††40] will further promote and protect the mental health and well-being of working Canadians. Employers can also

†† The National Standard of Canada for Psychological Health and Safety in the Workplace is a voluntary set of guidelines, tools and resources focused on promoting employees' psychological health and preventing psychological harm due to workplace factors. The Government of Canada supported the MHCC on the development of the Standard.

contribute to much-needed research on workplace mental health and suicide prevention particularly by helping to measure and assess the impact and effectiveness of various approaches, programs and solutions.

COMMUNITIES, GATEKEEPERS AND FIRST RESPONDERS

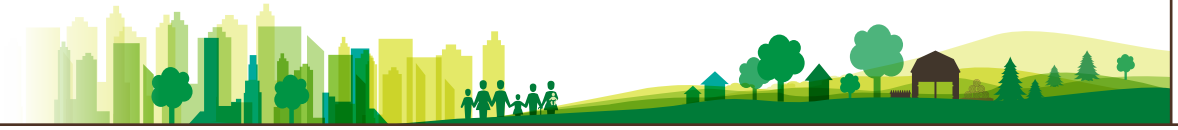
Many communities in Canada have undertaken local campaigns to raise awareness and encourage safe conversations about suicide, promote the mental health and well-being of citizens and provide support to those bereaved by suicide. Across Canada, community crisis centres provide emotional support and crisis intervention services, including helpline services for people in distress. Many of these services are provided by trained staff and volunteer responders. These efforts are further supported by gatekeepers—individuals in communities that come into contact with those at risk and are in a position to 'open the gate to help' (e.g., health professionals, family members, teachers or others in the community). Gatekeeper education trains these individuals to recognize warning signs and learn how to respond appropriately.

Gatekeepers may also include first responders—such as police, paramedics, firefighters, correctional officers and other emergency personnel— who not only play a role in suicide prevention, but may experience increased risk of suicide due to exposure to trauma as part of their work. Supporting the mental health and well-being of the first responder community contributes not only to the resilience of the organizations in which they serve, but also to that of the broader Canadian society.

SURVIVORS

Everyone affected by suicide has a potential contribution to make to improve our collective understanding of suicide. In particular, the experiences of survivors of suicide loss and survivors of suicide attempt provide first-hand knowledge of the complexity of suicide and can inform possible ways to prevent other suicides. Both survivors of suicide loss and survivors of suicide attempt have unique perspectives about the impact of suicide and about the factors that influence suicide, which need to be shared safely to find lasting solutions that inspire hope and healing in the prevention of suicide.

Some national and local organizations provide resources and peer or group support for survivors (e.g., peer groups



for survivors of attempt, survivor of loss groups and resources). The establishment of self-help groups for survivors, both of suicide attempt and for those bereaved by suicide, has increased significantly around the world since 2000.[5] The Canadian Association for Suicide Prevention compiles an inventory of suicide survivor resources, counselling and support services in each province and territory to take stock of available resources for survivors.

The federally-funded Mental Health Commission of Canada developed a *Toolkit for Survivors of Suicide Loss and Postvention Professionals* and is working with partners to develop and promote other survivor tools, resources and training.[41] Other organizations are increasing their focus on survivors in research and suicide prevention activities. Survivor groups have also organized themselves to support and advocate for vulnerable populations and are active in suicide prevention across Canada. Moving forward, there are many more opportunities to include the survivor perspective.

MEDIA AND SOCIAL MEDIA

All forms of media have an important role to play in shaping attitudes and raising awareness about suicide and are a key source of information that reaches a very wide and diversified audience. There are many misconceptions about suicide. Research shows that inappropriate reporting of suicide may lead to imitative or 'copycat' behaviour.[42] Responsible messaging by the news media can play an important role in dispelling myths.

While social media have been criticized with respect to cyberbullying and suicide, social media may also contribute to social connections that can foster mental health and well-being for youth in particular. In addition, supportive social media could improve access to resources and services for those at greatest risk. Researchers, clinicians and other professionals are exploring how social media can be used to help prevent suicide.[43]

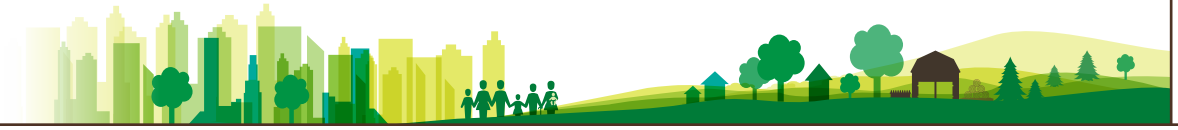
MOVING FORWARD

In order to achieve its strategic objectives under the Framework, the Government of Canada will continue work underway with partners and establish new activities on shared priorities. These partners include the provinces and territories, national Indigenous organizations, the Mental Health Commission of Canada, the National Collaborative for Suicide Prevention, the Canadian Association for Suicide Prevention, other organizations working in suicide prevention, as well as researchers and those who have the lived experience of suicide loss or suicide attempt.

MONITORING IMPLEMENTATION AND REPORTING ON PROGRESS

As mandated by *An Act respecting a Federal Framework for Suicide Prevention*, the Government of Canada will report to Canadians by December 2016 and every two years thereafter on its progress and activities under the Framework. Reporting will be conducted through existing federal mechanisms for public reporting, as well as through the Government of Canada's online resource on suicide prevention.

The first progress report by December 2016 will inform Canadians of progress under the Framework and serve as a guide for planning activities in future years (e.g., identifying adjustments to respond to new evidence and highlighting areas for improvement).



CONCLUSION

The Government of Canada has an important role to play in preventing suicide by aligning its efforts for greater impact.

This Framework guides federal initiatives, complements the work of others and builds on successful approaches to prevent suicide in Canada. It commits to developing new guidelines for public awareness to reduce stigma, connect Canadians, share information to improve collaboration and knowledge exchange and accelerate the use of research and best practices.

In the short term, these actions will improve the federal government's contribution to suicide prevention. Ultimately, these actions will help reduce rates of suicide by breaking down the stigma and silence around suicide, encouraging people to have an open dialogue about suicide prevention and promoting the development of suicide prevention initiatives throughout Canada using best practices that are informed by knowledge and research.

We wish to acknowledge the passionate input provided by many stakeholders including provinces and territories, non-governmental organizations, Indigenous organizations and members of the general public, including those affected by suicide who shared a broad range of information about many existing suicide prevention approaches and activities and the significant challenges associated with suicide prevention. This input has informed the Framework so that it reflects the Canadian context and its diverse communities.

Suicide can be prevented. Collaboration across all levels of government and across a variety of sectors and communities is critical to affect change. The Framework helps set the stage for a more comprehensive and coordinated way to prevent suicide in Canada, promoting mental health and well-being, inspiring hope and building resilience.

ANNEX A: SUICIDE IN CANADA

In 2012, suicide was the ninth leading cause of death among all Canadians.[1] It is reported that 3,926 Canadians—an average of more than ten people per day—died by suicide in 2012. In addition, there were over 16,000 Canadians admitted to hospital with self-inflicted injuries in 2011–12.[44]

These numbers, however, underestimate the magnitude of the issue.[45] Several factors contribute to under-reporting. Deaths by suicide may be misclassified as accidental or of undetermined cause. Under-reporting may also be associated with stigma, legal and financial implications for families and others.[46] Furthermore, some people never seek medical or professional help and are therefore absent from health care records.

Although suicide is a tragedy that can impact anyone regardless of their age, background, gender or socioeconomic status, certain segments of the population have higher rates of suicide.

Men and boys account for 75 percent of all deaths by suicide.

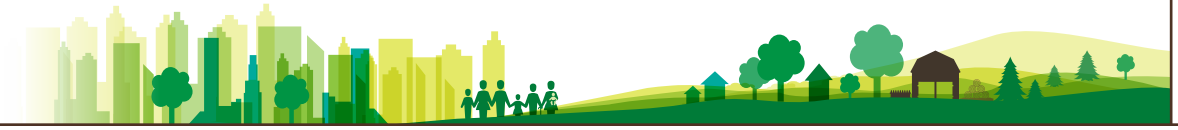
Across the lifespan, males have higher rates of death by suicide (about three times higher than that of females). For example, in 2012, three-quarters (2,972) of the reported 3,926 deaths by suicide were men and boys. In particular, middle-aged men (between the ages of 40 to 59) have the highest suicide rates. Men over the age of 80 have among the highest rates of suicide across all age groups and men account for the majority (about 80 percent) of deaths by suicide among seniors.[1]

Women have a higher rate of self-harm.

Women are hospitalized for self-harm at a rate that is one and a half times higher than men.[44] Self-harm can be a response to psychological distress and is a risk factor for suicide.[47]

Among youth (aged 15 to 24), suicide is the second leading cause of death.

Each year, around 500 youth die by suicide in Canada.[1] Because youth do not generally die from natural causes, suicide represents a relatively large percentage of all deaths in younger age groups (25 percent). Compared to female youth, male youth have historically higher rates of suicide, however there is an increasing trend in suicide rates among female youth (between 10 and 19 years of age) over the last two decades.[48]



Over the past five years, there has been an increasing trend among youth in the number of hospitalizations for intentional self-harm (e.g., self-inflicted poisoning or injury) with the bulk of the increase attributed to female youth.[49]

Thoughts of suicide and suicide-related behaviour are disproportionately prevalent among LGBTQ youth.

It is not known how many people affected by suicide identify as lesbian, gay, bisexual, trans, Two Spirit or queer/questioning (LGBTQ) or are struggling with questions about their sexual orientation or gender identity. Increasingly, studies confirm that thoughts of suicide and suicide-related behaviour are disproportionately prevalent among LGBTQ people, particularly youth, in comparison to their non-LGBTQ peers.[50,51]

Suicide rates are high in some First Nations and Métis communities, particularly among youth. Suicide rates are high in all Inuit regions in Canada.

First Nations and Inuit in Canada have some of the highest suicide rates in the world. The prevalence of suicide is a significant problem in some First Nations and Métis communities and all Inuit regions are impacted by high rates of suicide.

Although suicide is not a universal problem in all First Nations and Métis communities, it is a significant challenge for many communities across the country. Suicide and self-inflicted injuries are the leading causes of death for First Nations youth and adults up to 44 years of age.[52] First Nations youth die by suicide approximately five to six times more often than non-Indigenous youth.[53] The suicide rates for Inuit are among the highest in the world, at 11 times the national average.[54] Rates for youth living in Inuit Nunangat are 35 times higher for young males and 28 times higher for young females as compared to the rest of Canada.[55] Thirteen percent of First Nations adults living on reserve have attempted suicide at some point in their lifetime.[56] Less is known about suicide rates among Métis.

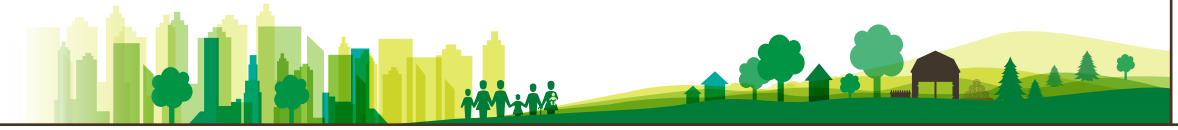
The incidence of suicide in federal correctional institutions is higher than that in the Canadian population.

Between the years 2000 and 2014, an average of nine federally incarcerated individuals died by suicide each year. Among this population, males are more likely than females to die by suicide. The female federally incarcerated population has proportionally higher suicide attempts or self-harm than their male counterparts.[57]

Survivors of suicide loss and survivors of suicide attempt face higher risk for suicide.

It is estimated that there are between 25 to 30 suicide attempts in the general population for every death by suicide.[58] Survivors of suicide attempt are those who have lived after deliberately taking action to end their lives or have struggled to cope with thoughts of suicide. A prior suicide attempt is an important risk factor for suicide in the general population.

For every death by suicide, there are also a minimum of seven to ten survivors (about 28,000 to 40,000 per year) who are profoundly affected by the loss.[59] Survivors of suicide loss are often bereaved family members, friends, peers, coworkers, teachers, health and social service providers, community workers, mental health clinicians and correctional staff, as well as first responders often on the frontlines of suicide (such as police, firefighters, paramedics and other emergency personnel). Survivor bereavement is linked to adverse mental health, social and economic outcomes, including depression, anxiety, marital breakup and financial troubles. It is also linked with a high risk of suicide among families already bereaved by suicide. People bereaved by suicide generally require support to deal with their grief and trauma in order to heal emotionally, physically and spiritually.[59]



ANNEX B: SUICIDE RISK AND PROTECTIVE FACTORS

Many factors influence mental health for both individuals and communities. No single cause explains or predicts suicide. Suicide emerges from a combination of factors that vary among people throughout the life span.

Risk factors are characteristics or conditions that, in combination with other factors, can make a person more vulnerable to suicide. Protective factors are capacities and resources within individuals, families, communities or the larger society that help build resilience and the ability to adapt in the face of adversity.

Risk and protective factors vary from person to person and can change over time. The likelihood that someone will think about, attempt or die by suicide may increase or decrease due to a complex interplay of these factors, which may include individual, relational, socioeconomic and/or cultural factors.[61] Strengthening protective factors should be an ongoing process in order to counter suicide risk and build resilience for individuals, families and communities.

There are many individual or personal factors that may increase suicide risk, including mental illness (e.g., depression), a prior suicide attempt, a recent loss, poor physical health, addiction (e.g., substances or gambling, etc.) as well as a history of family violence (e.g., child abuse or neglect) and/or self-harming behaviour.[6] Limited problem solving and coping mechanisms, feeling as though one is alone or a burden to others in particular may increase one's vulnerability. Thoughts of suicide and suicide-related behaviour may arise when someone faces significant life stressors and experiences including interpersonal conflicts (e.g., breakup of a significant relationship), peer victimization (e.g., bullying, cyberbullying), harassment and/or discrimination, problems with identity formation (e.g., personal, sexual, cultural) and/or exposures to trauma (e.g., sexual abuse, neglect, physical abuse, genocide, war, accidents, major losses, suicide loss, homicide loss, torture or natural disasters).[5]

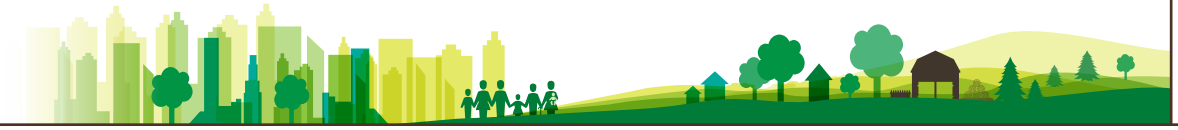
Socioeconomic factors, such as economic disadvantage (e.g., poverty, unemployment, homelessness‡‡,[62] substandard housing, inadequate health care, lack of recreational opportunities and barriers to resources), social isolation, low levels of education and literacy, as well as community instability can also affect suicide risk. Conversely, a sense of social inclusion, positive social and community support, access to health and social services, as well as a strong social network (e.g., family and school) are important factors for well-being and reduced suicide risk.[6]

Individual and social histories that form the Indigenous experience in Canada are important considerations for suicide prevention. This includes the history of colonialism and displacement, negative experiences in child welfare, adoption systems and residential schools, family histories of substance use, poverty, cultural losses and inadequate living conditions as well as trauma and violence. These experiences have an intergenerational impact, translating into lower educational attainment, lower incomes, higher unemployment, higher rates of substance use and higher levels of incarceration, all of which increase risk factors for suicide and may affect First Nations, Inuit and Métis and their communities.

The risk of suicide can be mitigated by strengthening protective factors, such as strong self-esteem, healthy relationships (e.g., familial and social connections), cultural identity, adaptive coping and problem-solving skills.[28] Responsible media reporting and public awareness also helps to mitigate suicide risk.[42] Inuit highlight cultural identity, resolved grief and social/economic development as factors which lead to resilience.

Culture pertains to the ways in which traditional practices and traditional knowledge influence or shape a person or community. For many, sense of identity is connected with traditions, values, language and culture and is critical to quality of life, sense of belonging and connectedness with family and community.[10] Culture provides a collective way of living, reflected in beliefs, customs, traditions and languages that are passed along from one generation to the next. The stresses of acculturation and dislocation are suicide

‡‡ Suicide among homeless people is a known health problem. Periods of early, transitional or chronic homelessness are associated with high risk for suicide and suicidal thoughts among adults and youth.



risk factors that affect people in various ways, including some First Nations, Inuit and Métis, newcomers including refugees, as well as incarcerated individuals.[5]

Some segments of the population and some communities (e.g., those that live in the same area or are linked by association or common characteristics, such as ethnicity, culture, religion or sexual orientation) may face experiences that increase suicide risk. Experiencing marginalization, inequality, racism, harassment, discrimination, isolation as well as stigma, can have a long-lasting impact on mental health and well-being. For example, lesbian, gay, bisexual, trans, Two Spirit or queer/questioning (LGBTQ) individuals may experience homophobia or transphobia alongside other forms of marginalization that negatively affect their mental health. Social stigma associated with sharing or expressing one's gender identity or sexual orientation can cause isolation and alienation, even loss of peer, family or social support.[51] These intersecting experiences can severely affect the mental health and well-being of LGBTQ individuals and communities. Key factors for positive mental health and well-being for LGBTQ individuals include support from family and friends, particularly for youth, as well as supportive and inclusive workplaces and communities.

A single suicide can severely affect entire communities quickly or over extended periods of time. When a death by suicide occurs in a community or area with similar cultural or social backgrounds, there is the potential that it can lead to an increased risk that others within the community or geographic area will attempt or die by suicide (i.e., a cluster of suicides). Cultural views of suicide, the degree of stigma or community support and the availability of culturally-appropriate services can have a profound impact on people in terms of seeking help or accessing support to recover, grieve and heal.

Efforts to strengthen individual and community identity and cohesion may help to reduce suicide risk. These approaches need to account for historic and current realities as well as community characteristics (e.g., language, culture, faith, tradition, socioeconomic factors, gender identity/expression, sexual orientation, ethnicity and ability) in order to be appropriate and safe in meeting the diverse needs of all Canadians.

GLOSSARY

Aboriginal Peoples is a collective name for the original peoples of North America and their descendants. The Canadian constitution recognizes three groups of Aboriginal Peoples of Canada: Indian (commonly referred to as First Nations), Inuit and Métis. These are three distinct peoples with unique histories, languages, cultural practices and spiritual beliefs.[63] It is best to characterize Aboriginal people through their specific identities (e.g., Anishinaabe, Haida, Siksika) as this more accurately captures the unique aspects of people or cultures.[64]

Crisis intervention refers to direct efforts and activities to prevent a person from considering or attempting suicide. Interventions may be immediate at the time of an acute crisis, when there is high risk for suicide, after a suicide attempt or over a period of time. These efforts and activities are aimed at helping a person recover, reduce their pain and suffering and build on their capacity to cope and live healthily from an emotional, cognitive and behavioural perspective (e.g., crisis line help, individual and group counselling and employee assistance programs).

Cultural competency is the culture-specific knowledge, skills and attitudes required to care for diverse populations. This includes being aware of different cultural attitudes, worldviews, cultural realities and environments and being self-aware of personal attitudes towards cultural differences. Therefore, culturally-appropriate services require an understanding of the communities they serve and cultural influences on individual behaviour. Cultural safety is an extension of this concept but goes beyond awareness and takes power-dynamics into account. Culturally-safe services are respectful, inclusive and empower specific populations/communities to participate in decision-making.

Cultural continuity refers to the persistence of cultural elements through time (i.e., connection with past, present and future). For Indigenous communities, several factors can contribute to cultural continuity, including tradition, language knowledge, land claims, self-government and availability of cultural facilities, as well as the provision of culturally-appropriate education, health, police and fire services. Cultural continuity fosters the sense of personal persistence and collective connectedness over time, which is protective against self-harm behaviours. The transmission of cultural heritage from one generation to the next is important for cultural continuity.

Gatekeeper is a term referring to people who can play a role in suicide prevention because of their primary contact with those that may be at risk for suicide. They include people trained and designated to help (e.g., those who work in the fields of medicine, social work, nursing and psychology) and community members who may not be formally trained in suicide prevention but emerge as potential gatekeepers (e.g., spiritual leaders, recreation staff, first responders, coaches, teachers and counsellors). Family and friends can also play a gatekeeper role, particularly for children and youth. Gatekeepers can 'open the gate to help' for people at risk of suicide. Gatekeeper training and tools are aimed at developing the knowledge, attitudes and skills to identify suicide risk and seek or refer help when necessary.

Guideline refers to a recommendation or recommendations, for a particular course of action.

Health inequalities are measurable differences in health status experienced by different groups.

Health promotion is the process of enabling people to increase control over and improve their health.[65] Health promotion activities aim to create supportive environments, strengthen community awareness and engagement, share information on available community supports, connect people to resources and provide programs that help victims and their families develop skills to enhance their resilience.

Indigenous means 'native to the area.' Indigenous peoples are descendants of the original people or occupants that inhabited a territory or land prior to colonization or formation of the present state.[64] Indigenous peoples around the world have unique and distinctive cultures, languages, traditions and social, legal and political systems and histories. In Canada, the term is often used interchangeably to refer to Aboriginal Peoples, Native Peoples or First Peoples.

Indigenous knowledge is information that is grounded in the indigenous worldview and passed down by generations through sacred societies, cultural practices and language. Most often kept and taught by Elders and cultural practitioners, it can also be transferred to individuals of any age. Along with cultural practices, Indigenous knowledge is considered a tool for healing within culturally-appropriate services.

Leading cause of death refers to the principal causes of death, which can be ranked based on deaths per 100,000. In Canada these include cancer, heart disease, stroke, chronic lower respiratory disease, accidents, diabetes, Alzheimer's disease, influenza and pneumonia, suicide and kidney disease. Notably, the first three causes combined account for 55 percent of all deaths in 2011.

Means restriction refers to "the techniques, policies and procedures designed to reduce access to or availability of means or methods of deliberate self-harm.[66]"

Mental illness is characterized by alterations in thinking, mood or behaviour associated with significant distress and impaired functioning. Arising from a complex interaction of genetic, biological, personality and environmental factors, mental illness affects people of all ages, education levels, income levels and cultures.

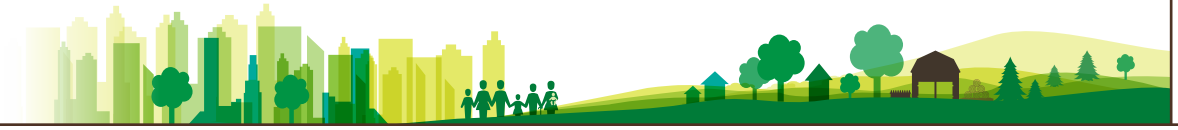
A **multi-sectoral** approach recognizes the complex nature of suicide and draws expertise from, coordinates between and collaborates with a variety of disciplines, professions and perspectives in order to address suicide in a holistic and collective way.

A **population health perspective** focuses on improving the health status of the population. Action is directed at the health of an entire population, or sub-population, including the reduction in health status inequalities between population groups.

Postvention refers to suicide prevention activities that provide support for people affected by suicide (e.g., those bereaved in the aftermath of suicide loss). These activities are crucial in coping with suicide loss and reducing further suicides and may include peer support, employee assistance programs, counselling, etc.

Questioning refers to the process of exploring and discovering one's gender, sexual orientation and/or sexual identity by people who may be unsure, still exploring or concerned about applying a social label to themselves.

Recovery refers to a process in which persons along the continuum of suicide are empowered to actively participate in their own well-being. Recovery builds on individual, family and community strengths and can be supported by a range of services and treatments. Principles of recovery include hope, self-determination and responsibility.



Regional Health Authority is a "regional governance structure set up by a provincial government to be responsible for the delivery and administration of health services in a specific geographical area."[67]

Resilience is a dynamic process through which psychological, social, cultural and physical resources are used to adapt to change and to sustain well-being in the face of illness, injury or hardship. Resilience can exist at multiple levels, including the individual, the family and the community. Inuit in Canada are working towards building resilience within their population. Inuit highlight resilience as coping with stress, mental wellness, development, family and social/community.

Self-harm and self-inflicted injuries refer to behaviour that is self-directed and deliberately results in injury or the potential for injury to oneself. Self-harm/self-inflicted injuries can include behaviours with and without the intention of suicide.[69]

Stigma refers to negative, unfavourable attitudes and the behaviour they produce. It is a form of prejudice that spreads fear and misinformation, labels individuals and perpetuates stereotypes.[69] Stigma against those who have experienced suicide-related behaviour, survivors of suicide attempt and survivors of suicide loss may prevent many from seeking help for themselves or for loved ones, denying them access to the support networks and treatment they need to recover.

Suicide-related behaviour refers to a range of behaviours related to suicide and include thinking about or considering suicide (thoughts), planning for suicide, intending, attempting suicide and suicide itself. The inclusion of thoughts in suicide-related behaviour is a complex issue about which there is meaningful ongoing academic dialogue. The decision to include thoughts in suicide-related behaviour was made for the purpose of simplicity since the diversity of research sources included in this report is not consistent in their positions on thoughts.

Thoughts of suicide refer to "thinking about, considering, or planning for suicide."[69] These can range from fleeting thoughts to detailed planning. Although the majority of people who experience thoughts of suicide do not go on to attempt suicide, it is a risk factor.

Suicide is "death caused by self-directed injurious behaviour with any intent to die as a result of the behaviour."[69] Many factors and circumstances can contribute to someone considering, attempting or dying by suicide (e.g., loss, addictions, childhood trauma or other forms of trauma, depression, serious physical illness, mental illness and major life changes).

Suicide attempt is "a non-fatal self-directed potentially injurious behaviour with any intent to die as a result of the behaviour. A suicide attempt may or may not result in injury."[69] Intent of suicide refers to the aim, purpose, or goal of ending one's life rather than the behaviour itself. Intent of suicide can be difficult to assess as it may be surrounded by ambivalence or even concealment.

Suicide contagion refers "to the process whereby one suicide … within a school, community or geographic area increases the likelihood that others will attempt or die by suicide. Suicide contagion can lead to a suicide cluster, where a number of connected suicides occur following an initial death."[70]

Suicide prevention is an umbrella term for the collective efforts of governments, local citizen organizations, mental health practitioners and related professionals to enhance safety from suicide-related behaviour and reduce the incidence of suicide.

Suicide rate is the number of deaths by suicide during a given year per 100,000 population.

Support is the action of providing assistance, encouragement and/or comfort to individuals or communities facing difficulties. This support can include increasing awareness, reducing stigma, providing information and delivering services.

Surveillance (or public health surveillance) is the "continuous, systematic collection, analysis and interpretation of health-related data needed for the planning, implementation and evaluation of public health practice."[71]

Survivors of suicide attempt refers to individuals who have lived through a suicide attempt.

Survivors of suicide loss refers to individuals who are affected or bereaved by the loss of someone by suicide.

REFERENCES

1 Statistics Canada. Deaths and mortality rate, by selected grouped causes, age group and sex, Canada. In CANSIM Table 102-0561. Ottawa, ON: Statistics Canada; 2015.

2 Arsenault-Lapierre G, Kim C, Turecki G. Psychiatric diagnoses in 3275 suicides: A meta-analysis. BMC Psychiatry. 2004;4(37):1–11.

3 Bobet E. Suicide statistics for Inuit regions, 1999–2003. Unpublished document. 2004.

4 World Health Organization. Health impact assessment: The determinants of health. Geneva, SW: World Health Organization; 2016. [2016; Cited 2016 April 18] Available from: **www.who.int/hia/en/**

5 World Health Organization. Preventing suicide: A global imperative. Geneva, SW: World Health Organization; 2014.

6 McLean J, Maxwell M, Platt S, Harris F, Jepson R. Risk and protective factors for suicide and suicidal behaviour: A literature review. Edinburgh: Scottish Government Social Research; 2008.

7 Schneidman E. Suicide as psychache: A clinical approach to self-destructive behavior. Northvale, NJ: Jason Aronson, Inc.; 1993.

8 Federal Framework for Suicide Prevention Act. S.C. 2012, c. 30.

9 Mental Health Commission of Canada. Changing directions, changing lives: The Mental Health Strategy for Canada. Ottawa, ON: Mental Health Commission of Canada; 2012.

10 Assembly of First Nations, Health Canada. First Nations mental wellness continuum framework summary report. Ottawa, ON: Health Canada; 2015.

11 Suicide Prevention Research Centre. Suicide prevention: The public health approach. Waltham, MA: Suicide Prevention Research Centre; 2015.

12 First Nations Health Authority. Hope, help, and healing. A planning toolkit for First Nations and Aboriginal communities to prevent and respond to suicide. West Vancouver, BC: First Nations Health Authority; 2015.

13 Joshi P, Damstrom-Albach D, Ross I, Hummelet C. Strengthening the safety net: A report on the Suicide Prevention, Intervention and Postvention Initiative for BC. Vancouver, BC: Crisis Intervention and Suicide Prevention Centre of BC; 2009.

14 Canadian Association for Suicide Prevention. The CASP blueprint for a Canadian National Suicide Prevention Strategy. Second edition. Winnipeg, MB: Canadian Association for Suicide Prevention; 2009.

15 Rolland-Harris E, Whitehead J, Matheson H, Zamorski M. Surgeon General report: 2015 report on suicide mortality in the Canadian Armed Forces (1995–2014). Ottawa, ON: Department of National Defence; 2015.

16 Sareen J, Cox BJ, Afifi TO, de Graaf R, Asmundson GJ, ten Have M, et al. Anxiety disorders associated with suicidal ideation and suicide attempts in the National Comorbidity Survey. J Nerv Ment Dis. 2005;193:450–4.

17 Sareen J, Cox BJ, Stein MB, Afifi TO, Fleet C, Asmundson GJ. Physical and mental comorbidity, disability and suicidal behavior associated with posttraumatic stress disorder in a large community sample. Psychosom Med. 2007;69:242–8.

18 Tarrier N, Gregg L. Suicide risk in civilian PTSD patients: Predictors of suicidal ideation, planning and attempts. Soc Psychiatry Psychiatr Epidemiol. 2004;39:655–61.

19 Statistics Canada. Rates of selected mental or alcohol disorders, full-time regular members of the Canadian Forces in the 12 months prior to the 2013 survey. Ottawa, ON: Statistics Canada; 2014.

20 National Defence and the Canadian Armed Forces. The CF 2002 supplement of the Statistics Canada Canadian Community Health Survey. Ottawa, ON: Department of National Defence; 2002.

21 Department of National Defence. Surgeon General's Mental Health Strategy: Canadian Forces Health Services Group: An evolution of excellence. Ottawa, ON: Department of National Defence; 2013.

22 Zamorski M. Report of the Canadian Forces Expert Panel on Suicide Prevention. Ottawa, ON: Department of National Defence; 2010.

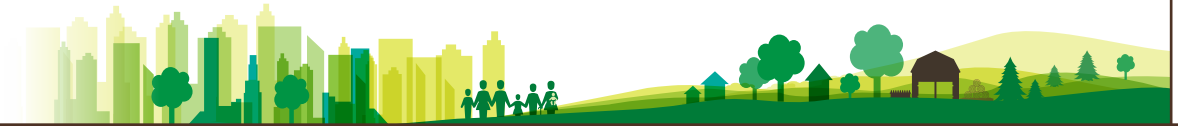
23 Statistics Canada. Canadian Forces Cancer and Mortality Study: Causes of death. Ottawa, ON: Statistics Canada; 2011.

24 Thompson JM, Van Til L, Poirier A, Sweet J, McKinnon K, Pedlar D et al. Health and well-being of Canadian Armed Forces Veterans: Findings from the 2013 Life After Service Study. Technical report. Ottawa, ON: Veterans Affairs Canada; 2014.

25 Thompson JM, Van Til L, Sweet J, Poirier A, McKinnon K, Pedlar D et al. Canadian Armed Forces Veterans: Mental health findings from the 2013 Life After Service Survey. Charlottetown, PEI: Veterans Affairs Canada; 2015.

26 Data provided by Veterans Affairs Canada's Statistics Directorate, 2015.

27 Canadian Forces Members and Veterans Re-establishment and Compensation Act. S.C. 2005, c. 21.



28 Centre for Suicide Prevention. Suicide prevention resource toolkit. Calgary, AB: Centre for Suicide Prevention; 2013.

29 Kirmayer LJ, Brass GM, Holton T, Paul K, Simpson C, Tait C. Suicide among Aboriginal people in Canada. Ottawa, ON: Aboriginal Healing Foundation; 2007.

30 Centre for Suicide Prevention. Statistics among Canada's Aboriginal peoples. Alert #52. Calgary, AB: Centre for Suicide Prevention; 2003.

31 Chandler MJ, Lalonde C. Cultural continuity as a hedge against suicide in Canada's First Nations. Transcult Psychiatry. 1998;35(2);191–219.

32 Indian Residential Schools Settlement Agreement. 2006.

33 Malenfant EC. Suicide in Canada's immigrant population. Health Reports. 2004;15(2):9–17.

34 Canadian Mental Health Association, BC Division. Suicide fact sheet. Vancouver, BC: Canadian Mental Health Association; 2012.

35 Hansson E, Tuck A, Lurie S. Rates of mental illness and suicidality in immigrant, refugee, ethnocultural and racialized groups in Canada: A review of the literature. Can J Psych. 2012;57:111.

36 Kirmayer LJ, Narasiah L, Munoz M, Rashid M, Ryder AG, Guzder J.et al. (2011). Common mental health problems in immigrants and refugees: general approach in primary care. CMAJ. 2011;183(12):E959–67.

37 Correctional Service of Canada. Report on plans and priorities 2016-2017. Ottawa, ON: Correctional Service of Canada; 2016.

38 Correctional Service of Canada. Research at a glance: Profile of Aboriginal men offenders: Custody and supervision snapshots. Ottawa, ON: Correctional Service of Canada; 2014.

39 Statistics Canada. Aboriginal peoples in Canada: First Nations People, Métis and Inuit. Ottawa, ON: Statistics Canada; 2014.

40 CSA Group and Bureau de normalisation du Quebec. Psychological health and safety in the workplace—Prevention, promotion and guidance to staged implementation. Ottawa, ON: Standards Council of Canada; 2013.

41 Mental Health Commission of Canada. Toolkit for survivors of suicide loss and postvention professionals. Ottawa, ON: Mental Health Commission of Canada; 2016.

42 World Health Organization and International Association for Suicide Prevention. Preventing suicide: A resource for media professionals. Geneva, SW: World Health Organization; 2008.

43 Coyle S. Social media and suicide prevention. Social Work Today. 2014:(14)8.

44 Skinner R, McFaull S, Draca J, Frechette M, Thompson W. Suicide and self-inflicted injury hospitalizations in Canada (1979-2012). [Unpublished report]. Ottawa, ON: Public Health Agency of Canada; 2015.

45 Rockett IRH, Kapusta ND, Bhandari R. Suicide misclassification in an international context: Re-visitation and update. Suicidol Online. 2011;2:48–61.

46 Campbell LA, Jackson L, Bassett R, Bowes MJ, Donahue M, Cartwright J, et al. Can we use medical examiners' records for suicide surveillance and prevention research in Nova Scotia? Can Comm Dis Rep. 2011 Sep; 31(4).

47 Emanuel LL, Taylor L, Hain A, Combes JR, Hatlie MJ, Karsh B, et al. The Patient Safety Education Program—Canada (PSEP—Canada) Curriculum module 13. Ottawa, ON: Canadian Patient Safety Institute; 2015.

48 Skinner R, McFaull S. Suicide among children and adolescents in Canada: Trends and sex differences, 1980–2008. CMAJ. 2012;12:1029–34.

49 Canadian Institute for Health Information. Intentional self-harm among youth in Canada. Ottawa, ON: Canadian Institute for Health Information; 2014.

50 King M, Semlyen J, Tai SS, Killaspy H, Osborn D, Popelyuk D, et al. A systematic review of mental disorder, suicide and deliberate self-harm in lesbian, gay and bisexual people. BMC Psychiatry. 2008;8:70.

51 Dyck DR. Report on outcomes and recommendations: LGBT youth suicide prevention summit. Toronto, ON: Egale Canada Human Rights Trust; 2012.

52 Health Canada. A statistical profile on the health of First Nations in Canada for the year 2000. Ottawa, ON: Queen's Printer; 2003.

53 Health Canada. Acting on what we know: Preventing youth suicide in First Nations. Ottawa, ON: Queen's Printer; 2002.

54 Inuit Tapiriit Kanatami. Inuit in Canada: A statistical profile. Referencing Health Canada, 2005, Suicide statistics for Inuit Regions, 1991–2003 [unpublished data]. Ottawa, ON: Health Canada; 2008.

55 Oliver L, Peters PA, Kohen DE. Mortality rates among children and teenagers living in Inuit Nunangat 1994–2008. Health Reports. 2012;23(3).

56 The First Nations Information Governance Centre. First Nations Regional Health Survey (RHS) Phase 2 (2008/10): National report on adults, youth and children living in First Nations Communities. Ottawa, ON: The First Nations Information Governance Centre; 2012.

57 Data provided by Correctional Service Canada, December 2014.

58 Crosby AE, Han B, Ortega L, Parks SE, Gfroerer J. Suicidal thoughts and behaviors among adults aged ≥18 years: United States, 2008–2009. MMWR Surveill Summ. 2011;60(SS13).

59 Canadian Association for Suicide Prevention. Suicide in Canada. Waterloo, ON: Canadian Association for Suicide Prevention; 2015. [Cited 2016 April 18]. Available from: **http://suicideprevention.ca/understanding/what-is-suicide/**

60 Canadian Association for Suicide Prevention. Grieving. Waterloo, ON: Canadian Association for Suicide Prevention; 2015. [Cited 2016 April 18]. Available from: **http://suicideprevention.ca/grieving/**

61 Centers for Disease Control and Prevention. Injury prevention and control: Suicide: risk and protective factors. Atlanta, GA: Centers for Disease Control; 2015. [2015 Aug 28; Cited 2016 April 18]. Available from: **www.cdc.gov/violenceprevention/suicide/riskprotectivefactors.html**

62 The Homeless Hub. Depression and suicide. Toronto, ON: Canadian Observatory on Homelessness; 2015. [2015; Cited 2016 April 18]. Available from: **http://homelesshub.ca/about-homelessness/mental-health/depression-and-suicide**

63 Aboriginal and Northern Development Canada. Aboriginal peoples and communities. Ottawa, ON: Indigenous and Northern Affairs Canada; 2015. [2015 April 10; Cited 2016 April 18]. Available from: **www.aadnc-aandc.gc.ca/eng/1100100013785/1304467449155**

64 National Aboriginal Health Organization. Terminology. Ottawa, ON: National Aboriginal Health Organization; 2016. [2016; Cited 2016 April 18]. Available from: **www.naho.ca/publications/topics/terminology/**

65 World Health Organization. Ottawa Charter for Health Promotion, 425–30. 1986.

66 U.S. Department of Health and Human Services (HHS). Office of the Surgeon General and National Action Alliance for Suicide Prevention. 2012 National Strategy for Suicide Prevention: Goals and objectives for action. Washington, DC: Department of Health and Human Services; 2012.

67 Manitoba Centre for Health Policy. Concept: Regional health authorities in Manitoba. Winnipeg, MB; Manitoba Centre for Health Policy; 2013. [2013 Dec 12; Cited 2016 April 18]. Available from: **http://mchp-appserv.cpe.umanitoba.ca/viewConcept.php?printer=Y&conceptID=1218**

68 Mental Health Commission of Canada. Stigma. Ottawa, ON: Mental Health Commission of Canada; 2016.

69 Crosby AE, Ortega L, Melanson C. Self-directed violence surveillance: Uniform definitions and recommended data elements. Atlanta, GA: Centers for Disease Control and Prevention; 2011.

70 Headspace. Suicide contagion. Melbourne, AU: Headspace; 2015.

71 World Health Organization. Public health surveillance. Geneva, SW: World Health Organization; 2016 [2016; Cited 2016 April 18]. Available from: **www.who.int/topics/public_health_surveillance/en/**