Mental Health Commission of Canada

Commission de la santé mentale du Canada

#308conversations Report

Executive Summary:

Each year in Canada, nearly 4,000 people die by suicide. In an effort to raise awareness about suicide prevention, mobilize leadership at the national level, and address this pressing public health issue on a pan-Canadian scale, the Mental Health Commission of Canada (MHCC) spearheaded a Canada-wide dialogue entitled #308conversations.

The MHCC offered all 308 federally elected Members of Parliament support and resources to host community conversations on suicide prevention. In so doing, the MHCC devised a means to identify successful initiatives at the local level, and to inform future plans for a community-based model of suicide prevention.

To date, more than 40 conversations have been held across the country. The interest generated by these frank dialogues has surpassed expectation. The involvement and support of mental health organizations at the local level, as well as the invaluable contributions of survivors, front-line health care providers, and those in the gatekeeping professions (such as educators) have informed a robust snapshot of the challenges and opportunities Canada is facing.

These discussions have resulted in a clear delineation of the many similarities communities share when it comes to addressing suicide prevention. While they have also highlighted the unique challenges faced by disparate regions and among diverse groups, the #308conversations clearly illustrate important steps that can be taken across all communities, regardless of population or geographic location.

The #308conversations events have demonstrated there are a number of initiatives that could improve circumstances for Canadians. These include creating a national distress line, providing training to front-line care providers and gatekeepers, offering resources to high risk groups, and commissioning research on disparities between provinces regarding matters of legal concern.

The success of #308conversations has extended well beyond community dialogues. The discussion has captured a great deal of interest on social media. The overwhelmingly positive feedback has inspired the MHCC to extend support for the events beyond the original duration of the campaign, and to offer resources throughout an entire calendar year. Gratitude is owed to all MPs who graciously hosted round-tables and town halls. Similarly, thanks are due to local organizations, concerned citizens, people with lived experience of mental health problems and mental illnesses, and survivors of suicide loss—who opened their hearts in the interest of helping others.

As these conversations continue, the MHCC will be positioned to offer further meaningful recommendations around addressing suicide prevention in Canada.

The MHCC vision is a society that values and promotes mental health and helps people living with mental health problems and mental illnesses to lead meaningful and productive lives.

Our mission is to promote mental health in Canada and change the attitudes of Canadians toward mental health problems and mental illnesses, and to work with stakeholders to improve mental health services and supports.

Part 1 Introduction

The initiative explored in this report, #308conversations, represents an exciting grassroots participatory approach to connecting communities, sharing best-practices, identifying challenges, and taking meaningful action to reduce suicide and the harmful impact of suicide and related behaviours in Canada. The success of this project is due, in large part, to the leadership role assumed by Members of Parliament, in collaboration with local mental health and suicide prevention stakeholders, in initiating community conversations on suicide prevention.

Guided by **Changing Directions, Changing Lives: The Mental Health Strategy for Canada**, the Mental Health Commission of Canada (MHCC) is a catalyst for improving the mental health system and changing the attitudes and behaviours of Canadians around mental health issues[1]. Suicide prevention is one of six strategic priorities identified by the MHCC in the Mental Health Strategy. Any discussion about suicide prevention must address mental health and mental illness. The MHCC has undertaken a number of initiatives around suicide prevention, intervention and postvention, within the Canadian context.

Suicide prevention refers to efforts centered on raising awareness, reducing stigma, and developing skills within the community to identify and support individuals before they reach a point of crisis. Intervention includes intervening appropriately for others, or self-coping when suicidal thinking or behaviour occurs. Finally, postvention includes knowledge, skills, and strategies for support and healing after the experience of suicidal thoughts, attempts or death[2]. For the purposes of this report, when suicide prevention is mentioned, it is meant to encompass the full continuum of activities, including intervention and postvention.

Through its unique mandate from Health Canada, the MHCC brings together leaders and organizations from across the country to accelerate changes in the mental health system and modify the attitudes and behaviours of Canadians around mental health issues. #308conversations is an initiative that draws from grassroots insight and expertise to inform the change taking place.

[1] Mental Health Commission of Canada. (2012). *Changing directions, changing lives: The mental health strategy for Canada.* Calgary, AB Retrieved from: http://strategy.mentalhealthcommission.ca/download/

[2] Canadian Association for Suicide Prevention (CASP). (2014) *What is Suicide Prevention, Intervention and Postvention?* Retrieved from: http://suicideprevention.ca/understanding/what-is-suicide-prevention-intervention-and-postvention/

WHY SUICIDE PREVENTION MATTERS

Suicide prevention, intervention and postvention is critical to a healthier and safer Canada. According to the World Health Organization, 800,000 people die due to suicide every year.[3] Every two hours a Canadian will die by suicide: a mother, a soldier, a youth, a father, a senior. Nearly 4,000 Canadians die by suicide every year.[4] This statistic is tragic and unacceptable – especially given that many of these deaths could be prevented.

A significant portion of people contemplating suicide are experiencing anxiety, depression, hopelessness, and lack of connection. Suicidal thoughts – also known as ideation – can be complex, difficult and frightening for both the affected individual and their loved ones. More than 90 per cent of people who die by suicide have a mental illness[5][6] and approximately 60 per cent of people who die by suicide have suffered from depression.[7] Further, these numbers represent only a small part of the reality of the challenge presented by suicide in Canada. It is estimated that for every death by suicide there are as many as 20 attempts.[8]

While suicide profoundly affects Canadian society, it is not a challenge without hopeful solutions. Suicide is often preventable, and we must all assume the collective responsibility to reduce suicide in Canada. Treatment is available for anxiety and depression and new resources are available to aid individuals experiencing suicidal ideation. Suicide prevention and mental health training programs such as ASIST, safeTALK, and Mental Health First Aid Canada (MHFA), including MHFA adaptations underway for specific communities, exist for friends, family and the public. These suicide prevention and mental health training courses inform people about the importance of asking someone if they are contemplating suicide and provide clear direction on appropriate actions to undertake. Although suicide is prevalent, the continued and increased focus on prevention represents hope for all Canadians affected by suicide.

[3] World Health Organization. Suicide Prevention (SUPRE). Available at: http://www.who.int/mental_health/prevention/suicide/suicideprevent/en/. Accessed November 16, 2014.

[4] Statistics Canada (2009) Retrieved from: http://www.statcan.gc.ca/pub/82-624-x/2012001/article/11696-eng.htm

[5] Weir E. Suicide: The hidden epidemic. *Canadian Medical Association Journal.* 2001;165(5):634

[6] Moscicki EK. Epidemiology of completed and attempted suicide: Toward a framework for prevention. *Clinical Neuroscience Research.* 2001;1:310-23

[7] Cavanagh JT, Carson AJ, Sharpe M. Psychological autopsy studies of suicide: A systematic review. *Psychological Medicine.* 2003;33:395-405

[8] World Health Organization. Suicide Prevention (SUPRE).

OUR COLLECTIVE CANADIAN RESPONSIBILITY

The MHCC effects real and lasting change in the lives of all Canadians by leading a pan-Canadian effort to reduce suicide in Canada. As a coordinating agent, the MHCC works to coalesce the efforts of all stakeholders, including: federal departments, provinces and territories, community organizations, front line workers, people with lived experience, survivors of suicide loss, and everyday Canadians. Any viable national solution requires the commitment and input of Canadians across the country.

While we know some individuals and certain groups are at higher risk for suicide, the solution rests with all of us. Suicide prevention is a lifespan issue, and it impacts Canadians at all stages of life. It is this profound sense of collective responsibility that propelled the development of the #308conversations initiative. At its heart, this undertaking is an effort to mobilize communities—from rural settings to urban centers—and learn from the strides being made by Canadians in each corner of the country.

> "It was valuable to hear what types of challenges different people and organizations are facing dealing with this work, including lack of resources, and in some cases duplication of resources."

> "It was a great opportunity and very useful to bring so many key stakeholders together in one room to talk about this issue."

BRIEF OVERVIEW OF #308CONVERSATIONS

Launched by the MHCC in May 2014, #308conversations is a grassroots campaign that encourages and supports each of Canada's 308 Members of Parliament to host a community meeting about suicide prevention in their riding. By embracing the social media aspect, in addition to more traditional means of communications, the MHCC has broadened the scope and interest in local communities.

Each #308conversations event brings together the wisdom and suggestions of interested community members, people with lived experience and stakeholders. Together, they are gathering to share what's working and to identify gaps in access, treatment, and support. The goal of #308conversations is to glean best practices, and work together to reduce stigma and create lasting solutions. Since May 2014, more than 40 such discussions have been held with over 1,200 Canadians participating.

At the federal level, #308conversations bring together – for the first time – community best practices from coast-to-coast-to-coast, which will inform decision making and strategy to address the urgent issue of suicide. Furthermore, the data collected from these discussions, and from future conversations, will be used to inform MHCC's suicide prevention strategic activities as well as to produce a working community model. This model will include tools and solutions that can be shared as a resource for communities across Canada.

At the local level, #308conversations provides citizens with information on the actions and initiatives taking place in their own communities. Thus, they are able to learn how they can become involved in suicide prevention, make a difference, and potentially save lives.

Online, #308conversations has been embraced by social media. The @MHCC_308 twitter handle has over 550 followers and a growing online community. The #308conversations hashtag is also being regularly mobilized by suicide prevention stakeholders to draw attention to suicide prevention related tweets, community resources and other suicide prevention events.

#308conversations has been effective because the invitation to participate is broad enough to include everyone who wants to be involved. To date, meetings have taken place in libraries, school gyms, legions and other public gathering places. Events have included local experts, healthcare providers, police, teachers, social workers, service clubs, survivors, faith-based community leaders/groups, members of the military, veterans, community leadership (local and provincial), interested citizens and local media in a variety of combinations.

When the MHCC launched #308conversations with MPs, it was intended to be a summer-long initiative (from May 2014 to August 2014). However, due to the success of events, continued interest in participation from Canadian Members of Parliament, and community involvement, the MHCC has decided to continue #308conversations over a calendar year from May 2014 to May 2015.

APPROACH

#308conversations employed a grassroots participatory approach to learning about suicide prevention in Canada. While the initiative relies on leadership from MPs, it also requires community support and engagement.

To encourage and inspire MPs to participate in the initiative, the MHCC hosted a launch event on Parliament Hill, inviting all parliamentarians to attend. Brief remarks from an MP from each of the three main political parties helped to drive home the point that this was an issue for all Canadians, in every part of the country.

The MHCC developed and distributed an event planning kit to MPs, and posted it in a #308conversations section on its website. In addition to the event kit, the website also includes a short webinar with tips for appropriate language and ideas for holding a safe and welcoming meeting. The event kit includes templates and examples that can easily be adapted depending on the meeting parameters determined by the hosts. The planning resources include:

- Backgrounder
- Links to Partner Resources
- Links to Postvention Resources
- Discussion Guide
- Suggested Agenda and Roll-Out for the Event
- Public notice Template
- News Release Template
- OpEd Template
- Meeting Signage
- Facilitator Questions
- Power Point Template
- Thank you letters for guest speakers Template

Community conversations about suicide prevention have represented an opportunity to enable a participatory bottom-up approach, rather than a prescriptive top-down approach, for setting MHCC goals around suicide prevention.

As a result of this approach, the design of each event was determined by the community hosts and varied depending on the availability of space, participants and resources. Other than the mental health and suicide prevention subject that was central to all meetings, each #308conversations event was unique and relevant to specific community contexts.

#308conversations were variably structured as roundtables, town halls, world café, working groups and presentations. Some meetings included guest speakers from local mental health organizations, bereaved survivors, and community members occupying roles that increase their opportunity to identify people with suicidal thoughts and behaviours. In numerous instances two or more MPs joined together to host suicide prevention meetings in communities where one central event made the most geographical sense.

In addition to determining the best framework for the meeting, MPs were given the opportunity to design parameters for data collection that worked best for their event. Although the use of note-takers was universal, some MPs invited participants to submit briefings, stories, suggestions and resources separately, that were then collected and delivered to the MHCC. As a result, the MHCC received diverse feedback from #308conversations events ranging from formal reports, to suicide prevention resources, to handwritten personal accounts and suggestions. The diversity of materials enriches the depth and knowledge of this truly pan-Canadian perspective.

Part 2 Results from #308conversations events

As of November 2014, #308conversations events have taken place in all regions of Canada. Each event produced insights, best practices, and recommendations around addressing suicide in Canada. Although each community is unique, and certain populations face specific challenges, common themes clearly dominated the discussions thus far. At this time, there are reports from #308conversations events that have yet to be submitted. This report represents an initial overview of major commonalities across Canadian communities.

THREE CONSISTENT FINDINGS:

1. Underlying many of the specific challenges identified in each report were three significant elements. To begin with, many reports noted and called for a **Canadian National Suicide Prevention Strategy**.
2. Secondly, participants felt that the **reduction of stigma** continued to be a main priority and an underlying factor contributing to suicide prevention challenges.
3. Finally, a common refrain from #308conversations meetings was the concern that addressing immediate suicide crises often translates to a lack of resources for **programs focused on prevention**.

These three elemental factors appear to influence the cohesiveness and success of ongoing suicide prevention activities.

> "It was a packed house! 20 expected. 42 attended. On a SUNNY FRIDAY AFTERNOON in the SUMMER!! That speaks VOLUMES!!!"

COMMON THEMES

The following are recurring themes and discussions that arose during the community conversations that have taken place to date. They are placed approximately in order of the significance accorded them based on the number of times they appeared in event reports and the space given to their discussion.

NATIONAL DISTRESS LINE

It was noted repeatedly within event reports that Canada lacks a unified national distress line. Several studies have documented the benefits of accessing a distress line for people who are suicidal or in crisis. Benefits of accessing a crisis line include changes in the caller's crisis state during the call, resources for improved crisis management, development of action plans, and access to referrals or resource recommendations.[9] Evidence also shows significant reduction of the intent to die, hopelessness, and psychological pain for suicidal callers by the end of their call.[10]

Canada currently has a fragmented system of crisis lines. In some areas the crisis lines are provincial, in others the lines are regional, and some areas of the country do not have crisis lines at all. Well known distress lines like Kids Help Phone are instrumental to providing mental health support for Canadian youth. Kids Help Phone estimates that young people reach out for support from the service on an average of 5,000 times each week. They offer three counselling formats: a phone helpline, internet-based message board counselling and a live chat option. Since 2010 telephone counselling at Kids Help Phone has increased 127 per cent with a 22 per cent increase in counselling sessions for young people with thoughts of suicide.[11]

Similarly, the development of a national crisis line presents an opportunity for innovation and a service expected to be well utilized. Participants of #308conversations noted the need for a national distress line to ensure all Canadians have access to crisis support.

OPPORTUNITY:

The timing is opportune to support the creation of a national crisis line. A Canadian crisis line would ensure that individuals in various time zones and rural or remote areas would have comparable 24/7 access to crisis support.

Once the task of creating a sustainable pan-Canadian distress line has been undertaken, the next phase would likely be to further engage in innovative e-mental health initiatives that take advantage of online resources and social media as way of communicating with a vast population that is not exclusively youth.

SUICIDE PREVENTION TRAINING

Increased training on mental health and suicide prevention was mentioned in every single #308conversations event that took place. Often repeated were target groups that included educators, health care professionals, and gatekeeper populations. Gatekeepers are people who have primary contact or are strategically placed to potentially interact with those at risk for suicide. The following sections outline specific contextual information and opportunities for action in relation to these three groups.

[9] Lifeline Research Foundation (2013) *Summary of Research and Evaluation of Crisis Helplines.* Retrieved from: https://www.lifeline.org.au/About-Lifeline/Publications-Library/Publications#research_reports

[10] Gould, M.S., Kalafat, J., Harris Munfakh, J.L. & Kleinman, M. (2007). *An evaluation of crisis hotline outcomes: Part II Suicidal callers. Suicide and Life-threatening Behavior,* 37 (3), 338-352.

[11] Kids Help Phone (2014) Stats & Resources. Retrieved from: http://org.kidshelpphone.ca/media/stats-resources/

EDUCATORS

In Canada, suicide accounts for 24 per cent of all deaths among 15-24 year olds and 16 per cent among 16-44 year olds. Suicide is the second leading cause of death for Canadians between the ages of 10 and 24.[12] Seventy-three per cent of hospital admissions for attempted suicide are for people between the ages of 15 and 44.[13] #308conversations participants noted that most mental health issues emerge frequently at younger ages and, if addressed early, may result in better outcomes.

Educators often represent a first line of contact for students of diverse ages who are experiencing suicidality or are coping with severe mental illnesses. Teachers are well-positioned to observe students' behaviour and to act when they suspect a student may be at risk of self-harm.[14]

Therefore, suicide prevention efforts which target school professionals' ability to recognize suicidal behaviour in their students and act appropriately, has the potential to save lives. It also has the benefit of reducing the debilitating emotional and economic costs experienced by families, schools and society as a result of suicide.[15]

In addition to acting in a gatekeeper capacity, teachers also play significant roles in the event of a student death by suicide. They are uniquely placed to oversee appropriate postvention activities within a school community. Training and relevant policies and protocols can help educators identify and support at-risk young people.

OPPORTUNITY:

School boards that have mental health strategies and suicide prevention and postvention protocols should ideally share these excellent resources as prototypes with other school boards lacking current strategies and policies. With the permission of school boards, the MHCC could adapt their suicide prevention and intervention protocol into a template example for use by other school boards.

Provincially, MHFA or various suicide prevention training could become a mandatory part of the teacher training curriculum, and be integrated into ongoing professional development requirements. It is clear from #308conversations reports that the challenge is lack of access to training rather than lack of interest. It is apparent that teachers are eager to learn more about how to support their students within their schools.

[12] Canadian Psychiatric Association (2002). Mental Illness Awareness Week fact sheet.

[13] Canadian Mental Health Association (2014) Suicide Statistics [Internet Source]. Retrieved November 18th, 2014, from http://toronto.cmha.ca/mental_health/suicide-statistics/

[14] Nemeroff, R., Levitt, J.M., Faul, L., Wonpat-Borja, A, Bufferd, S, Setterberg, S, & Jensen, P.S. (2008). *Establishing ongoing, early identification programs for mental health problems in our schools: A feasibility study.* Journal of the American Academy of Child and Adolescent Psychiatry, 47(3), 328-338.

[15] Crawford, S., & Caltabiano, N. J. (2009). *The School Professionals' Role in Identification of Youth at Risk of Suicide.* Australian Journal of Teacher Education, 34(2). Retrieved from: http://dx.doi.org/10.14221/ajte.2009v34n2.3

HEALTH CARE PROFESSIONALS

Participants of #308conversations represented a variety of suicide prevention stakeholders including health care professionals – many of whom were also individuals with lived experience of mental illness, bereaved survivors, and/or attempt survivors.

The reports reflected a consistent call for increased mental health and suicide prevention training for all health care professionals, including physicians, emergency room staff, nurses, social workers, child and youth workers, etc. These requests for training came both from citizen stakeholders and health care workers themselves. A 2005 review outlined the importance of training for health care professionals. Based on reviews of the progress of evidence-based prevention strategies for suicide, Mann et al. found that education of primary care physicians led to a 22 per cent – 73 per cent decline in the annual rate of suicide.[16]

Physicians are often the frontline for many people experiencing mental health challenges, particularly when mental illnesses also present physical symptoms that result in an individual seeing a physician. In addition, to access many mental health professionals most Canadians must connect with a physician to obtain referrals for psychiatric or psychological services. Thus, physicians represent key gatekeepers in the context of accessing medical and mental health support.

Anecdotally, #308conversations event reports included individual accounts from people who had experienced suicidal thoughts and found their physicians ill-equipped to provide support. In some instances participants shared that physicians did not understand the magnitude of the situation, did not react appropriately to a patient's distress, and/or dismissed the individual.

Event reports also included accounts from healthcare professionals indicating that they did not feel sufficiently equipped to support patients with severe mental illnesses. Some felt there was a lack of resources and lack of adequate training for front line healthcare workers to sufficiently understand their role when interacting with patients experiencing suicidal thoughts.

OPPORTUNITY:

MHFA training courses and suicide prevention training programs exist. However, there is still work to be done in order to make the training more prevalent, accessible and geared towards a variety of health care professionals. There is also an opportunity to explore adapted innovative web-based suicide prevention training for a variety of healthcare and community support professionals.

[16] Mann JJ, Apter A, Bertolote J, et al. Suicide prevention strategies: a systematic review. JAMA 2005;294:2064-74

GATEKEEPERS AND MEMBERS OF THE PUBLIC

Consistently identified in various #308conversations reports was the need to reduce stigma and increase the availability of mental health and suicide prevention training programs for the general public and gatekeepers. This includes training for parents, caregivers, family, friends, and people whose occupations and community involvement could make them more likely to interact with, or identify, individuals contemplating suicide.

The purpose of identifying and training gatekeepers is to develop the knowledge, attitudes, and skills of strategically placed individuals so they can identify those at risk for suicide, assess levels of risk, and facilitate referral to appropriate resources.[17] Gatekeepers hold a variety of occupations. For example, lawyers, coaches, bartenders, occupational therapists, and many other similarly employed individuals, should be made aware that they may be gatekeepers. Subsequently, providing accessible training can increase the capacity of these individuals to play a role in preventing suicide.

Although we recognize that certain groups are more at risk for suicide, we also know that suicide can affect anyone of any age, gender or background. The role of family, friends, and gatekeepers in recognizing suicidal behaviour and knowing how to act appropriately is critical and can literally save lives. In the same way that educating the public on CPR and First Aid creates a safer community, so does increasing the number of people trained in MHFA and suicide prevention techniques. The United Nations[18], along with numerous review articles on general methods of suicide prevention, have recommended that gatekeeper training be considered when implementing an effective strategy to prevent suicide.[19]

OPPORTUNITY:

At present, there is an opportunity to develop and implement public awareness activities to ensure that people recognize their potential role and importance as gatekeepers. The first step is in educating individuals about the impact they can have.

As interest in participating in gatekeeper and general suicide prevention training gains momentum the availability and accessibility of this training must keep pace. Increasing access to suicide prevention training for target populations of gatekeepers may be an effective tool in reducing incidents of Canadians dying by suicide in diverse communities. In addition, continuing to promote the existence of current training programs will help ensure people take advantage of existing resources.

[17] Gould MS, Kramer RA. (2001) *Youth suicide prevention.* Suicide Life Threat Behaviour.;31(Suppl):6 –31.

[18] United Nations Department for Policy Coordination and Sustainable Development. (1996) *Prevention of suicide: guidelines for the formulation and implementation of national strategies.* New York (NY): United Nations.

[19] Beautrais A, Fergusson D, Coggan C, et al. (2007) *Effective strategies for suicide prevention in New Zealand: a review of the evidence.* N Z Med J.;120:U2459.; (JJ. Mann, et al. 2005); (Gould & Kramer, 2001).

HOSPITAL AND EMERGENCY ROOM ENVIRONMENTS

Multiple #308conversations reports noted challenges for people experiencing thoughts of suicide and individuals supporting those people when they interact with hospitals and emergency rooms (ER). In particular, difficulties having individuals admitted or even assessed in a context where physical injury is often given precedence to mental crisis is an obstacle. As a result, a suicidal person may simply leave the hospital without having received treatment, or may wait unaided for hours only to be released without an appropriate safety plan and outpatient supports in place.

Many people experiencing thoughts of suicide come into contact with the emergency room. Most mental health care first aid and suicide prevention training advises people to call 911 or bring someone to the ER if they are experiencing thoughts of suicide or have a plan for suicide. Thus, when an individual arrives at the ER it is often a crisis situation. As noted previously, increasing training for health care professionals working in hospitals and emergency room settings may better equip them to support patients experiencing suicidal thoughts and behaviour.

Some hospitals have appropriate protocols in place to support emergency room patients who present with suicidal ideation and also have policies to ensure a safe transition out of the hospital environment. This is critical given a Canadian study that demonstrated significant risk in the post-discharge period for high risk patients. Of the study cohort, 4 of 120 participants died by suicide in the six months after discharge and 41 of 104 reported suicidal behaviour.[20]

Provinces and hospitals have varying degrees of policy and process in place. However, studies show that early contact after discharge and improving community linkages can lead to significant reductions in suicide reattempts.[21]

OPPORTUNITY:

Evidence demonstrates that ensuring all hospitals provide staff with appropriate suicide prevention training as well as develop and implement suicide prevention and postvention protocols has a marked influence on suicide reduction in the community. Initiating policies for the creation of safety plans and follow-up policies post-discharge is an opportunity to improve the outcome for patients experiencing suicidality who come into contact with the hospital environment.

[20] Isaac, M., Elias, B., Katz, L. Y., Belik, S., Deane, F. P., Enns, M. W. & Sareen, J. (2009). *Gatekeeper training as a preventative intervention for suicide: A systematic review.* Canadian Journal of Psychiatry-Revue Canadienne de Psychiatrie, 54 (4), 260-268

[21] Knesper DJ. (2011) *Continuity of care for suicide prevention and research: suicide attempts and suicide deaths subsequent to discharge from the emergency department or psychiatric inpatient unit.* Newton (MA): American Association of Suicidology and the Suicide Prevention Resource Centre, Education Development Center.. Available: www.sprc.org/library/continuityofcare .pdf (November 18, 2014)

RESOURCES FOR HIGH-RISK GROUPS

Suicide can affect anyone: however, the MHCC Strategy for Canada notes that particular groups are subject to high overall suicide rates, including older men, First Nations and Inuit youth, and LGBTQ youth.[22] These high-risk groups may also have fewer resources that fit their particular context and cultural experience. Reports from #308conversations noted a particular lack of suicide prevention resources for seniors, First Nations, Metis, Inuit and new immigrant populations.

The statistics surrounding Aboriginal populations in Canada and the impact of suicide among this community is staggering. First Nations youth die by suicide approximately 5 to 6 times more often than non-Aboriginal youth.[23] Suicide rates for Inuit people are 11 times higher than the national average and young Inuit men die by suicide at rates 28 times higher than the national average.[24] These rates of suicide are among the highest in the world.

At the same time, people who work with specific populations like seniors note that they require training and resources that speak specifically to the challenges they experience. Baby boomers are amongst the largest population cohorts in Canada and have had higher suicide rates than previous generations.[25] As the population ages, this may result in increased rates of suicide. Already, middle-aged and senior men are particularly at risk for suicide. In addition, identifying and gauging the intention of older adults to suicide may be more difficult because they tend to discuss suicide less and may live in social isolation. Further, they tend to use more lethal means and the cause of death may be less rigorously investigated in the case of seniors.[26]

OPPORTUNITY:

Leadership and inclusion of high-risk groups in the development and implementation of all strategies and resources is central to creating effective change. Engagement is required in order to better understand the realities of individuals within these groups who are experiencing suicidal thoughts or behaviours.

Further opportunity also exists in increasing awareness and dissemination of strategies and resources that are already being deployed. Examples include the Government of Nunavut's Suicide Prevention Strategy, Québec's provincial strategy and the resources created by the Canadian Coalition for Senior's Mental Health.

Moving forward, high-risk groups will also benefit from the development and dissemination of mental health and suicide prevention training that is created with their insight and collaboration.

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[22] Mental Health Commission of Canada. (2012). *Changing directions, changing lives: The mental health strategy for Canada.* Calgary, AB Retrieved from: http://strategy.mentalhealthcommission.ca/download/

[23] Canada, Health Canada (n.d). *First Nations, Inuit and Aboriginal health: mental health and wellness* [Internet site]. Retrieved from http://www.hc-sc.gc.ca/fniah-spnia/promotion/mental/index-eng.php

[24] Working Group for a Suicide Prevention Strategy for Nunavut. (2009). *Qaujijausimajuni Tunngaviqarniq: using knowledge and experience as a foundation for action.* A discussion paper on suicide prevention in Nunavut. Retrieved from http://www.inuitknowledge.ca/content/qaujijausimajuni-tunngaviqarniq-using-knowledge-and-experience-foundation-action-discussion-

[25] Centre for Suicide Prevention Resource Toolkit (2012) *'Plus 65 at the end of the day...'* Senior Canadian Coalition for Mental Health, p. 4.

[26] Centre for Suicide Prevention Resource Toolkit (2012)

LEGAL ISSUES

AGE OF CONSENT

Personal accounts submitted with #308conversations reports noted parents' difficulty with diverse ages of consent for mental health treatment in various Canadian provinces. Participating school administrators also noted the difficulty in explaining to parents why the age of majority within the school system is 18 but different or non-existent within the medical system.

Age of consent varies across Canada. New Brunswick legislation ensures that minors 16 years or older have the same right as adults to refuse consent to medical treatment. The New Brunswick Medical Consent of Minors Act also provides that a minor under the age of 16 can make decisions as long as certain conditions are met.[27] In Québec the Civil Code states that 14-year-olds can consent to care as long as care sought is not medically necessary or entails a health risk at which time parental authority is also required.[28] Alternatively, Ontario, Alberta, British Columbia, Manitoba, and Saskatchewan follow the "mature minor doctrine[29]" which does not specify an age at which minors can exercise independent consent for health care. In these instances, physicians can determine a child's capacity to consent in the same way they would for an adult.[30]

OPPORTUNITY:

Further exploration of the historical context of the age of majority for mental health consent within various jurisdictions could be undertaken. Additional inquiry into the experiences and insights of parents would be beneficial in determining the scope of this particular challenge, which was identified through #308conversations.

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[27] Gilmour JM. *Children, adolescents, and health care.* In: Downie J, Caulfield T, Flood C, editors. Canadian health law and policy. 2nd edition. Toronto: Butterworths; 2002. pp. 204–49.

[28] Gilmour JM. (2002)

[29] College of Physicians and Surgeons of Ontario. Consent to medical treatment, Policy #4-05 [reviewed and updated September 2005]. College of Physicians and Surgeons of Ontario; 2006. Available from: http://www.cpso.on.ca/Policies/consent.htm; College of Physicians and Surgeons of Alberta. Consent for minor patients. College of Physicians and Surgeons of Alberta; 2006. Available from: http://www.cpsa.ab.ca/publicationsresources/attachments_other/Consent_for_Minor_Patients.pdf; College of Physicians and Surgeons of British Columbia. Consent of "minors": Infants Act. In: Physician resource manual. College of Physicians and Surgeons of British Columbia; n.d. Available from: https://www.cpsbc.ca/cps/physician_resources/publications/resource_manual/interantmedical; Manitoba Law Reform Commission. Consent to medical treatment. In: Substitute consent to health care. Report No. 110. Winnipeg: Office of the Queen's Printer; 2004. pp. 5–9. Available from (on College of Physicians and Surgeons of Manitoba website): http://www.gov.mb.ca/justice/mlrc/reports/110.pdf ; Salte B. Recent legislative change. College Newsletter [of the College of Physicians and Surgeons of Saskatchewan] 2002; 18(51): 7. Available from: http://www.quadrant.net/cpss/pdf/CPSS_December_Newsletter.pdf

[30] Government of Ontario. Health Care Consent Act, 1996 [last amendment 2007], c. 2. Available from: http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_96h02_e.htm

PRIVACY CONSIDERATIONS

As healthcare providers and community supports seek to coordinate care to more fully support individuals with mental health challenges, they note in #308conversations reports that privacy concerns and uncertainty can hinder their efforts. In a survey distributed by the Change Foundation in Ontario, 27 per cent of home care providers and support services respondents were not satisfied with information provided to them prior to a first visit with a client recently transferred from hospital. Rather than access relevant information through a coordinated care plan, more than one third of care providers regularly relied on information from clients and their informal caregivers.[31]

In particular, #308conversations participants in community support and social services roles found that barriers to information were negatively impacting outcomes for clients with mental health illnesses. For example, in Ontario, health information custodians can access patient information and fully participate in the circle of care for a client. A program or service for community mental health whose primary purpose is the provision of healthcare are considered health information custodians. However, many social service agencies do not qualify for this status because the main purpose of the organization is not specifically providing healthcare to clients.[32] Although the context of privacy concerns differ between provinces and territories, additional obstacles to integrated care include: lack of standardized communication tools and processes for health care or community facilities; lack of compatible information technology; lack of time, staff, and resources to allocate towards the development of "circle of care" planning and processes.[33]

OPPORTUNITY:

Further exploration of existing privacy legislation in Canadian provinces and territories will provide a fuller picture of coordinated care in Canada. Additional inquiries can uncover common challenges for service providers and identify innovative practices already in motion. Analysis of the national context will aid in determining the scope of this particular challenge as it relates to mental health care and suicide prevention services for Canadians.

[31] Health Quality Ontario. Best Path, A Resource for Health Links – Evidence Informed Improvement Package, Transitions of Care. Toronto, ON: Queen's Printer for Ontario, 2013.

[32] Ministry of Health and Long-Term Care (2004). *Personal Health Information Protection Act, 2004: An Overview for Health Information Custodians.* Retrieved from: http://www.health.gov.on.ca/en/common/legislation/priv_legislation/docs/info_custodians.pdf

[33] Ontario Medical Association. (2014) *Key Elements to Include in a Coordinated Care Plan.* Retrieved from: https://www.oma.org/Resources/Documents/CoordinatedCarePlan_June2014.pdf

SUCCESSES REPORTED FROM VARIOUS #308CONVERSATIONS EVENTS:

In addition to discussing challenges around suicide prevention, participants of #308conversations also identified successes, resources, and positive steps forward. These successes help spread a hopeful message and are crucial to a holistic discussion on the topic of suicide.

EXISTING TOOLS AND RESOURCES

In some cases, specific tools and resources were identified, such as the Nova Scotia Tool for Assessment, or the Halifax and Region Military Family Resource Centre (HRMFRC) Personal Assessment resource. The best approach for these submissions may be to try and increase the dissemination of these pre-existing tools and/or explore the potential of adapting them for other communities. Similarly, the Bluewater District School Board shared their mental health strategy and suicide prevention, intervention, and postvention protocol which could benefit other school boards who do not have these protocols in place.

> We had an amazingly diverse group of people at the table with representation from the faith community, Children's Aid, children's mental health, mental health services, Grey Bruce Health Services (our local hospital), both Catholic and public board of mental health leads, GSA representation, First Nations, health unit, OPP, military, family health team youth addictions, United Way, as well as two suicide survivors. Two moms of young men who died by suicide. We also had three youth voices, as well as members of the media.

TRAUMA-INFORMED CARE

Various participants of #308conversations meetings mentioned the increasing uptake and importance of trauma informed care in hospitals. Trauma-informed systems and organizations ensure that everyone has a basic understanding of the "psychological, neurological, biological, social and spiritual impact that trauma and violence can have on individuals seeking support."[34]

The 2013 Trauma Toolkit notes that a trauma-informed model shifts the conversation from asking "What is wrong with you?" to "What has happened to you?"[35] Further encouraging the adoption of trauma-informed care can result in health care services that are more effective and compassionate.

WINNIPEG'S INNOVATIVE CRISIS RESPONSE CENTRE

#308conversations participants in various communities across Canada identified the Winnipeg Crisis Response Centre (CRC) as a positive example to further explore. The CRC provides 24/7 walk-in and scheduled urgent care services, as well as functions as the base for the mental health Mobile Crisis Team. The Centre provides assistance to people experiencing emotional crisis, severe anxiety, depression, suicidal thoughts or who are dealing with an urgent ongoing mental health condition. It gathers in one place a health team that includes crisis specialists with nursing, social work or psychology backgrounds, paraprofessional crisis workers, physician assistants, and psychiatrists.[36] Located in close proximity to Winnipeg's Health Sciences Centre, the CRC provides people in crisis with a warm and welcoming environment in which to find crisis assessment and intervention. Further exploration of the work being done by the CRC and its impact on the surrounding community should be closely followed. It is possible that additional centers such as the CRC should be encouraged in more Canadian cities and communities.

HUBS OF ACTION AND CIRCLES OF CARE

Many #308conversations reports discussed circles of care in regard to both challenges and successes. Some noted the need to further clarify and encourage cooperation between various healthcare practitioners who are working with a particular patient. Examples were also given of community initiatives to connect the various stakeholders involved in supporting mental health within a community. It appears that these hubs occur primarily for the integrated support of children and youth. Opportunities also exist to model integrated hubs for the mental and physical health of adults, seniors, and other at-risk groups.

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[34] Klinic Community Health Centre (2013) *The Trauma Toolkit: A resource for service organizations and providers to deliver services that are trauma-informed.* 2 ed. Retrieved from: http://trauma-informed.ca/wp-content/uploads/2013/10/Trauma-informed_Toolkit.pdf

[35] Trauma Toolkit (see 20), pg. 16

[36] http://www.wrha.mb.ca/wave/2013/05/mental-health-crc-opens.php

OTTAWA POLICE MENTAL HEALTH UNIT

There were indications from some #308conversations events that links between police and community supports for people with mental illness are stronger and more effective than in the past. For example, when asked to identify community successes, multiple participants at an Ottawa event identified the work of the Ottawa Police Mental Health Unit as positive progress. The feedback from Ottawa's #308conversations event was in relation to a pilot program introduced in 2012 by Dr. Peter Boyles. At the Ottawa Police Mental Health Unit, psychiatrists partner with a plainclothes officer in an unmarked police vehicle and respond to live calls that are thought to involve people with mental illnesses. Studies show that between 1 and 31 per cent of all police dispatches or police encounters in Canada involve persons with mental health problems or mental illnesses. Most people with mental illness do not commit criminal acts; however, contact with the police is common among this population.[37] The work of the Ottawa Police Mental Health Unit is an example of community success.[38]

PEER SUPPORT

Multiple #308Conversation participants, many of whom were suicide attempt survivors or bereaved family members, referenced peer support as something positive, beneficial, and important for recovery. The MHCC Guidelines for the Practice and Training of Peer Support note that peer support "is a supportive relationship between people who have lived experience in common."[39] The common experience they have might be related to their own mental health, in the case of attempt survivors or that of a loved one, in the case of bereaved survivors.

Research and anecdotal information from #308conversations sessions indicates that peer support can help a person gain control over their symptoms, reduce instances of hospitalization and improve quality of life through social connection and support.[40] The success of peer support can be attributed in part to the greater feelings of empathy and connectedness between a peer support worker who shares a common experience with someone, rather than with a patient-therapist relationship that is built on different foundations.[41]

Recognizing the beneficial impact that peer support programs and peer support workers have for all those affected by suicide it is evident that further expansion of peer support programs would be advantageous. They represent a low-cost, effective, compassionate response to supporting Canadians who have been touched by suicide.

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[37] Brink, J., Livingston, J., Desmarais, S., Greaves, C., Maxwell, V., Michalak, E., Parent, R., Verdun-Jones, S., & Weaver, C. (2011). *A study of how people with mental illness perceive and interact with the police.* Calgary, Alberta: Mental Health Commission of Canada. Retrieved from http://www.mentalhealthcommission.ca

[38] Boyles, P., Palmer, D., Quesnel. (2013) *Side by Side.* Gazette. Vol. 75 no.2. Retrieved from: http://www.rcmp-grc.gc.ca/gazette/vol75no2/cover-dossier/hospital-hopital-eng.htm

[39] Sunderland, Kim, Mishkin, Wendy, Peer Leadership Group, Mental Health Commission of Canada. (2013). *Guidelines for the Practice and Training of Peer Support.* Calgary, AB: Mental Health Commission of Canada.Retrieved from: http://www.mentalhealthcommission.ca

[40] Ochocka, J., Nelson, G., Janzen, R., Trainor, J. (2006). *A longitudinal study of mental health consumer/survivor initiatives: Part III – A qualitative study of impacts on new members.* Journal of Community Psychology, 34, pp. 273-283.

[41] Coatsworth-Puspoky, R., Forchuk, C., Ward Griffin, C. (2006). *Peer support relationships: an unexplored interpersonal process in mental health.* Journal of Psychiatric and Mental Health Nursing, 13, pp. 490-497.

Part 3 Discussion/Moving Forward

#308conversations owes it ongoing success to the leadership of Canadian MPs and the engagement of local suicide prevention stakeholders. Events have been consistently well attended with participant numbers regularly exceeding expectations, ranging from 20 to over 200 people discussing suicide in the community. Open dialogue has contributed to reducing stigma and has connected community members with a shared interest in reducing suicide. Importantly, it has also connected community members to their local members of government. Suicide prevention stakeholders have reported their optimism and gratitude for the opportunity to discuss community concerns and successes with their MP.

#308conversations events are gaining momentum and continue to take place across Canada. In response to requests from local stakeholders, the MHCC is expanding #308conversations and making the event kit available to all community leaders. Information on #308conversations and the corresponding downloadable event kit documents are available on the MHCC #308conversations website. The MHCC continues to encourage MPs to act as catalysts and facilitators for events in their communities. However, if an MP is unable to host a meeting other local community leaders and mental health groups are invited to organize #308conversations meetings.

Ongoing feedback from #308conversations events will continue to update the national perspective and will inform the development of an MHCC community model for suicide reduction. Furthermore, MHCC is partnering with the World Health Organization to explore opportunities to implement the Canadian #308conversations model internationally.

Suicide prevention in Canada is gaining momentum as communities work to reduce stigma, provide support, create innovative resources, and help one another to reduce the impact of suicide. All #308conversations events have identified challenges to reducing suicide in Canada. However, more importantly, each report clearly spoke of hope for the future. Each and every participant, including MPs, people with lived experience, doctors, social workers, therapists, bereaved survivors, and attempt survivors shone their light on the topic, added their voice, and started a much-needed national conversation on suicide prevention. Moving forward, it is up to all Canadians to continue the discussion.

If you are a Member of Parliament interested in holding a #308conversations meeting, please contact the MHCC at **308@MENTALHEALTHCOMMISSION.CA**

If you are a community member interested in attending a #308conversations event. Find out who your MP is by clicking here: **HTTP://WWW.PARL.GC.CA/PARLINFO/COMPILATIONS/HOUSEOFCOMMONS/MEMBERBYPOSTALCODE.ASPX?MENU=HOC**

If you are a suicide prevention organization interested in holding a #308conversations even in your community, click here for more information: **HTTP://WWW.MENTALHEALTHCOMMISSION.CA/ENGLISH/308CONVERSATIONS**