DOING WHAT WORKS:

Rethinking the Federal Framework for Suicide Prevention

Report of the Standing Senate Committee on Social Affairs, Science and Technology

The Honourable Ratna Omidvar, Chair
The Honourable Jane Cordy, Deputy Chair

JUNE 2023

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A Note to Readers

As part of this study, the Standing Senate Committee on Social Affairs, Science and Technology (the committee) received testimony and written submissions from people with lived and living experience with suicide. The committee wishes to thank everyone who shared these experiences, acknowledging that for many in the past and still today, stigma prevents suicide from being discussed openly and frankly.

The committee also recognizes that suicide and suicide prevention are challenging topics and therefore wishes to warn readers that this report includes discussion of the following: suicidal ideation, suicide methods, suicide and suicide attempts and substance use and addiction.

If you need additional support, the Government of Canada provides the following information:

If you or someone you know is in crisis

If you are in immediate danger or need urgent medical support, call 911.

If you or someone you know is thinking about suicide, call Talk Suicide Canada at 1-833-456-4566. For residents of Quebec, call 1-866-277-3553 or visit suicide.ca/en. Support is available 24 hours a day, 7 days a week.

You can also access the Wellness Together Canada portal for immediate, free and confidential mental health and substance use help, 24 hours a day, 7 days a week. Virtual services are available in English and French, with interpretation services available over the phone in over 200 languages and dialects. Call 1-866-585-0445 or text WELLNESS to 741741.

Visit Talk Suicide Canada for the distress centres and crisis organizations nearest you.

For Indigenous peoples

Call 1-855-242-3310 (toll-free) or connect to the online Hope for Wellness chat.

Services are available to all Indigenous peoples across Canada who need immediate emotional support, crisis intervention or referrals to community-based services, including experienced and culturally sensitive help line counsellors. Services are available in English and French and on request, in Cree, Ojibway and Inuktitut.

Table of Contents

A Note to Readers 3
Table of Contents 4
The Committee Membership 5
Order of Reference 7
Executive Summary 9
List of Recommendations 10
Part 1: Evaluating the Federal Framework for Suicide Prevention 13
    Introduction 13
    Developing the Federal Framework for Suicide Prevention 13
    Trends in Suicide Rates and Data in Canada 15
    Strengths of the Current Federal Framework for Suicide Prevention 16
    Challenges of the Federal Framework for Suicide Prevention 17
        Evidence-Based Interventions 18
        Data Gathering, Research and Measuring Outcomes 21
    Supporting Populations Overrepresented in Canada’s Suicide Rate: Indigenous Peoples and Boys and Men 30
        Indigenous Peoples 31
        Boys and Men 36
        The Impact of Substance Use and Addiction 38
    Towards a More Effective Framework 39
    Conclusion 43
Part 2: Suicide Prevention in Canada 44
    Jurisdictional Responsabilities and Challenges 44
    Experiences of Some Racialized and Ethnic Communities 45
    Youth Mental Health 47
    Federal Tools, Programs and Plans for Suicide Prevention 48
        Wellness Together Canada Portal and PocketWell Application 48
        National 3-Digit Crisis Support Number 50
        National Action Plan on Suicide Prevention 51
        National Suicide Prevention Strategy 52
    Lived and Living Experiences with Suicide and Suicide Prevention 54
Appendix 1: List of Witnesses 57
Appendix 2: List of Briefs 59

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Ex-officio members of the committee:

The Honourable Marc Gold, P.C. or Patti Laboucane-Benson
The Honourable Donald Plett or Yonah Martin

Other Senators who have participated in the study:

The Honourable Patricia Bovey (retired)
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Order of Reference

Extract from the *Journals of the Senate* of Thursday, April 28, 2022:

With leave of the Senate,

Resuming debate on the motion of the Honourable Senator Kutcher, seconded by the Honourable Senator Boehm:

That the Standing Senate Committee on Social Affairs, Science and Technology be authorized, when and if it is formed, to examine and report on the Federal Framework for Suicide Prevention, including, but not limited to:

(a) evaluating the effectiveness of the Framework in significantly, substantially and sustainably decreasing rates of suicide since it was enacted;

(b) examining the rates of suicide in Canada as a whole and in unique populations, such as Indigenous, racialized and youth communities;

(c) reporting on the amount of federal funding provided to all suicide prevention programs or initiatives for the period 2000–2020 and determining what evidence-based criteria for suicide prevention was used in each selection;

(d) determining for each of the programs or interventions funded in paragraph (c), whether there was a demonstrated significant, substantive and sustained decrease in suicide rates in the population(s) targeted; and

(e) providing recommendations to ensure that Canada's Federal Framework for Suicide Prevention and federal funding for suicide prevention activities are based on best available evidence of impact on suicide rate reduction; and

That the committee submit its final report on this study to the Senate no later than December 16, 2022.

After debate,

The question being put on the motion, it was adopted, on division.

Extract from the *Journals of the Senate* of Tuesday, December 6, 2022:

> The Honourable Senator Omidvar moved, seconded by the Honourable Senator Saint-Germain:
>
> > That, notwithstanding the order of the Senate adopted on Thursday, April 28, 2022, the date for the final report of the Standing Senate Committee on Social Affairs, Science and Technology in relation to its study on the Federal Framework for Suicide Prevention be extended from December 16, 2022, to June 30, 2023.
>
> After debate,
>
> The question being put on the motion, it was adopted.

Interim Clerk of the Senate

Gérald Lafrenière

Executive Summary

Ten years have passed since the idea of a federal framework for suicide prevention was realized through the adoption of the Federal Framework for Suicide Prevention Act. This Act required the Government of Canada to develop such a framework—an obligation that was fulfilled in 2016 with the release of the Federal Framework for Suicide Prevention (the Framework). The Framework's stated mission is to "prevent suicide in Canada" however, there has been no significant change to the suicide rate in Canada since the Framework has been in place. In fact, for the Canadian population as a whole, the suicide rate has remained largely stable over the past 20 years. This seemingly stable rate obscures the overrepresentation of some populations—Indigenous peoples, and more specifically Inuit; and boys and men.

It is evident that the success of the Framework remains limited. The Standing Senate Committee on Social Affairs, Science and Technology (the committee), therefore, undertook a study to evaluate the effectiveness of the Federal Framework for Suicide Prevention, hearing from the Minister of Mental Health and Addictions, medical experts and clinicians, advocates and persons with lived and living experience with suicide. The Minister of Mental Health and Addictions informed the committee that work is being done to update the Framework and therefore, a major theme throughout the study was identifying how an updated Framework could be strengthened.

While this study aimed to evaluate the Framework, the committee acknowledges that in many ways, the Framework is intertwined with the broader topic of suicide prevention in Canada, and thanks witnesses who shared information on that topic as well. Given that the committee has not yet had the opportunity to study such an important subject at the level of detail it requires, this report is divided into two parts. The first part evaluates the Federal Framework for Suicide Prevention and provides recommendations for its improvement. The second part provides a summary of the testimony shared with the committee about suicide prevention more generally.

List of Recommendations

Recommendation 1

That the Government of Canada commit to updating the Federal Framework for Suicide Prevention to produce an approach that effectively works at preventing suicide in Canada, and prioritize:

– identifying and promoting evidence-based public health and clinical interventions that are known to have a meaningful impact on suicide in Canada (measured through decreased suicide rates and/or decreased hospital visits due to suicide attempts), such as means restriction;

– moving away from supporting interventions and programs that are not evidence-based;

– replacing concepts of "hope and resilience" in the Framework with "meaning and connectedness;" and

– providing programming based on data that measures the impact of suicide prevention interventions, specifically: suicide rate, number of emergency room visits associated with a suicide attempt and number of hospitalizations associated with a suicide attempt.

Recommendation 2

That the Government of Canada establish specific priorities in the updated Framework, namely:

– identifying local public health and clinical health interventions that are demonstrated to be effective, and scaling them nationwide;

– targeting populations that are currently overrepresented in Canada's suicide rates: First Nations, Métis and Inuit; boys and men; racialized communities; and persons with mental illnesses; and

– funding research into promising initiatives for suicide prevention.

Recommendation 3

That the Government of Canada establish an independent critical review of revenue-generating suicide prevention and intervention programs operating in Canada; and that the results of this review be appended to the Framework.

Recommendation 4

That the updated Framework require that comprehensive Gender-based Analysis Plus training be added to the existing body of clinical and professional suicide prevention and treatment training, resources and development instruction provided to healthcare providers, so as to ensure that public health and clinical intervention treatments respond to the particular cultural, historical, socio-economic contexts and related contributing gendered factors that are distinct, given the diversity of individuals and groups in need of care.

Recommendation 5

That the Government of Canada collaborate with provinces, territories and civil society organizations to improve national suicide and suicide prevention data collection and analysis by:

– creating a national database on a) suicide, including indicators such as suicide rate, number of emergency room visits associated with a suicide attempt and number of hospitalizations associated with a suicide attempt; b) effective suicide prevention programs and research; and c) contributing and causal factors for suicide identified through GBA Plus;

– standardizing coroners’ reports;

– collecting sufficient demographic and geographic data for disaggregated analysis; and

– collaborating with provincial and territorial authorities on making suicide and suicide attempts incidents reportable to a specific authority.

Recommendation 6

That the Public Health Agency of Canada improve its reports on progress related to the Framework by establishing meaningful measurable outcomes and by evaluating suicide prevention programming against these benchmarks.

Recommendation 7

That the updated Framework explicitly acknowledge the additional challenges faced by certain populations in Canada—rural, remote and Northern communities; English- and French-second-language speakers; refugees and immigrants; persons with disabilities; racialized communities—in accessing mental healthcare, and provide resources and programming to mitigate these challenges; and, that the updated Framework acknowledge the high level of stigma attached to suicide, and respond by supporting mental healthcare access in all communities.

Recommendation 8

That the Government of Canada return to the Standing Senate Committee on Social Affairs, Science and Technology to share the updated Federal Framework for Suicide Prevention.

Recommendation 9

That the updated Framework acknowledge the crisis of Indigenous overrepresentation in Canada’s suicide rate, and:

– recognize the expertise and knowledge of community members by engaging directly with Indigenous experts with lived and living experience in suicide prevention;

– integrate life promotion into suicide prevention models;

– provide flexible financial support for programming that can be devised and managed by community members autonomously;

– create programming designed to train Indigenous community members in mental healthcare and intervention; and

– ensure a trauma-informed, culturally-appropriate approach when providing care to Indigenous peoples.

Recommendation 10

That the updated Framework acknowledge the overrepresentation of boys and men in Canada's suicide rate, and:

– recognize that men and women may require different forms of therapeutic interventions;

– target research towards treatment innovations for boys and men; and

– recognize the additional stigma that boys and men may face in discussing mental health and suicide and seeking mental healthcare.

Recommendation 11

That the updated Framework recognize the impact of substance use and addiction on suicide prevention in Canada, and that funding and programming associated with suicide prevention include research and interventions into substance abuse and addiction.

Part 1: Evaluating the Federal Framework for Suicide Prevention

Introduction

The Federal Framework for Suicide Prevention was published in 2016, following a period of consultation with various stakeholders, including the public. The Framework is intended to provide direction in federal activities related to suicide prevention, while complementing provincial, territorial and non-governmental suicide prevention efforts.

Other than the Framework's stated mission to prevent suicide in Canada, there are no outcome measurements included within the document. Therefore, the most obvious way to evaluate the success of the Framework in preventing suicides is to look to Canada's suicide rate. With the exception of a slight decrease in 2020 (which witnesses attributed to pandemic-related social supports), the suicide rate in Canada has been either 11/100,000 or 12/100,000 in every year since 2000. The Federal Framework for Suicide Prevention has not had a noticeable impact on the suicide rate in Canada.

The committee began its study by hearing from the Honourable Carolyn Bennett, Minister for Mental Health and Addictions, who not only acknowledged the existing weaknesses of the Framework, but also committed to publishing an updated Framework in fall 2023. This ministerial commitment guided the discussion at committee, seeking to understand how best to strengthen the Framework and resulting in 11 recommendations. The committee heard from 23 witnesses and received five written submissions, as well as written follow-ups from witnesses.

The committee's mandate, through the order of reference granted on April 28, 2022, was to evaluate the Federal Framework for Suicide Prevention. This mandate included seeking detailed information on the Government of Canada's funding for suicide prevention programs and initiatives, as well as the desired outcomes and success at achieving them. The committee requested this information from various witnesses, but had only received basic funding and outcome information for select programming by the time of this report's publication. The committee hopes that the updated Framework will allow for more readily available public information on funding, outcomes and progress.

Developing the Federal Framework for Suicide Prevention

On December 14, 2012, the *Federal Framework for Suicide Prevention Act* (the Act) received Royal Assent, establishing a "requirement for the Government of Canada to develop a federal framework for suicide prevention in consultation with relevant non-governmental organizations, the relevant entity in each province and territory, as well as with relevant federal departments."[1] As required by the Act, the Public Health Agency of Canada (PHAC) then began gathering information to inform the future framework through consultations and meetings with government departments, non-

[1] *Federal Framework for Suicide Prevention Act*, S.C. 2012, c. 30, Summary.

governmental organizations, national Indigenous organizations, officials from provinces and territories, community stakeholders and the public.

On November 24, 2016, the result of the consultations was published: the Federal Framework for Suicide Prevention. "The Framework sets out the Government of Canada's strategic objectives, guiding principles and commitments in suicide prevention."[2] The Framework's stated vision is "a Canada where suicide is prevented and everyone lives with hope and resilience" and its mission is to "prevent suicide in Canada, through partnership, collaboration and innovation while respecting the diversity of cultures and communities that are touched by this issue."[3]

The Act identified six priority areas that the Government of Canada would assume responsibility for as part of the future framework:[4]

1. providing guidelines to improve public awareness and knowledge about suicide;
2. disseminating information about suicide, including information concerning its prevention;
3. making publically available existing statistics about suicide and related risk factors;
4. promoting collaboration and knowledge exchange across domains, sectors, regions and jurisdictions;
5. defining best practices for the prevention of suicide; and
6. promoting the use of research and evidence-based practices for the prevention of suicide.

These six legislated elements were incorporated into the Framework under the following three strategic objectives:[5]

1. reduce stigma and raise public awareness;
2. connect Canadians, information and resources; and
3. accelerate the use of research and innovation in suicide prevention.

The Framework also included five principles aimed to "guide the approach and actions undertaken to achieve the strategic objectives identified" in the Framework:[6]

1. build hope and resilience;
2. complement current initiatives in suicide prevention;

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[2] "Introduction" in Public Health Agency of Canada, *Working Together to Prevent Suicide in Canada: the Federal Framework for Suicide Prevention*, 24 November 2016.
[3] "Framework Overview" in Public Health Agency of Canada, *Working Together to Prevent Suicide in Canada: the Federal Framework for Suicide Prevention*, 24 November 2016.
[4] *Federal Framework for Suicide Prevention Act*, S.C. 2012, c. 30, ss. 2(b).
[5] "Framework Overview" in Public Health Agency of Canada, *Working Together to Prevent Suicide in Canada: the Federal Framework for Suicide Prevention*, 24 November 2016.
[6] "Framework Overview" in Public Health Agency of Canada, *Working Together to Prevent Suicide in Canada: the Federal Framework for Suicide Prevention*, 24 November 2016.

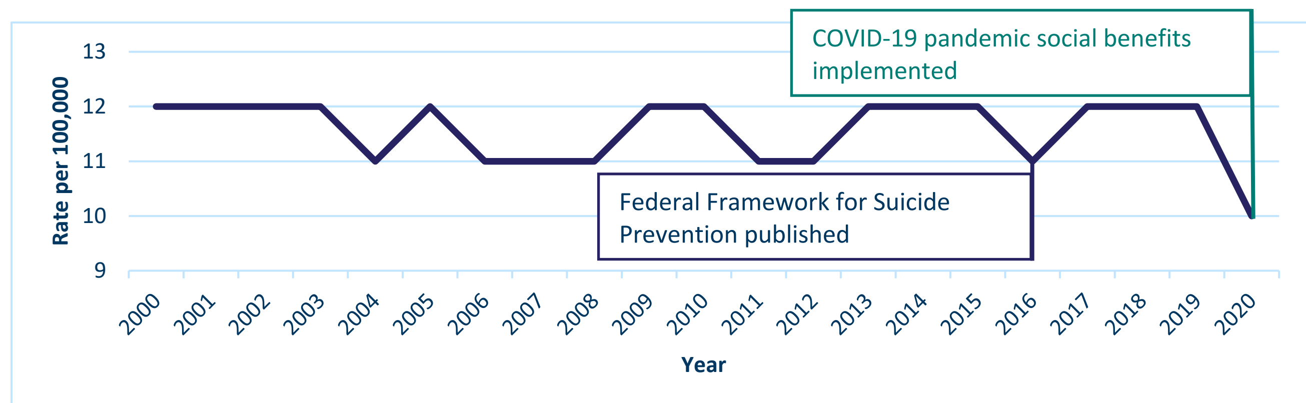
3. be informed by current research and best available evidence;
4. apply a public health approach; and
5. leverage partnerships.

Despite a purpose, a vision, a mission, three strategic objectives, six legislated priority areas and five guiding principles, the Federal Framework for Suicide Prevention has not been demonstrably successful in preventing suicide in Canada.

Trends in Suicide Rates and Data in Canada

As shown in Figure 1, suicide rates[7] in Canada have remained largely steady since 2000, hovering around 11/100,000.[8]

Figure 1: Suicide Rate in Canada per 100,000 (2000–2020)



Source: Statistics Canada, "Table 71-607-X: Visualizing mortality in Canada: Rates and counts by age group for select causes of death," Database, accessed 13 December 2022.

Dr. Tyler Black, Clinical Assistant Professor of Psychiatry at the University of British Columbia, provided nuance to this apparent "stable" rate. He shared that from 2000 to 2012, "there was a small but significant declining trend" in the suicide rate, which halted in 2012 and began trending upwards, with outliers in 2016 and 2020.[9] In 2020, the suicide rate fell to 10/100,000, which witnesses attributed to both the emphasis on supporting Canadians financially and mentally, as well as the need for increased unity during the COVID-19 pandemic. Nitika (Rewari) Chunilall, Director of Prevention and Promotion Initiatives for the Mental Health Commission of Canada, agreed, noting that the "communal trauma related to the COVID-19 pandemic may have caused a

[7] Mortality rates in Canada, including the suicide rate are most often expressed as an age-specific rate per 100,000 Canadians, which represents the number of deaths per 100,00 population in the same age group as of July 1 of the same year.
[8] Statistics Canada, "Table 71-607-X: Visualizing mortality in Canada: Rates and counts by age group for select causes of death," Database, accessed 13 December 2022.
[9] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 5 October 2022 (Dr. Tyler Black, Clinical Assistant Professor, Department of Psychiatry, University of British Columbia, as an individual).

decrease in suicide rates in 2020, possibly reflecting the effects of social cohesion and shared suffering."[10]

However, while the suicide rate may have decreased slightly, Minister Bennett noted that from 2020 to 2022, many Canadians reported an increase in anxiety, depression and loneliness, and that suicidal ideation was found to be "significantly higher" in 2021 than in 2019.[11] Statistics Canada reported that among adults, the prevalence of suicidal ideation since the beginning of the pandemic was reported to be 4.2%, while before the pandemic began in 2019, it was 2.7%.[12] Given that detailed information for 2021 and 2022 are not yet available, it is difficult to ascertain whether the increase in suicidal ideation will result in a higher suicide rate.

Both witness testimony and data reveal that the COVID-19 pandemic and related social supports have had more of an impact on the suicide rate in Canada than the Federal Framework for Suicide Prevention.

> "I would say that the evaluation of the federal framework is rather poor. If it were not for the COVID-19 pandemic and likely economic supports, and the pull-together effect and other things, I don't think we would have seen a 17% decrease in suicides in 2020. The rates were increasing since the Framework's been passed."
>
> Dr. Tyler Black, Clinical Assistant Professor of Psychiatry, University of British Columbia

Strengths of the Current Federal Framework for Suicide Prevention

Despite the strong criticisms shared about the current Framework, witnesses also highlighted specific strengths that they hoped would be retained in the updated Framework. Several experts spoke to the importance the Framework places on both public health and clinical interventions, with E. David Klonsky, Professor of Psychology at the University of British Columbia, noting that "one strong point is that it decouples suicide from mental illness and includes a public health approach."[13] Mara Grunau, the Executive Director of the Centre for Suicide Prevention, agreed that suicide prevention requires "both a mental health approach focused on individuals and a public health approach focused on populations."[14]

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[10] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 20 October 2022 (Nitika (Rewari) Chunilall, Director, Prevention and Promotion Initiatives, Mental Health Commission of Canada).
[11] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 29 September 2022 (The Honourable Carolyn Bennett, P.C., M.P., Minister of Mental Health and Addictions).
[12] Statistics Canada, "Prevalence of suicidal ideation among adults in Canada: Results of the second Survey on COVID-19 and mental health," Health Reports, 18 May 2022.
[13] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 5 October 2022 (E. David Klonsky, Professor, Department of Psychology, University of British Columbia, as an individual).
[14] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 5 October 2022 (Mara Grunau, Executive Director, Centre for Suicide Prevention).

Witnesses also appreciated the Framework's support of knowledge exchange between researchers and practitioners. Dr. Sidney Kennedy, Professor of Psychiatry at the University of Toronto, observed that a strength was "connecting Canadians and providing information and resources and accelerating research."[15] Dr. Allison Crawford, Associate Chief of Virtual Mental Health and Outreach at the Centre for Addiction and Mental Health, agreed, adding that the Framework "has brought diverse partners together to take stock of suicide prevention in Canada."[16]

Challenges of the Federal Framework for Suicide Prevention

With the exception of a few specific strengths, the majority of testimony heard by the committee focused on existing challenges of the Framework and areas in which it could be strengthened.

> "The Federal Framework for Suicide Prevention cannot be aspirational or ephemeral, it has to be involved up with tangible and reportable outcomes like fewer deaths, hospitalizations, or fewer attempts. For people who experience suicidality and for families who survive suicides, we do not need documents containing platitudes or kind words, but government action that creates tangible and measurable benefits."
>
> Dr. Tyler Black, Clinical Assistant Professor of Psychiatry, University of British Columbia

The committee heard that the current Framework does not promote interventions and programs that have provided evidence for reducing the suicide rate, and that it is difficult to even assess whether programs and interventions are having an impact because data is inconsistent and unavailable. Witnesses also shared that in general, the Framework is abstract rather than concrete, dealing in emotion rather than fact.

> "The Framework's vision centres hope and resilience, which is great, but I might suggest including meaning and connectedness. I think it would be equally well received, but more grounded in the evidence."
>
> E. David Klonsky, Professor of Psychology, University of British Columbia

[15] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 6 October 2022 (Dr. Sidney Kennedy, Professor, Department of Psychiatry, University of Toronto, as an individual).
[16] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 5 October 2022 (Dr. Allison Crawford, Associate Chief of Virtual Mental Health and Outreach, and co-chair of ECHO Ontario and ECHO Ontario Mental Health, Centre for Addiction and Mental Health).

Evidence-Based Interventions

At its most basic, an evidence-based intervention is a treatment, program, policy, or practice that has been proven effective through measured outcomes and evaluations. Many witnesses expressed that the current Framework does not prioritize evidence-based interventions for suicide prevention, which not only creates potential for wasted federal spending, but, as has been shown, does not prevent suicide. Dr. Joanna Henderson, Director of the Margaret and Wallace McCain Centre for Child, Youth and Family Mental Health, stated that "the Framework needs to be strengthened by increasing its emphasis on clinical intervention, evidence-based practices and outcome data."[17]

Witnesses once again emphasized the value of public health and clinical interventions within the Framework, sharing that both provide different levels of treatments, with the public health approach at a broader level and the clinical approach at an individual level. Tyler Black stated that "the importance of the clinical aspect comes from our knowledge that people who do have mental illness or other forms of health suffering can interact with professionals, and those professionals, given knowledge and training and support, can actually be part of suicide prevention."[18]

However, when it comes to determining which evidence-based practices to include in an updated Framework, existing options are limited, especially when it comes to clinical interventions. E. David Klonsky cautioned that most existing clinical interventions are "better than nothing but not a whole lot better than nothing."[19] He did acknowledge, though, that we also "need an emphasis on developing new [interventions] using the latest knowledge that hasn't yet been incorporated into existing treatments."[20]

> "Best practices are important, but they may not be the most evidence-based treatments. I think there is a risk of endorsing treatments based on their accessibility rather than necessarily proven efficacy and, indeed, safety."
>
> Dr. Sidney Kennedy, Professor of Psychiatry, University of Toronto

The committee heard that only one public health intervention thus far has been identified as having an evidence-based impact on suicide: means restriction. Witnesses also shared that there is

[17] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 5 October 2022 (Dr. Joanna Henderson, Director, Margaret and Wallace McCain Centre for Child, Youth and Family Mental Health; Senior Scientist, Child, Youth and Emerging Adult Program, Centre for Addiction and Mental Health).
[18] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 5 October 2022 (Dr. Tyler Black, Clinical Assistant Professor, Department of Psychiatry, University of British Columbia, as an individual).
[19] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 5 October 2022 (E. David Klonsky, Professor, Department of Psychology, University of British Columbia, as an individual).
[20] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 5 October 2022 (E. David Klonsky, Professor, Department of Psychology, University of British Columbia, as an individual).

evidence demonstrating the value of primary care physician training in identifying, diagnosing and treating depression.

Means Restriction

Means are the ways by which someone might attempt suicide. Means restriction aims to make the most common and lethal methods of suicide more difficult to access. Many suicide attempts take place during a short-term crisis so making lethal means of suicide more difficult and/or slower to access offers a real opportunity at prevention.

> "A PERSON WHO SURVIVES A SUICIDE ATTEMPT ONLY HAS A 20% CHANCE OF DYING BY SUICIDE FOR THE REST OF THEIR LIVES; SO IT IS REALLY IMPORTANT TO TRY AND MAKE IT AS DIFFICULT AS POSSIBLE FOR PEOPLE TO GET ACCESS TO THE MOST LETHAL METHODS."
>
> DR. J. JOHN MANN, DIRECTOR OF THE CONTE CENTER FOR SUICIDE PREVENTION, COLUMBIA UNIVERSITY

E. David Klonsky shared that means restriction "is the only truly evidence-based intervention at the population level" and urged for it to be "featured" in an updated Framework.[21] Nitika (Rewari) Chunilall agreed that "one of the most effective ways to prevent suicide is through means safety and means restriction."[22] Dr. J. John Mann, Director of the Conte Center for Suicide Prevention at Columbia University shared his perspective as an American:[23]

> As you know, south of the border in the U.S., we have a terrible problem because the country is awash with firearms, so people are killing themselves. Half of the suicides in the United States are as a result of self-inflicted firearm wounds. The problem with firearms is that the fatality rate per attempt is extremely high, and it's very hard to rescue people. If you can stop people having access to the most lethal methods, then they're forced to use less lethal methods or they are just discouraged from making any attempt.

Tyler Black shared that suicide by firearm is not an issue isolated to the American context. He stated that while hanging/suffocation is the most common means of suicide in Canada overall, in rural and remote areas, suicide by firearm is more common.[24] In a follow-up, the Centre for Suicide Prevention suggested recommendations to further restrict access to firearms as a means of suicide,

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[21] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 5 October 2022 (E. David Klonsky, Professor, Department of Psychology, University of British Columbia, as an individual).
[22] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 20 October 2022 (Nitika (Rewari) Chunilall, Director, Prevention and Promotion Initiatives, Mental Health Commission of Canada).
[23] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 6 October 2022 (Dr. J. John Mann, Director, Conte Center for Suicide Prevention, Columbia University, as an individual).
[24] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 5 October 2022 (Dr. Tyler Black, Clinical Assistant Professor, Department of Psychiatry, University of British Columbia, as an individual).

including continuing to limit gun ownership and strengthening border surveillance on firearms trafficking.[25]

The Centre for Suicide Prevention shared other opportunities for means restriction including in the areas of transportation (railways and subways), infrastructure and pharmaceuticals, noting that there are not currently any efforts being undertaken to prevent suicide by these means.[26]

> "Even if people are at a point of suicidal desire because of pain and hopelessness, and perhaps lower connectedness, they need the capability to attempt suicide, which involves some version of the courage to do something scary and the practical means to do it."
>
> E. David Klonsky, Professor of Psychology, University of British Columbia

Primary Care Physician Training

The committee heard about the role of primary care physicians in identifying and addressing persons at risk of suicide. Witnesses shared that this form of training has been shown to prevent suicide and, therefore, presents a valuable avenue for further study as an evidence-based intervention.

John Mann presented the conclusion of a paper he and other colleagues wrote for the *American Journal of Psychiatry*, stating that "the single most effective measure [of suicide prevention] shown in studies is to train primary care physicians to better recognize and diagnose major depression and then treat it more effectively."[27] He added that most people who die by suicide in the United States interact at double the rate with primary care physicians, internists and obstetrics and gynecological physicians than psychiatrists or mental health professionals, concluding that training programs could be extended to include physicians in internal medicine, emergency rooms, OB/GYNs, etc. to "possibly get a multiplicative effect on this."[28]

However, Sidney Kennedy clarified that primary care physicians don't necessarily need to be screening the whole population: "I think we haven't identified in our mental health services who needs intense treatment, where the specialists don't do […] primary interventions. They do tertiary interventions."[29] John Mann also cautioned that "it is clear from these kinds of medical education interventions that you have to have an ongoing education program with refresher courses;

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[25] Centre for Suicide Prevention, *Suicide Prevention Initiatives in Canada*, Brief submitted to the Standing Senate Committee on Social Affairs, Science and Technology, 28 October 2022.
[26] Centre for Suicide Prevention, *Suicide Prevention Initiatives in Canada*, Brief submitted to the Standing Senate Committee on Social Affairs, Science and Technology, 28 October 2022.
[27] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 6 October 2022 (Dr. J. John Mann, Director, Conte Center for Suicide Prevention, Columbia University, as an individual).
[28] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 6 October 2022 (Dr. J. John Mann, Director, Conte Center for Suicide Prevention, Columbia University, as an individual).
[29] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 6 October 2022 (Dr. Sidney Kennedy, Professor, Department of Psychiatry, University of Toronto, as an individual).

otherwise, after two years, everything that has been taught fades away."[30] Minister Bennett noted that the College of Family Physicians is currently planning to extend the two-year residency to three years to accommodate additional training in mental health, addictions and pain.[31] Heather Jeffrey, Associate Deputy Minister at Health Canada, added that this extension is "precisely to ensure that new doctors feel confident and well versed in the mental health and addiction space" in order to limit referrals to specialists "who are in short supply and may not be required by all."[32]

> "If you can train the nation's primary care physicians to do a better job of recognizing and treating depression, you're going to save a lot of lives."
>
> Dr. J. John Mann, Director of the Conte Center for Suicide Prevention, Columbia University

Data Gathering, Research and Measuring Outcomes

While data collection, research priorities and outcome evaluation were all identified independently as areas for improvement in an updated Framework, they are also interdependent. Research priorities inform data collection, available data informs research opportunities and outcome evaluation relies on accurate data.

> "There is a history in suicidology of well-meaning people with credentials having ideas, creating group treatments, and doing things at a community level that turn out not to be helpful or even sometimes to be harmful in terms of increasing people's suicide risk."
>
> E. David Klonsky, Professor of Psychology, University of British Columbia

Data Collection and Dissemination

Data collection and dissemination can be considered the foundation on which research and outcomes are built. Witnesses identified gaps and barriers to both adequate data collection and dissemination regarding suicide and suicide attempts.

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[30] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 6 October 2022 (Dr. J. John Mann, Director, Conte Center for Suicide Prevention, Columbia University, as an individual).
[31] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 29 September 2022 (The Honourable Carolyn Bennett, P.C., M.P., Minister of Mental Health and Addictions).
[32] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 29 September 2022 (Heather Jeffrey, Associate Deputy Minister, Health Canada).

> "Investing in timely access to informative data on suicide and suicidal behaviour will be a game changer for communities across Canada. Data plays a crucial role in identifying who is at risk, why, under what circumstances, how often, means used and where the opportunities for interventions and preventions lie. This must be a top priority, as lack of timely data connected across systems often means missed opportunities and lives lost."
>
> Nitika (Rewari) Chunilall, Director of Prevention and Promotion Initiatives, Mental Health Commission of Canada

One existing challenge with suicide data is that the rate, both in Canada, and elsewhere, is likely to be underreported. In a brief submitted to the committee, the Centre for Suicide Prevention stated that the annual suicide rate in Canada is likely 10–30% higher than what is reported.[33] Underreporting is a byproduct of stigma and a lack of standardization on how information relating to suicide is recorded and reported.

Given the stigma and guilt that can accompany determining suicide as cause of death can bring, Heather Jeffrey pointed to coroners and care providers trying to spare loved ones' pain as one of the key contributing factors to underreporting.[34] Stephanie Priest, Director General of the Centre for Mental Health and Well-being at PHAC, noted that the PHAC surveillance team is currently "working at strengthening relationships with coroners and chief medical examiners to address the matter of misrepresenting certain deaths, how they are categorized and how they are coded."[35] The phenomenon of underreporting may also be exacerbated among some populations. Wendy Stewart, Director of the Community Wellbeing Branch for the Métis Nation of Ontario, noted that "what health data is available suggests that most available statistics underestimate the health disparities and outcomes for Métis."[36]

In terms of what data to collect, witnesses argued for more standardization across jurisdictions, in addition to a maximalist approach to suicide-related data. E. David Klonsky recommended that Canada track nonfatal suicide attempts and suicidal ideation, noting that "most suicidal attempts do not end in deaths."[37] E. David Klonsky also cautioned against conflating suicide, suicide attempts and suicidal ideation with non-suicidal self-injury, as the latter is far more common and often the

[33] Centre for Suicide Prevention, *Suicide data gaps in Canada*, Brief submitted to the Standing Senate Committee on Social Affairs, Science and Technology, 28 October 2022.
[34] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 29 September 2022 (Heather Jeffrey, Associate Deputy Minister, Health Canada).
[35] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 29 September 2022 (Stephanie Priest, Director General, Centre for Mental Health and Well-being, Health Promotion and Chronic Disease Prevention Branch, Public Health Agency of Canada).
[36] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 19 October 2022 (Wendy Stewart, Director, Community Wellbeing Branch, Métis Nation of Ontario, Métis National Council).
[37] E. David Klonsky, *Follow-Up Information*, Brief submitted to the Standing Senate Committee on Social Affairs, Science and Technology, 27 October 2022.

result of different factors than suicide and suicide attempts.[38] Rhonda Kropp, Associate Vice-President of Research-Strategy at the Canadian Institutes of Health Research, noted the importance of defining data types needed to answer different questions, including surveillance data, research data and methodologies.[39]

Witnesses also emphasized the need for more timely and interconnected data built into the care system. Tyler Black spoke to the importance of timely data, noting that "it requires federal support, likely, to create real-time or near-real-time monitoring," adding that the timeliness, and its ability to be shared nationally are key to making the data useful.[40] Joanna Henderson recommended the establishment and funding of an integrated data platform that would facilitate data collection and dissemination from and among hospitals, community mental health services, substance use programs, and ultimately, to research professionals as well.[41] Rhonda Kropp emphasized the importance of continual evaluation: "I think there is an opportunity for us to think about building evidence and building evaluation into care itself so that it is both evidence producing, evidence generating and also evidence using in a quicker manner than we currently do."[42]

> "We need standardization of the data that is available to surveil suicide on a national level. It needs to be more timely so that we can see trends as they develop. It has to be standardized across provinces—what they collect when someone dies by suicide. We don't know what we're measuring right now, so it is very hard to evaluate things effectively."
>
> Dr. Allison Crawford, Associate Chief of Virtual Mental Health and Outreach, Co-Chair of ECHO Ontario and ECHO Ontario Mental Health, Centre for Addiction and Mental Health

In response to concerns about gaps in data, Joanna Henderson stressed that we should not ignore the data that is currently available, stating that "we need to leverage what we already have in place, where we have existing common data platforms and minimum data sets [and] we can't wait until we have better measures because then it will take us a long time to get where we need to go."[43] Allison Crawford also cautioned against only relying on quantitative data stating that "it is

[38] E. David Klonsky, *Follow-Up Information*, Brief submitted to the Standing Senate Committee on Social Affairs, Science and Technology, 27 October 2022.
[39] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 29 September 2022 (Rhonda Kropp, Associate Vice-President, Research – Strategy, Canadian Institutes of Health Research).
[40] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 5 October 2022 (Dr. Tyler Black, Clinical Assistant Professor, Department of Psychiatry, University of British Columbia, as an individual).
[41] Dr. Joanna Henderson, *Follow-up information provided to the Standing Senate Committee on Social Affairs, Science and Technology for consideration regarding the Suicide Prevention Framework*, Brief submitted to the Standing Senate Committee on Social Affairs, Science and Technology, 28 October 2022.
[42] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 29 September 2022 (Rhonda Kropp, Associate Vice-President, Research—Strategy, Canadian Institutes of Health Research).
[43] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 5 October 2022 (Dr. Joanna Henderson, Director, Margaret and Wallace McCain Centre for Child, Youth and Family Mental Health; Senior Scientist, Child, Youth and Emerging Adult Program, Centre for Addiction and Mental Health).

important, but qualitative data that allows you to richly understand people's perspectives before you know what to measure at a population health level or just using numbers, that qualitative step, is also very important."[44]

Several witnesses spoke about the importance of disaggregated data, especially with regard to populations overrepresented in the suicide rate. Tyler Black questioned; "if we as a nation purport to care about suicide and the 2SLGBTQI+ populations, why do we have virtually no information on suicide deaths, attempts, or hospitalizations regarding them?"[45] Mara Grunau also commented on the importance of disaggregated data, stating that "some groups of people or priority populations experience suicide more than the general population" and there is not currently a systematic way to collect data that could be more useful.[46] Therefore, she suggested expanding and standardizing death certificates; collecting additional information like Indigeneity, ethnicity, occupation and gender identity.

Research Priorities and Agenda

Given the limited number of existing evidence-based interventions for suicide, research is crucial to the development and exploration of new interventions and approaches. An updated Framework with a strong focus on data collection would provide the foundation for clearly defined research priorities.

Witnesses observed that suicide prevention research in Canada is currently rudderless. Gustavo Turecki stated that "there has not been a clear policy in Canada to promote research on suicide. There is certainly research on suicide, but there's no action plan in that sense."[47] E. David Klonsky added that a current barrier to advancing research on suicide prevention is dissent among experts on how to best understand suicide and respond to it; and therefore suggested that the Government of Canada will likely need to prioritize specific research streams, and perhaps, even specific researchers.[48]

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[44] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 5 October 2022 (Dr. Allison Crawford, Associate Chief of Virtual Mental Health and Outreach, and co-chair of ECHO Ontario and ECHO Ontario Mental Health, Centre for Addiction and Mental Health).
[45] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 5 October 2022 (Dr. Tyler Black, Clinical Assistant Professor, Department of Psychiatry, University of British Columbia, as an individual).
[46] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 5 October 2022 (Mara Grunau, Executive Director, Centre for Suicide Prevention).
[47] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 6 October 2022 (Dr. Gustavo Turecki, Professor and Chair, Department of Psychiatry, McGill University).
[48] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 5 October 2022 (E. David Klonsky, Professor, Department of Psychology, University of British Columbia, as an individual).

> "It is essential to invest in research. We need to invest heavily in the development of new knowledge to better identify, in a more precise manner, individuals at risk and then determine how to better respond."
>
> Dr. Gustavo Turecki, Professor and Chair of Psychiatry, McGill University

Witnesses made comments on the importance of using culturally-relevant approaches to data collection and research. Stephanie Priest acknowledged existing research gaps in structural stigma, emphasizing the importance of "understanding more about some of those other broader system barriers and how they impact different groups in help-seeking in particular, but also on how that affects suicide prevention and accessing services."[49]

Joanna Henderson commented on the fact that modern data collection and research have been established in a colonial system, stating that:[50]

> One of our precautions about looking only to our existing evidence is it does reflect a colonizing approach to knowledge. Part of the solution going forward will really be to work in collaboration with the community and have community leadership based in culture. That allows us to expand our definition of knowledge and evidence, and that will bring us to new kinds of approaches that will translate into outcomes. We need to focus our attention on how to support new evidence generation and innovation in this space so that we can actually achieve better outcomes and also broaden our approach to research so that the kind of evidence we generate is more inclusive and takes into consideration cultural and identity and intersectionality more robustly than we have in the past.

Wendy Stewart agreed, stating that "it is essential for Métis communities to have access to appropriate health data to fully understand and inform any initiatives moving forward" and that this involves "meaningful inclusivity of Métis health data to apply the best available evidence, knowledge and practices."[51] Jocelyn Formsma, Executive Director of the National Association of Friendship Centres (NAFC), added that "it is known that a lot of Indigenous organizations, communities and governments are missing the capacity to do their own data collection and

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[49] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 29 September 2022 (Stephanie Priest, Director General, Centre for Mental Health and Well-being, Health Promotion and Chronic Disease Prevention Branch, Public Health Agency of Canada).
[50] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 5 October 2022 (Dr. Joanna Henderson, Director, Margaret and Wallace McCain Centre for Child, Youth and Family Mental Health; Senior Scientist, Child, Youth and Emerging Adult Program, Centre for Addiction and Mental Health).
[51] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 19 October 2022 (Wendy Stewart, Director, Community Wellbeing Branch, Métis Nation of Ontario, Métis National Council).

analysis."[52] She also noted that in cases where there is data, the capacity to analyze and disseminate it is missing.[53]

> "Although we see numbers now, it is the first time we have seen them. The data was presented without consultation. In some of the co-analysis that is happening right now, Métis are often an afterthought. All we're asking for is to have that meaningful engagement—you know, dialogue about data up front. We're also asking for meaningful consultation in terms of asking the communities what something might mean instead of having it interpreted and presented to us afterwards."
>
> Wendy Stewart, Director of the Community Wellbeing Branch, Métis Nation of Ontario

Measuring Outcomes and Evaluating Progress

The ability to evaluate the result of an initiative requires the comparison of data to measurable outcomes. In addition to the stated challenges with data related to suicide prevention in Canada, the Framework does not include measurable outcomes. Therefore, it is difficult to evaluate the success of the Framework beyond its failure to have a significant impact on the suicide rate.

> "It's really hard to do complete analysis of the issue when there's insufficient data and information about the actual incidence and some of the preventive measures that may have been employed."
>
> Kimberly Fairman, Executive Director, Institute for Circumpolar Health Research

The committee heard that the updated Framework must include an evaluatory component, in addition to measurable outcomes. Mara Grunau suggested that "we need to develop a companion evaluation framework so that we can assess the work as it is implemented. We need to be measuring what works, where and why so that we can support as many people as possible."[54] Gustavo Turecki recommended that "there have to be specific measures as to what it is that the Framework needs to achieve and in what particular time frame."[55] Allison Crawford also commented on the timeliness cautioning that "frequent evaluation — [..] iterative evaluation or

[52] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 19 October 2022 (Jocelyn W. Formsma, Executive Director, National Association of Friendship Centres).
[53] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 19 October 2022 (Jocelyn W. Formsma, Executive Director, National Association of Friendship Centres).
[54] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 5 October 2022 (Mara Grunau, Executive Director, Centre for Suicide Prevention).
[55] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 6 October 2022 (Dr. Gustavo Turecki, Professor and Chair, Department of Psychiatry, McGill University).

quick evaluation—is very important. It can't wait until the end of something. We have to be able to see those gaps as they emerge."[56]

> "THE FRAMEWORK HAS NO BUILT-IN EVALUATION SECTION, AND THAT'S A GLARING WEAKNESS."
>
> THE HONOURABLE SENATOR PATRICK BRAZEAU

While the Framework itself does not have a built-in evaluation mechanism, part of the *Federal Framework for Suicide Prevention Act* mandates that PHAC "report to Canadians on its progress and activities related to" the Framework within four years of the coming into force of the Act, and every two years subsequently.[57] Three previous reports were tabled in 2016, 2018 and 2020. When officials from PHAC appeared before the committee in September 2022, they confirmed that the next progress report would be tabled in December 2022.[58]

On December 28, 2022, the Government of Canada released the executive summary of the *2022 Progress Report: The Federal Framework for Suicide Prevention* online, with the full report available online in February 2023.[59] The committee and public were able to obtain advance PDF copies of the full report. The report includes a section entitled "Snapshot of Suicide in Canada" with various data on suicide and suicide prevention in Canada. However, the majority of this data dates to 2019–2020, providing little update since the 2020 progress report.[60] These data also include the results of the 2020 Survey on COVID-19 and Mental Health (initially published in 2021, with updates in 2022). The report states that results from the next Survey on COVID-19 and Mental Health will be available in late 2023 or early 2024.[61]

The report also provided an update on programs and activities undertaken in various federal departments between November 2020—November 2022, categorized by the Framework's three strategic objectives: reduce stigma and raise public awareness; connect Canadians, information and resources; and accelerate the use of research and innovation in suicide prevention.

Regarding Indigenous populations, the progress report notes that the Framework "is not an Indigenous developed and led framework" and therefore, encourages, "readers to reach out to Indigenous organizations directly to learn more about [Indigenous-led strategies and frameworks]

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[56] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 5 October 2022 (Dr. Allison Crawford, Associate Chief of Virtual Mental Health and Outreach, and co-chair of ECHO Ontario and ECHO Ontario Mental Health, Centre for Addiction and Mental Health).
[57] *Federal Framework for Suicide Prevention Act*, S.C. 2012, c. 30, s. 4.
[58] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 29 September 2022 (Candice St-Aubin, Vice-President, Health Promotion and Chronic Disease Prevention Branch, Public Health Agency of Canada).
[59] Government of Canada, *2022 Progress Report: The Federal Framework for Suicide Prevention*, 2023.
[60] "Facts about suicide in Canada," in Government of Canada, *Working Together to Prevent Suicide in Canada: The Federal Framework for Suicide Prevention – 2020 Progress Report*, 2020.
[61] "Snapshot of suicide in Canada," in Government of Canada, *Working Together to Prevent Suicide in Canada, The Federal Framework for Suicide Prevention: 2022 Progress Report*, 2023.

and how they are improving the lives of Indigenous peoples across Canada."[62] Aside from stating that the Government of Canada will collaborate with Indigenous peoples on the future Action Plan, the report does not discuss the importance of targeting suicide prevention strategies to populations overrepresented in Canada's suicide rate.

The report concludes by recognizing the "need to evolve and incorporate new evidence from national and international research, policy and community practice" and announcing that the federal government will be shifting its focus from the Framework to the development of the National Suicide Prevention Action Plan, for which consultation is to begin in "the coming months."[63] The report also confirms that future progress reports will evaluate not only the Framework, but also the future Action Plan.

Evaluating Federal Suicide Prevention Programming

Given that outcome measurements are not currently part of the Framework, many suicide prevention programs and initiatives are funded by the Government of Canada with scant information on targeted outcomes and progress.

Going forward, witnesses emphasized the importance of incorporating outcomes and evaluation into federal funding for suicide prevention, in order to support programs that work and not waste resources on those that do not.

Allison Crawford stated that "looking at outcomes is essential to ensure a strong return on investment and to inform future strategic direction."[64] Joanna Henderson agreed, recommending that all federally funded suicide prevention programming "must be accompanied by evaluation using appropriate reliable and valid outcome measures."[65]

As part of its mandate for this study, the committee was interested in collecting available information on federally funded suicide prevention and life promotion programming. Follow-up information provided by PHAC stated various mental health funding initiatives from 2016 to 2020:[66]

- Between 2016 and 2020, PHAC spent nearly $10 million on suicide prevention initiatives. Over half of this amount ($5,970,264) was committed to in 2020 for the launch of Talk Suicide Canada.

[62] "Indigenous Suicide Prevention and Life Promotion," in Government of Canada, *Working Together to Prevent Suicide in Canada, The Federal Framework for Suicide Prevention: 2022 Progress Report*, 2023.
[63] "Going Forward," in Government of Canada, *Working Together to Prevent Suicide in Canada, The Federal Framework for Suicide Prevention: 2022 Progress Report*, 2023.
[64] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 5 October 2022 (Dr. Allison Crawford, Associate Chief of Virtual Mental Health and Outreach, and co-chair of ECHO Ontario and ECHO Ontario Mental Health, Centre for Addiction and Mental Health).
[65] Dr. Joanna Henderson, *Follow-up information provided to the Standing Senate Committee on Social Affairs, Science and Technology for consideration regarding the Suicide Prevention Framework*, Brief submitted to the Standing Senate Committee on Social Affairs, Science and Technology, 28 October 2022.
[66] Public Health Agency of Canada, *SOCI Follow-up*, Brief submitted to the Standing Senate Committee on Social Affairs, Science and Technology, 31 October 2022.

- The Canadian Institutes for Health Research invested over $17 million in "suicide prevention research through its investigator-led and priority-driven research initiatives."
- Indigenous Services Canada invested $1.8 billion into the Mental Wellness Program, part of which helps support the National Inuit Suicide Prevention Strategy.
- Correctional Services Canada (CSC) invested $481.5 million in mental health services that align with CSC's May 2019 Suicide Prevention and Intervention Strategy.
- The RCMP invested $7.75 million in its Employee Assistance Program, its support for operational stress injury program and the psychological health screening program.

Other than CSC, none of the funding initiatives had clear or demonstrable impacts related to the suicide rate. With regards to CSC, they stated that "suicide numbers within federal institutions are normally low" and that from 2021 to 2022, "there were eight suicide deaths in federal custody."[67]

Another federally funded suicide prevention initiative presented to the committee was the Mental Health Commission of Canada (MHCC)'s Roots of Hope. Nitika (Rewari) Chunilall shared that since 2018, MHCC has been working "with several communities across Canada to implement a made-in-Canada, community-led approach to suicide prevention and life promotion."[68] Roots of Hope is currently implemented in Saskatchewan, New Brunswick, Newfoundland and Labrador and Yukon.

In response to the committee's request for more detailed information regarding Roots of Hope's funding mechanisms, MHCC confirmed that since 2019, they have contributed $1.2 million dollars to Roots of Hope through Health Canada.[69] MHCC stated that funding for the Roots of Hope research demonstration project was allocated to various activities between 2019 and 2022: principal investigator and research fees; project planning and coordination; implementation supports and resources; promising practice exchange; collaborative problem solving; and coordination of implementation and research communities of practice.[70] MHCC did not provide financial contribution information specific to the various communities supported by Roots of Hope, as "that is within the jurisdiction of their funders."[71] Furthermore, MHCC did not provide information to the committee detailing the effectiveness of their suicide programs in preventing suicide. Overall, the committee is unable to determine if the funds provided to MHCC for suicide prevention have had any impact in reducing suicide rates in Canada.

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[67] Public Health Agency of Canada, *SOCI Follow-up*, Brief submitted to the Standing Senate Committee on Social Affairs, Science and Technology, 31 October 2022.
[68] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 20 October 2022 (Nitika (Rewari) Chunilall, Director, Prevention and Promotion Initiatives, Mental Health Commission of Canada).
[69] Mental Health Commission of Canada, *Roots of Hope Demonstration Project – Funding Question*, Brief submitted to the Standing Senate Committee on Social Affairs, Science and Technology, 20 January 2023.
[70] Mental Health Commission of Canada, *Roots of Hope Demonstration Project – Funding Question*, Brief submitted to the Standing Senate Committee on Social Affairs, Science and Technology, 20 January 2023.
[71] Mental Health Commission of Canada, *Roots of Hope Demonstration Project – Funding Question*, Brief submitted to the Standing Senate Committee on Social Affairs, Science and Technology, 20 January 2023.

Supporting Populations Overrepresented in Canada's Suicide Rate: Indigenous Peoples and Boys and Men

Canada's suicide rate presents an illusion of stability when examined at the national level. Once disaggregated, it becomes clear that certain groups are overrepresented, when compared to their population in Canada. To have a real impact on the suicide rate in Canada, more attention must be focused on these groups, specifically: Indigenous peoples and boys and men.

> "If we want to reduce the greatest number of suicides in Canada, we need to focus research, programs and evaluations on those populations that commit suicide most. All researchers agree that those people are Indigenous people and men. If suicides in those two groups alone were halved, the entire picture in Canada would change."
>
> The Honourable Senator Patrick Brazeau

In a brief submitted to the committee, Dr. Rob Whitley, Associate Professor of Psychiatry at McGill University, agreed, stating that "any effective suicide prevention strategy must have a focus on men, given that they account for over 75% of suicides" and must specifically focus on other overrepresented groups like Indigenous men, veterans and men with mental illness.[72]

Senator Brazeau asked the committee "to recognize men and boys as a gender and to mobilize resources aimed at steering them away from making that final fatal choice" and recommended "for the next decade that the federal government deals with and comes up with [suicide prevention] programs, especially for Indigenous peoples, there has to be strong language that we target" Indigenous peoples and boys and men.[73]

> "I would argue that the Federal Framework for Suicide Prevention has not shown its true effectiveness to date. Since its release, deaths by suicide have been consistent or increasing, disproportionately so, for certain populations, like men, First Nations, Inuit and Métis people, young people and the 2SLGBTQIA+ community."
>
> Nitika (Rewari) Chunilall, Director of Prevention and Promotion Initiatives, Mental Health Commission of Canada

[72] Dr. Rob Whitley, *Written evidence submitted by Dr Rob Whitley (McGill University) to the Senate Committee Studying the Federal Framework on Suicide Prevention*, Brief submitted to the Standing Senate Committee on Social Affairs, Science and Technology, 19 October 2022.
[73] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 20 October 2022 (The Honourable Senator Patrick Brazeau).

Indigenous Peoples

> "Until the overrepresentation of Indigenous peoples in suicide rates is better addressed, I will stand by my position that the government is not concerned about Indigenous suicide prevention."
>
> The Honourable Senator Patrick Brazeau

Indigenous peoples are not more vulnerable to or at-risk for suicide, nor are all Indigenous populations equally overrepresented in the suicide rate. Realities differ quite a bit from First Nations, to Métis, to Inuit and; from urban Indigenous peoples to those on reserves, or in rural areas. Different realities imply different ideas for care and intervention and the committee heard that, in this area, there is much work to be done.

> "For Indigenous people, suicide rates are horrific, we see a severe over-representation in the First Nations people and Inuit, with young Inuit men and women dying at rates of suicide 24 times that of the non-Indigenous population. I use the phrase 'overrepresentation' instead of saying 'increased risk' as the risk is not inherent to Indigenous people, but a reflection of the traumas inflicted by colonization and systemic discrimination."
>
> Dr. Tyler Black, Clinical Assistant Professor of Psychiatry, University of British Columbia

Life Promotion Among the Inuit: the National Inuit Suicide Prevention Strategy

The committee heard testimony from Natan Obed, President of Inuit Tapiriit Kanatami, that "Inuit experience suicide at roughly 6 to 25 times the national rates, depending upon region and also demographics."[74] However, he stated that Inuit, "as a people, just by the very nature of being Inuit, are not at a higher risk of suicidality" and that instead, "there are a multitude of factors that have placed us in this scenario."[75] He further added that while suicide is a Canadian challenge, "the Inuit specificity is paramount in the way in which the federal government responds to this crisis we have."[76]

[74] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 19 October 2022 (Natan Obed, President, Inuit Tapiriit Kanatami).
[75] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 19 October 2022 (Natan Obed, President, Inuit Tapiriit Kanatami).
[76] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 19 October 2022 (Natan Obed, President, Inuit Tapiriit Kanatami).

Natan Obed therefore recommended that to improve the Framework's ability to support Inuit people, the Inuit Nunangat Policy be considered in the Framework and referenced therein:[77]

> Previous to the adoption of the Inuit Nunangat Policy, there had been a scattershot approach to the way Inuit are considered in areas that affect Indigenous peoples. This Inuit Nunangat Policy, when applied to the Framework, the implementation of the Framework and associated funds, would also be an essential help to the implementation.

Natan Obed shared that the National Inuit Suicide Prevention Strategy was released in 2016, and "was actually the first strategy that was met on day one with federal funding."[78] He further discussed the strategy as:[79]

> being globally informed, evidence-based and Inuit-specific. [K]ey priority areas within the strategy are creating social equity, creating cultural continuity, nurturing healthy Inuit children, ensuring access to a continuum of mental wellness services for Inuit, healing unresolved trauma and grief and mobilizing Inuit knowledge for resilience and suicide prevention.

Natan Obed added that the goal of the strategy is "to change the lives of people in the community [and] to give people more resources" so that if people are at risk of suicide, they have the resources they need and therefore, hope.[80]

Life Promotion is Suicide Prevention

Indigenous witnesses shared that suicide prevention efforts should include ideas of life promotion, noting the importance of cultural connectivity. Wendy Stewart noted that in the Métis worldview, "suicide and life promotion are interconnected" as "everything that promotes life can also prevent suicide."[81]

The committee heard that funding limited to suicide prevention may ignore and exclude earlier interventions that could prevent Indigenous peoples from reaching a crisis point in the first place. Natan Obed stated that he "wished for more opportunities for there to be just positive community-based programming that is celebrated for just that."[82] Wendy Stewart emphasized that "a suicide

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[77] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 19 October 2022 (Natan Obed, President, Inuit Tapiriit Kanatami).
[78] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 19 October 2022 (Natan Obed, President, Inuit Tapiriit Kanatami).
[79] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 19 October 2022 (Natan Obed, President, Inuit Tapiriit Kanatami).
[80] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 19 October 2022 (Natan Obed, President, Inuit Tapiriit Kanatami).
[81] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 19 October 2022 (Wendy Stewart, Director, Community Wellbeing Branch, Métis Nation of Ontario, Métis National Council).
[82] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 19 October 2022 (Natan Obed, President, Inuit Tapiriit Kanatami).

prevention model without a life-promotion focus neglects the unique circumstances of Métis people, our histories and the continued impact of colonization on our well-being."[83]

Jocelyn Formsma added:[84]

> The way I look at it, whether it's suicide prevention or mental health, in my opinion, the governments are likely spending the money anyway. It's about where they are putting the priority. You are going to be spending the money in the child welfare system, in the justice system, prisons and jails. So you are paying for that anyway.
>
> What we are saying is if we provide upfront investments in prevention, in connection and what builds strength, then we will see the decrease down the line. We want to see the upfront investment. We will see more people wanting to continue their lives and to continue contributing to their communities if we are able to do those upstream and upfront investments.

Kimberly Fairman, Executive Director of the Institute for Circumpolar Research, spoke to the impact of colonialism on Indigenous wellbeing:[85]

> I also want to emphasize the importance of culture, language and way of life for Indigenous people as something that has been disrupted by colonial systems and need to be reestablished as elements of identity that need to be supported.

"I would say first and foremost that we need our children to be loved. We need them to grow up in safe, healthy environments, with enough food to eat, with education, but first and foremost to be safe. If I were to do one thing, I would try to do that first."

Natan Obed, President, Inuit Tapiriit Kanatami

A New Model of Care—By and For Indigenous Peoples

Witnesses emphasized the importance of providing accessible care and intervention to all Indigenous peoples, whether they live in urban, rural, or remote environments. Furthermore, this care should be informed by, and whenever possible, provided by community members.

Senator Brazeau commented that the current reality in Indigenous communities is that there are "non-Indigenous peoples and healthcare workers who are not necessarily sensitized to Aboriginal

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[83] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 19 October 2022 (Wendy Stewart, Director, Community Wellbeing Branch, Métis Nation of Ontario, Métis National Council).
[84] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 19 October 2022 (Jocelyn W. Formsma, Executive Director, National Association of Friendship Centres).
[85] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 20 October 2022 (Kimberly Fairman, Executive Director, Institute for Circumpolar Health Research).

realities and cultures. That poses problems."[86] Jocelyn Formsma agreed that "we have better outcomes when we do it for ourselves."[87]

> "We need to ensure crisis services are culturally safe and meaningful for everyone who needs them. A particular priority is crisis services provided by and for First Nations, Inuit and Métis communities."
>
> Dr. Allison Crawford, Chief Medical Officer, Talk Suicide Canada

Dr. Polina Anang, Assistant Professor of Psychiatry at the University of Manitoba's Max Rady College of Medicine, observed that "therapeutic alliance has been shown to be the most beneficial aspect of talking therapy" and that "most Inuit patients prefer talking therapy to psychopharmacological options."[88] However, a barrier to care for Inuit patients is that few clinicians practising talk therapy remain with the communities for long enough to establish this therapeutic alliance.

As a solution to community care in remote and Northern areas, Polina Anang proposed building local capacity, which would not only allow for greater continuity of care, but also improved cultural literacy and reduced language barriers.[89]

Polina Anang acknowledged that while it may not be possible to "stay in the community and get a Master of Social Work or a degree in psychology," it is possible for universities to work with communities to create standardized quality training that does not require leaving the community.[90] She shared that training could be delivered virtually or in-person and "targeted to people who are on the ground who are already, in some capacity, working in the health centres or in community halls."[91] She further suggested that when mental health professionals are serving Northern communities, part of their mandate could be to deliver training.[92]

Witnesses also cautioned that due to the dearth of public mental healthcare options available, remote and Northern communities are especially vulnerable to dubious private, revenue-generating services, which lack standardization and may not provide the best care. Polina Anang

[86] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 20 October 2022 (The Honourable Senator Patrick Brazeau).
[87] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 19 October 2022 (Jocelyn W. Formsma, Executive Director, National Association of Friendship Centres).
[88] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 19 October 2022 (Dr. Polina Anang, Assistant Professor of Psychiatry, Max Rady College of Medicine, University of Manitoba, as an individual).
[89] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 19 October 2022 (Dr. Polina Anang, Assistant Professor of Psychiatry, Max Rady College of Medicine, University of Manitoba, as an individual).
[90] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 19 October 2022 (Dr. Polina Anang, Assistant Professor of Psychiatry, Max Rady College of Medicine, University of Manitoba, as an individual).
[91] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 19 October 2022 (Dr. Polina Anang, Assistant Professor of Psychiatry, Max Rady College of Medicine, University of Manitoba, as an individual).
[92] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 19 October 2022 (Dr. Polina Anang, Assistant Professor of Psychiatry, Max Rady College of Medicine, University of Manitoba, as an individual).

shared that "when there is a high demand and an even higher degree of helplessness, private-sector entities may attempt to fill the gaps with offers that deliver all the buzzwords but very little evidence-based experience."[93] This is not a phenomenon unique to rural, remote and Northern communities in Canada and Minister Bennett stated that she would welcome the committee's suggestion that the Government of Canada undertake an "external review of some of the industry players in suicide prevention."[94]

> "INUIT MENTAL HEALTH WORKERS WILL REVITALIZE THE TALKING THERAPY AND CREATE A NEW CULTURAL ACCEPTANCE OF MENTAL HEALTH AS INHERENTLY BENEFICIAL FOR COMMUNITY MEMBERS. THEY WILL DISMANTLE MENTAL HEALTH STIGMA BY ROLE MODELLING OPENNESS TO BOTH TRADITIONAL INUIT VALUES—INUIT QAUJIMAJATUQANGIT—AND THE PSYCHOLOGICAL VALIDATION OF ACCEPTING EMOTIONS AND SEEING COURAGE IN SHARING FEELINGS WITH OTHERS. INUIT MENTAL HEALTH PROVIDERS WILL ENHANCE THE RESILIENCE OF THEIR COMMUNITIES BY SHIFTING OWNERSHIP OF WELL-BEING."
>
> DR. POLINA ANANG, ASSISTANT PROFESSOR OF PSYCHIATRY, MAX RADY COLLEGE OF MEDICINE, UNIVERSITY OF MANITOBA

Indigenous Engagement

A representative of Indigenous Services Canada shared that the Government of Canada is working with First Nations, Inuit and Métis community members towards "supporting Indigenous-led evaluation of outcomes."[95] Jocelyn Formsma confirmed that the NAFC had been consulted recently by the federal government, but shared challenges of nation-to-nation engagement in that "when it comes time to do a lot of the dialogue and conversations and action planning and strategic planning around anything Indigenous, there is no federal forum for us to engage that is not through a representative means."[96] She further added that nation-to-nation engagement can neglect urban Indigenous voices, and what is needed is "a voice that is outside of that nation-to-nation relationship where we can provide our perspective, our realities and our experiences from the hundreds of thousands of people we serve every day and the millions of people we serve every year."[97]

Wendy Stewart, of the Métis National Council, recognized positive recent changes, sharing that "on the health technical table[,] we have started to have meaningful dialogue" with Crown-Indigenous

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[93] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 19 October 2022 (Dr. Polina Anang, Assistant Professor of Psychiatry, Max Rady College of Medicine, University of Manitoba, as an individual).
[94] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 29 September 2022 (The Honourable Carolyn Bennett, P.C., M.P., Minister of Mental Health and Addictions).
[95] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 29 September 2022 (Dr. Tom Wong, Chief Medical Officer of Public Health, Indigenous Services Canada).
[96] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 19 October 2022 (Jocelyn W. Formsma, Executive Director, National Association of Friendship Centres).
[97] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 19 October 2022 (Jocelyn W. Formsma, Executive Director, National Association of Friendship Centres).

Relations and Northern Affairs Canada and Indigenous Services Canada.[98] However, she stated that since 2016, Métis people have been left out of the progress reports and action plans and there remains nothing "to appropriately address the needs for Métis people."[99]

> "Moving forward, we will know that our engagement has been meaningful on this Framework when Métis suicide rates and distinction-based approaches to life promotion and suicide intervention are included and funded."
>
> Cassidy Caron, Métis National Council

While witnesses emphasized the critical importance of including Indigenous peoples in funding and programming decisions that impact their communities, they urged the government to acknowledge the financial, emotional and resource burdens that consultation and engagement may impose. Wendy Stewart noted that "all of us in the Indigenous world can say that engagement is exhausting. Our communities are exhausted."[100] She also added that a particular challenge is the multiple jurisdictions and agencies by which organizations are contacted for consultation.[101] Jocelyn Formsma added that "the capacity that we have does not match the need" and that while engagement has increased, the capacity for NAFC to participate meaningfully in consultations has not.[102]

Senator Brazeau also noted that "many Indigenous interventions are happening across the country, but knowledge about it is not widely known by experts specifically in this field. If there were resources for those Indigenous peoples and communities who have intervention processes, that would help the health practitioners collectively to deal with this issue."[103]

Boys and Men

The committee received less testimony regarding boys and men, and recognizes that this population should be considered in further depth in future studies on suicide prevention in Canada. What testimony it did receive clearly demonstrates that more research and focus should be placed on this population.

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[98] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 19 October 2022 (Wendy Stewart, Director, Community Wellbeing Branch, Métis Nation of Ontario, Métis National Council).
[99] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 19 October 2022 (Wendy Stewart, Director, Community Wellbeing Branch, Métis Nation of Ontario, Métis National Council).
[100] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 19 October 2022 (Wendy Stewart, Director, Community Wellbeing Branch, Métis Nation of Ontario, Métis National Council).
[101] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 19 October 2022 (Wendy Stewart, Director, Community Wellbeing Branch, Métis Nation of Ontario, Métis National Council).
[102] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 19 October 2022 (Jocelyn W. Formsma, Executive Director, National Association of Friendship Centres).
[103] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 20 October 2022 (The Honourable Senator Patrick Brazeau).

> "One Canadian male is lost to suicide every three hours. The heartbreaking frequency of this loss means that an effective suicide prevention strategy must have a special focus on men."
>
> Dr. Rob Whitley, Associate Professor of Psychiatry, McGill University

Senator Brazeau stated that "there are some basic facts about male suicide and prevention principles that all of us need to know."[104] Rob Whitley elaborated that the three major social determinants of men's mental health and male suicide involve occupational, employment and educational issues; family and divorce issues; and adverse childhood experiences.[105] E. David Klonsky added that it is not rates of suicidal feeling and attempted suicide that are higher for men and boys, but rather that "rates of dying by suicide are higher in men," due in part to their choosing more lethal means of suicide, like firearms.[106] Tyler Black agreed, adding that men are more likely than women to use firearms as a means of suicide.[107]

> "When we see that three out of four suicides are committed by men, maybe we're just doing what historically we've always done in thinking that men are strong, men are supposed to be tough, and men don't have to get help, and they'll sort it out on their own. I'm living proof that that's not the case. That's simply not the case."
>
> The Honourable Senator Patrick Brazeau

Senator Brazeau noted that "there is a huge gap or disparity between what is available for women and what's available for men" and that "in this particular case, given the data," a gender-based analysis should be conducted on suicide prevention.[108]

A meta-analysis submitted to the committee concluded that "for men, not only are the causes of suicide occasionally based on sociological and psychological constructions of gender, but men are also less likely to seek therapy or social support when they need it," and therefore, "their risk is

[104] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 20 October 2022 (The Honourable Senator Patrick Brazeau).
[105] Dr. Rob Whitley, *Written evidence submitted by Dr Rob Whitley (McGill University) to the Senate Committee Studying the Federal Framework on Suicide Prevention*, Brief submitted to the Standing Senate Committee on Social Affairs, Science and Technology, 19 October 2022.
[106] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 5 October 2022 (E. David Klonsky, Professor, Department of Psychology, University of British Columbia, as an individual).
[107] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 5 October 2022 (Dr. Tyler Black, Clinical Assistant Professor, Department of Psychiatry, University of British Columbia, as an individual).
[108] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 20 October 2022 (The Honourable Senator Patrick Brazeau).

twofold."[109] Rob Whitley noted that treatment may also differ from men to women. "The current mental health system offers two main modalities of healing: medication and 'talking therapies,'" however, research suggests that men prefer "action-based modalities of healing," which may include regular exercise, religious and traditional healing.[110] Like with women, "there is no one-size-fits-all solution vis-à-vis men's mental illness and suicide prevention."[111]

> "Many men's mental health and male suicide prevention campaigns focus attention on men's supposed silence and reticence to discuss problems. These often take an accusatory tone, leading to a harmful narrative that blames and berates men for their mental health woes. This approach is known as victim blaming in public health, and is studiously avoided in women's mental health campaigns."
>
> Dr. Rob Whitley, Associate Professor of Psychology, McGill University

The Impact of Substance Use and Addiction

The committee heard that while substance use and addiction have broader implications, they also have an impact on suicide and suicide prevention. Witnesses discussed the link between substance use, harm reduction strategies and suicide prevention.

Rob Whitley characterized drug-related overdose deaths as "slow-motion suicide" and emphasized that substance use and addiction should "be targeted as part of upstream suicide prevention efforts."[112]

Witnesses also discussed the impact of substance use on specific populations, namely Indigenous peoples, and boys and men. Rob Whitley noted that substance use and addictions affect more men than women, and that "research indicates that men make up around 80% of drug-related overdose deaths."[113]

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[109] Sophie Roy, *Suicide Prevention and Mental Health Needs Among Canadian Boys and Men: Research, Programs and Services*, Brief submitted to the Standing Senate Committee on Social Affairs, Science and Technology, 17 October 2022.
[110] Dr. Rob Whitley, *Written evidence submitted by Dr Rob Whitley (McGill University) to the Senate Committee Studying the Federal Framework on Suicide Prevention*, Brief submitted to the Standing Senate Committee on Social Affairs, Science and Technology, 19 October 2022.
[111] Dr. Rob Whitley, *Written evidence submitted by Dr Rob Whitley (McGill University) to the Senate Committee Studying the Federal Framework on Suicide Prevention*, Brief submitted to the Standing Senate Committee on Social Affairs, Science and Technology, 19 October 2022.
[112] Dr. Rob Whitley, *Written evidence submitted by Dr Rob Whitley (McGill University) to the Senate Committee Studying the Federal Framework on Suicide Prevention*, Brief submitted to the Standing Senate Committee on Social Affairs, Science and Technology, 19 October 2022.
[113] Dr. Rob Whitley, *Written evidence submitted by Dr Rob Whitley (McGill University) to the Senate Committee Studying the Federal Framework on Suicide Prevention*, Brief submitted to the Standing Senate Committee on Social Affairs, Science and Technology, 19 October 2022.

Wendy Stewart noted that, at present, "Métis have zero access to culturally appropriate substance-use services and supports."[114] Natan Obed acknowledged that "substance and alcohol abuse are a challenge within Inuit communities" and concluded that "we need to do a better job of having a more sustainable, normalized relationship with these substances and do a better job of understanding the links between the policies and attitudes towards substances and suicidal ideation and risk."[115] Senator Brazeau agreed that "alcohol needs to be dealt with in Indigenous communities," while acknowledging that due to the depth of intergenerational trauma, "that is not going to be fixed overnight." [116]

> "When I asked the youth group, we mostly talk about what they want to see change in their community, what they are proud of and what they want to improve for their children. But when I asked the youth, 'What is the one thing you don't want to see?' the answer was unanimous, and it was alcohol."
>
> Dr. Polina Anang, Assistant Professor of Psychiatry at the Max Rady College of Medicine, University of Manitoba

Towards a More Effective Framework

Various witnesses suggested that to improve the usefulness and effectiveness of the Federal Framework for Suicide Prevention, it should be restructured under general guiding principles that can be adapted and applied to individual circumstances. The overarching principles would fall under a public health approach with individual interventions available at the clinical level. In addition to these general principles, witnesses also emphasized that it is essential that a more effective Framework explicitly target overrepresented populations.

E. David Klonsky suggested that there might be universal principles that guide suicide prevention that can then be applied to "very different contexts in ways that are ideographic, in ways that appreciate the differences between communities."[117] Tyler Black added, "what we have to do is target a principled approach to suicide risk and then possibly use the deploying of those principles to targets of high concern, as the sort of framework for that."[118]

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[114] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 19 October 2022 (Wendy Stewart, Director, Community Wellbeing Branch, Métis Nation of Ontario, Métis National Council).
[115] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 19 October 2022 (Natan Obed, President, Inuit Tapiriit Kanatami).
[116] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 20 October 2022 (The Honourable Senator Patrick Brazeau).
[117] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 5 October 2022 (E. David Klonsky, Professor, Department of Psychology, University of British Columbia, as an individual).
[118] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 5 October 2022 (Dr. Tyler Black, Clinical Assistant Professor, Department of Psychiatry, University of British Columbia, as an individual).

> "THERE ARE FOUR PATHWAYS TO SUICIDE—PAIN, HOPELESSNESS, CONNECTION AND CAPABILITY—THAT I THINK CAN BE APPLIED UNIVERSALLY."
>
> E. DAVID KLONSKY, PROFESSOR OF PSYCHOLOGY, UNIVERSITY OF BRITISH COLUMBIA

In light of the testimony and expertise shared with the committee, and considering the Government of Canada's intention to continue working on improving suicide prevention in Canada, the committee recommends:

Recommendation 1

That the Government of Canada commit to updating the Federal Framework for Suicide Prevention to produce an approach that effectively works at preventing suicide in Canada, and prioritize:

– identifying and promoting evidence-based public health and clinical interventions that are known to have a meaningful impact on suicide in Canada (measured through decreased suicide rates and/or decreased hospital visits due to suicide attempts), such as means restriction;

– moving away from supporting interventions and programs that are not evidence-based;

– replacing concepts of "hope and resilience" in the Framework with "meaning and connectedness;" and

– providing programming based on data that measures the impact of suicide prevention interventions, specifically: suicide rate, number of emergency room visits associated with a suicide attempt, and number of hospitalizations associated with a suicide attempt.

Recommendation 2

That the Government of Canada establish specific priorities in the updated Framework, namely:

– identifying local public health and clinical health interventions that are demonstrated to be effective, and scaling them nationwide;

– targeting populations that are currently overrepresented in Canada's suicide rates: First Nations, Métis and Inuit; boys and men; racialized communities; and persons with mental illnesses; and

– funding research into promising initiatives for suicide prevention.

Recommendation 3

That the Government of Canada establish an independent critical review of revenue-generating suicide prevention and intervention programs operating in Canada; and that the results of this review be appended to the Framework.

Recommendation 4

That the updated Framework require that comprehensive Gender-based Analysis Plus training be added to the existing body of clinical and professional suicide prevention and treatment training, resources, and development instruction provided to healthcare providers, so as to ensure that public health and clinical intervention treatments respond to the particular cultural, historical, socio-economic contexts, and related contributing gendered factors that are distinct, given the diversity of individuals and groups in need of care.

Recommendation 5

That the Government of Canada collaborate with provinces, territories, and civil society organizations to improve national suicide and suicide prevention data collection and analysis by:

– creating a national database on a) suicide, including indicators such as suicide rate, number of emergency room visits associated with a suicide attempt, and number of hospitalizations associated with a suicide attempt; b) effective suicide prevention programs and research; and c) contributing and causal factors for suicide identified through GBA Plus;

– standardizing coroners' reports;

– collecting sufficient demographic and geographic data for disaggregated analysis; and

– collaborating with provincial and territorial authorities on making suicide and suicide attempts incidents reportable to a specific authority.

Recommendation 6

That the Public Health Agency of Canada improve its reports on progress related to the Framework by establishing meaningful measurable outcomes and by evaluating suicide prevention programming against these benchmarks.

Recommendation 7

That the updated Framework explicitly acknowledge the additional challenges faced by certain populations in Canada—rural, remote, and Northern communities; English- and French-second-language speakers; refugees and immigrants; persons with disabilities; racialized communities—in accessing mental healthcare, and provide resources and programming to mitigate these challenges; and, that the updated Framework acknowledge the high level of stigma attached to suicide, and respond by supporting mental healthcare access in all communities.

Recommendation 8

That the Government of Canada return to the Standing Senate Committee on Social Affairs, Science and Technology to share the updated Federal Framework for Suicide Prevention.

Recommendation 9

That the updated Framework acknowledge the crisis of Indigenous overrepresentation in Canada's suicide rate, and:

– recognize the expertise and knowledge of community members by engaging directly with Indigenous experts with lived and living experience in suicide prevention;

– integrate life promotion into suicide prevention models;

– provide flexible financial support for programming that can be devised and managed by community members autonomously;

– create programming designed to train Indigenous community members in mental healthcare and intervention; and

– ensure a trauma-informed, culturally-appropriate approach when providing care to Indigenous peoples.

Recommendation 10

That the updated Framework acknowledge the overrepresentation of boys and men in Canada's suicide rate, and:

– recognize that men and women may require different forms of therapeutic interventions;

– target research towards treatment innovations for boys and men; and

– recognize the additional stigma that boys and men may face in discussing mental health and suicide, and seeking mental healthcare.

Recommendation 11

That the updated Framework recognize the impact of substance use and addiction on suicide prevention in Canada, and that funding and programming associated with suicide prevention include research and interventions into substance abuse and addiction.

Conclusion

Data and witnesses tell the same story: the Federal Framework for Suicide Prevention is not doing enough to prevent suicide in Canada. It is centred around ideas of what feels good instead of seeking out what works. This committee was presented with the opportunity to understand what is not working in the current Framework and how the Framework should be updated to perform better in the future.

The committee heard that data on suicide and suicide attempts is inconsistent at best, and unavailable at worst. The lack of data makes tracking progress, measuring outcomes and evaluating evidence-based interventions difficult and acts as a barrier to effective suicide prevention in Canada.

The data readily available now, including Canada's suicide rate, also conceals key identity factors and, therefore may negatively impact the effectiveness of prevention interventions. Disaggregated data reveals that certain groups are overrepresented in Canada's suicide rate, despite how stable the overall national rate might seem. Boys and men represent 75% of suicide deaths in Canada, and Inuit experience a suicide rate 6–25 times that of the Canadian rate (depending on the region and demographics), with other Indigenous peoples also overrepresented.

In its current iteration, the Framework does not specifically target these overrepresented populations. It is unlikely that Canada's "stable" suicide rate will see any significant progress towards decreasing without providing additional supports for, resources to, and research into overrepresented groups. Right now, these groups are boys and men and Indigenous peoples. In the future, that could change, in which case, the targeting must change too.

Suicide is a serious subject and it requires thoughtful data and research. At present, there is only one intervention that has demonstrated evidence-based success in preventing suicide: means restriction. This must be included in an updated Framework, which should also provide clear direction for research and innovation into suicide prevention. The updated Framework should promote what works now and find out what else might work even better.

Preventing suicide means saving lives, it is essential that it be done right.

Part 2: Suicide Prevention in Canada

Although the mandate of the committee's study was to evaluate the Federal Framework for Suicide Prevention, there was inevitable discussion on suicide prevention in Canada more generally. While the committee has not yet had an opportunity to study this issue in more depth, it wishes to present witness' comments and experiences in this part of the report.

> "SUICIDE IS COMPLEX BECAUSE PEOPLE ARE COMPLEX. EACH PERSON WHO CONSIDERS SUICIDE DOES SO FOR REASONS UNIQUE TO THEM. THERE ARE MANY PRECIPITATING FACTORS THAT CAN LEAD SOMEONE TO CONSIDER SUICIDE, SOME BASED IN MENTAL ILLNESS, OTHERS BASED IN SOCIAL DETERMINANTS. FOR MOST PEOPLE, IT IS THE INTERACTION OF THESE FACTORS THAT BRINGS THEM TO THE POINT OF SUICIDALITY. THE PEOPLE WHO THINK ABOUT AND ATTEMPT SUICIDE DO NOT WANT TO DIE. THEY WANT A WAY OUT OF THEIR INTENSE PSYCHOLOGICAL PAIN OR THEIR DEEP SENSE OF BURDENSOMENESS."
>
> MARA GRUNAU, EXECUTIVE DIRECTOR, CENTRE FOR SUICIDE PREVENTION

Jurisdictional Responsabilities and Challenges

Jurisdictional responsibilities in matters of health are complex. The Constitution explicitly gives jurisdiction over most of healthcare to the provinces, including exclusive responsibility for the delivery of most medical services, the education of physicians and data and reporting standards.[119] However, through its jurisdiction over criminal law and spending power, the federal government also has responsibilities in health, in addition to being responsible for specific populations. Minister Bennett acknowledged the latter recognizing that "as much as we work with provinces and territories on this very important issue, we have some of the worst outcomes in the people for whom we have direct responsibility: First Nations, Inuit, Métis, the military, RCMP, Corrections. We actually have to be accountable across all government departments as we go forward."[120]

In terms of federal/provincial/territorial cooperation, Heather Jeffrey noted that Minister Bennett's appointment has provided "a spotlight on mental health and addiction, and she has direct counterparts in many of the provinces and territories" that she often engages with and that "provinces and territories proactively identity these issues as critical priorities to forward."[121] Candice St-Aubin added that given that many provinces and territories have some sort of suicide

[119] For more information, see Martha Butler and Marlisa Tiedemann, *The Federal Role in Health and Health Care*, Publication No. 2011-91-E, Library of Parliament, 20 September 2013.
[120] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 29 September 2022 (The Honourable Carolyn Bennett, P.C., M.P., Minister of Mental Health and Addictions).
[121] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 29 September 2022 (Heather Jeffrey, Associate Deputy Minister, Health Canada).

prevention, strategy or programming, the Government of Canada's role is as an interlocutor and facilitator of best practices nationwide "in a complementary way."[122]

Minister Bennett stated that thus far, "it is really clear that the provinces and territories have identified six priority areas they want to work with: integrated youth services, better training for family doctors in mental health, the use of digital, health and human resources, substance use treatment and complex mental illness."[123]

However, the Chief Medical Officer of Public Health at Indigenous Services Canada cautioned that "we need a table for federal, provincial, territorial, First Nations, Inuit, Métis and other marginalized groups" to gather together and better coordinate successful strategies.[124]

> "Jurisdictional wrangling is a problem that we have not even begun to start talking about. There is no forum for addressing the challenges that federalism has caused due to the division between provincial and federal jurisdictions. They look at urban Indigenous or Indigenous peoples. Where we are, as jurisdictions, we need to look at it as people and how we help people, regardless of jurisdiction. So, yes, it's a problem. We need to solve that because it's welfare, health, education–all of those issues."
>
> Jocelyn Formsma, Executive Director, National Association of Friendship Centres

Experiences of Some Racialized and Ethnic Communities

While certain groups are currently overrepresented in the suicide rate in Canada, they and others may also face additional challenges accessing mental healthcare and discussing mental health and suicide openly.

> "If there is a huge stigma, people don't seek help. They are too embarassed to seek help or to admit they are struggling. We want to see people able to access care for mental health."
>
> The Honourable Carolyn Bennett, Minister of Mental Health and Addictions

Nitika (Rewari) Chunilall observed that "there is a lack of understanding of the distinct experiences of suicidal behaviour among ethno-racialized groups and other equity-seeking groups," and that

[122] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 29 September 2022 (Candice St-Aubin, Vice-President, Health Promotion and Chronic Disease Prevention Branch, Public Health Agency of Canada).
[123] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 29 September 2022 (The Honourable Carolyn Bennett, P.C., M.P., Minister of Mental Health and Addictions).
[124] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 29 September 2022 (Dr. Tom Wong, Chief Medical Officer of Public Health, Indigenous Services Canada).

"programs and services are not tailored enough to meet their needs."[125] Minister Bennett reminded the committee that in certain South Asian and African communities, "the stigma is so high that they won't even tell their parents or families, including foreign students."[126] Nitika (Rewari) Chunilall also commented that "as someone who belongs to the South Asian community, most of the supportive conversations in my culture take place at the kitchen table. Suicide prevention happens at homes, family doctors' offices, workplaces, grocery stores, theatres, liquor stores and hockey rinks."[127] Kimberly Fairman added that in certain communities, "there are very limited culturally appropriate resources available" and that "sometimes racism in the health care system is a huge issue in communities."[128]

Officials from Health Canada and PHAC shared some information about community-based solutions to support mental health and wellness for Black Canadians, including: a dedicated network of Black therapists established in Edmonton; a primary care evaluation carried out through the TAIBU Community Health Centre in Scarborough; and a study evaluating mental health supports for Black post-secondary students being conducted by the Harriet Tubman Institute at York University.[129]

> "I'M NOT 100% SURE THAT WE GO HOME AND TALK ABOUT MENTAL HEALTH NAMING IT MENTAL HEALTH, OR MENTAL ILLNESS, OR NAMING IT IN A VERY DIAGNOSTIC WAY OR DIAGNOSTIC LANGUAGE, SO MEETING THE COMMUNITY WHERE THEY ARE AT IN TERMS OF WHAT ARE THE WORDS THAT THEY USE TO DESCRIBE MENTAL HEALTH, MENTAL WELLNESS, MENTAL ILLNESS IN THEIR COMMUNITY; WHAT ARE THE WORDS THAT THEY USE WHEN SOMETHING IS NOT GOING RIGHT AND SUPPORT IS NEEDED IS VALUABLE. I DO THINK THERE IS VALUE IN REALLY UNDERSTANDING THE DIFFERENT CULTURES AND IN GIVING SOME FLEXIBILITY FOR FOLKS WITHIN THAT CULTURE TO PROVIDE GUIDANCE INTO HOW MENTAL HEALTH, MENTAL ILLNESS AND SUICIDE PREVENTION CAN BE BETTER DISCUSSED AT THOSE TABLES."
>
> NITIKA (REWARI) CHUNILALL, DIRECTOR OF PREVENTION AND PROMOTION INITIATIVES, MENTAL HEALTH COMMISSION OF CANADA

[125] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 20 October 2022 (Nitika (Rewari) Chunilall, Director, Prevention and Promotion Initiatives, Mental Health Commission of Canada).
[126] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 29 September 2022 (The Honourable Carolyn Bennett, P.C., M.P., Minister of Mental Health and Addictions).
[127] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 20 October 2022 (Nitika (Rewari) Chunilall, Director, Prevention and Promotion Initiatives, Mental Health Commission of Canada).
[128] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 20 October 2022 (Kimberly Fairman, Executive Director, Institute for Circumpolar Health Research).
[129] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 29 September 2022 (The Honourable Carolyn Bennett, P.C., M.P., Minister of Mental Health and Addictions) and (Candice St-Aubin, Vice-President, Health Promotion and Chronic Disease Prevention Branch, Public Health Agency of Canada).

Youth Mental Health

Allison Crawford advised addressing suicide across the entire human lifespan, with a particular emphasis on early childhood intervention, and outlined some of the challenges facing youth, stating that "children exposed to early childhood adversity including abuse and trauma are at much higher risk for suicide throughout life."[130] Joanna Henderson emphasized the importance of focusing on youth intervention, stating that "youth are unique in that they are navigating a rapid series of developmental stages, tasks and milestones on their journey from childhood to full adulthood."[131]

> "DESPITE THE BENEFITS OF SPECIALIZED TREATMENT FOR TRAUMA, MENTAL HEALTH AND SUBSTANCE USE CONCERNS, A MAJORITY OF YOUTH WHO COULD BENEFIT FROM THESE SERVICES DO NOT RECEIVE THEM."
>
> DR. JOANNA HENDERSON, DIRECTOR OF THE MARGARET AND WALLACE MCCAIN CENTRE FOR CHILD, YOUTH AND FAMILY MENTAL HEALTH, AND SENIOR SCIENTIST OF THE CHILD, YOUTH AND EMERGING ADULT PROGRAM, CENTRE FOR ADDICTION AND MENTAL HEALTH

Various witnesses spoke of the role of Integrated Youth Services (IYS) in potentially reducing suicide rates among youth. Joanna Henderson stated that:[132]

> Integrated Youth Services have been co-created with youth, family members, service providers and researchers to address the significant gaps that have existed in services for youth [and] they bring together mental health, primary health care, substance use, education, employment, cultural, housing and other community and social supports into a one-stop-shop model of service delivery emphasizing timely and easy access to developmentally tailored clinical interventions for youth aged 12–25.

Heather Jeffrey noted that IYS can be especially helpful as they provide peer support and peer counselling – some of the most effective interventions.[133] Joanna Henderson also spoke to the future of IYS stating that the next step is to develop "a pan-Canadian learning health system, IYS-Net, that will allow youth, families community leaders, service providers and researchers

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[130] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 5 October 2022 (Dr. Allison Crawford, Associate Chief of Virtual Mental Health and Outreach, and co-chair of ECHO Ontario and ECHO Ontario Mental Health, Centre for Addiction and Mental Health).
[131] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 5 October 2022 (Dr. Joanna Henderson, Director, Margaret and Wallace McCain Centre for Child, Youth and Family Mental Health; Senior Scientist, Child, Youth and Emerging Adult Program, Centre for Addiction and Mental Health).
[132] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 5 October 2022 (Dr. Joanna Henderson, Director, Margaret and Wallace McCain Centre for Child, Youth and Family Mental Health; Senior Scientist, Child, Youth and Emerging Adult Program, Centre for Addiction and Mental Health).
[133] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 29 September 2022 (Heather Jeffrey, Associate Deputy Minister, Health Canada).

throughout Canada to work together to answer questions that we have not been able to answer separately."[134]

Witnesses also highlighted the specific needs of Indigenous youth. Jocelyn Formsma stated that "the current federal funding for Indigenous youth is quite sparse" and that "the amount of funding is nowhere near the amounts that are needed."[135]

> "You look at the landscape of federal funding and the federal landscape, and the investment specifically in Indigenous children and youth well-being is very sparse and it is not coordinated."
>
> Jocelyn Formsma, Executive Director, National Association of Friendship Centres

Federal Tools, Programs and Plans for Suicide Prevention

The committee heard testimony about what the Government of Canada has planned on the horizon for suicide prevention, in addition to opinions on how to better guide the federal future of suicide prevention.

Wellness Together Canada Portal and PocketWell Application

The Wellness Together Canada (WTC) online portal was created as part of the Government of Canada's response to the COVID-19 pandemic. The WTC portal offers free, immediate, 24/7 access to a range of mental health and substance use resources, supports and services, including online peer support, therapist-assisted services, Internet-based cognitive behavioural therapy, mental health and substance use literacy tools, self-directed courses and 24/7 phone and text triage.[136]

In response to the committee's request for additional outcome information on the Wellness Together Canada (WTC) portal, Health Canada stated that the portal was launched as part of the Government of Canada's emergency response to the COVID-19 pandemic. Budget 2020 provided $68 million to create and maintain the portal from April 2020 to April 2021.[137]

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[134] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 5 October 2022 (Dr. Joanna Henderson, Director, Margaret and Wallace McCain Centre for Child, Youth and Family Mental Health; Senior Scientist, Child, Youth and Emerging Adult Program, Centre for Addiction and Mental Health).

[135] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 19 October 2022 (Jocelyn W. Formsma, Executive Director, National Association of Friendship Centres).

[136] Health Canada, *Health Canada's response to a request for information made by the Standing Senate Committee on Social Affairs, Science and Technology on September 29, 2022*, Brief submitted to the Standing Senate Committee on Social Affairs, Science and Technology, 30 January 2023, p. 2.

[137] Health Canada, *Health Canada's response to a request for information made by the Standing Senate Committee on Social Affairs, Science and Technology on September 29, 2022*, Brief submitted to the Standing Senate Committee on Social Affairs, Science and Technology, 30 January 2023, p. 2.

Regarding the evaluation of outcomes, Health Canada noted that there are some limitations with user data. To facilitate and encourage use, there are several resources available that do not require users to register for an account, and when users do create an account, they can opt into providing information relating to the state of their mental health and quality of life.[138] These factors make it difficult to fully assess the user base of the portal and application, as well as the impact of these resources.

With these limitations in mind, Health Canada was able to share outcome measurements for select indicators: access, usage, user satisfaction and impact.[139] Health Canada shared that by December 12, 2022, over 3 million individuals had accessed the WTC portal itself, and the portal had hosted over 8.4 million web sessions.[140] In 2022, the median number of monthly active users was 33,091, which represented a 12% increase from the 2021 median monthly active users.[141] Data from 2021 and 2022 indicate that users reported a positive change on all three self-assessment scales between their first time visiting the portal and after accessing resources or support.[142] This data also showed that users who engaged with the site more (e.g., clicking links, accessing resources) demonstrated more improvement than users who did not access as many resources.

The PocketWell application was designed to complement the use of the WTC portal by supporting daily tracking of mood, well-being and mental health functionality, as well as providing another platform to access free and confidential counselling services and mental health and substance use resources.[143] Similar limitations apply to the PocketWell mobile application user data as to the WTC portal data in that the goal is to make the resources as accessible as possible, and therefore, accounts are not required and limited client data is tracked.[144] As of November 14, 2022, the PocketWell application had been downloaded 31,092 times and there were 18,351 registered

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[138] Health Canada, *Health Canada's response to a request for information made by the Standing Senate Committee on Social Affairs, Science and Technology on September 29, 2022*, Brief submitted to the Standing Senate Committee on Social Affairs, Science and Technology, 30 January 2023, p. 1.
[139] Health Canada, *Health Canada's response to a request for information made by the Standing Senate Committee on Social Affairs, Science and Technology on September 29, 2022*, Brief submitted to the Standing Senate Committee on Social Affairs, Science and Technology, 30 January 2023, p. 2.
[140] Health Canada, *Health Canada's response to a request for information made by the Standing Senate Committee on Social Affairs, Science and Technology on September 29, 2022*, Brief submitted to the Standing Senate Committee on Social Affairs, Science and Technology, 30 January 2023, p. 2.
[141] Health Canada, *Health Canada's response to a request for information made by the Standing Senate Committee on Social Affairs, Science and Technology on September 29, 2022*, Brief submitted to the Standing Senate Committee on Social Affairs, Science and Technology, 30 January 2023, p. 2.
[142] Health Canada, *Health Canada's response to a request for information made by the Standing Senate Committee on Social Affairs, Science and Technology on September 29, 2022*, Brief submitted to the Standing Senate Committee on Social Affairs, Science and Technology, 30 January 2023, p. 2.
[143] Health Canada, *Health Canada's response to a request for information made by the Standing Senate Committee on Social Affairs, Science and Technology on September 29, 2022*, Brief submitted to the Standing Senate Committee on Social Affairs, Science and Technology, 30 January 2023, p. 3.
[144] Health Canada, *Health Canada's response to a request for information made by the Standing Senate Committee on Social Affairs, Science and Technology on September 29, 2022*, Brief submitted to the Standing Senate Committee on Social Affairs, Science and Technology, 30 January 2023, p. 3.

users.[145] Users accessed 19,396 resources and completed 50,428 "mood check-ins" using the application's unique Mood Meter.[146]

National 3-Digit Crisis Support Number

On December 11, 2020, the House of Commons gave unanimous consent to a motion that[147]

> call[ed] on the government to take immediate action, in collaboration with the provinces, to establish a national suicide prevention hotline that consolidates all suicide crisis numbers into one easy to remember three-digit (988) hotline that is accessible to all Canadians.

On August 31, 2022, the Canadian Radio-television and Telecommunications Commission (CRTC) announced that 988 would be implemented on November 30, 2023, offering information on local mental health crisis and suicide prevention services by call and text.[148] Speaking to the committee, Minister Bennett reiterated the Government of Canada's commitment to implementing 988.[149]

Allison Crawford, also Chief Medical Officer of Talk Suicide Canada provided more information about the services currently available with Talk Suicide Canada, and the intentions for the 988 number:[150]

> Talk Suicide Canada provides crisis support to people living in Canada by trained responders in both English and French and is available 365 days a year, 24/7. Our service priorities include building a community-based network of crisis centres, training crisis responders across Canada in suicide prevention, enhancing the equity of crisis services—in other words, ensuring that we're reaching a diverse range of communities—bringing an evidence-based approach to crisis response and suicide prevention and challenging the stigma around suicide by promoting open conversations about suicide. We believe that 988 will provide easy access to life-saving support for people across the country who are experiencing suicide-related crises.

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[145] Health Canada, *Health Canada's response to a request for information made by the Standing Senate Committee on Social Affairs, Science and Technology on September 29, 2022*, Brief submitted to the Standing Senate Committee on Social Affairs, Science and Technology, 30 January 2023, p. 3.

[146] Health Canada, *Health Canada's response to a request for information made by the Standing Senate Committee on Social Affairs, Science and Technology on September 29, 2022*, Brief submitted to the Standing Senate Committee on Social Affairs, Science and Technology, 30 January 2023, p. 3.

[147] House of Commons, *Journals*, 11 December 2020.

[148] Canadian Radio-television and Telecommunications Commission, *9-8-8 number for mental health and suicide prevention.*

[149] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 29 September 2022 (The Honourable Carolyn Bennett, P.C., M.P., Minister of Mental Health and Addictions).

[150] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 5 October 2022 (Dr. Allison Crawford, Associate Chief of Virtual Mental Health and Outreach, and co-chair of ECHO Ontario and ECHO Ontario Mental Health, Centre for Addiction and Mental Health).

Discussing the importance of measuring outcomes, Minister Bennett also informed the committee that in designing and implementing the 988 number, the research and academic communities were consulted to develop accountability and data transparency policies that will enable more monitoring and evaluation of outcomes than has been possible with the Framework.[151]

National Action Plan on Suicide Prevention

Minister Bennett shared that a national action plan on suicide prevention is in development with a preliminary publication date of fall 2023 and that throughout 2023 the Government of Canada will be:[152]

> engaging across federal departments, with provinces and territories, with Indigenous communities and people with lived and living experience to move the existing Framework to a much more action-oriented, evidence-based, comprehensive plan… With [the committee's] help, I am committed to building an effective, comprehensive and evidence-based federal suicide prevention action plan.

Various government officials, including representatives from PHAC and Health Canada, shared that a federal coordinating committee, whose "main focus currently is information sharing and helping to develop the progress reports for the Framework," continues to meet regularly in order to coordinate Framework actions across the federal government.[153]

The Canadian Association for Suicide Prevention recommended that "the federal government needs to turn its attention to creating a national strategy for suicide prevention before any work can properly proceed on an action plan."[154] Nitika (Rewari) Chunilall suggested that "the action plan has sufficient flexibility and investment allotted for communities to adapt implementation within their own unique contexts."[155]

Officials from Health Canada and PHAC also shared the following information about the proposed national action plan:

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[151] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 29 September 2022 (The Honourable Carolyn Bennett, P.C., M.P., Minister of Mental Health and Addictions).
[152] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 29 September 2022 (The Honourable Carolyn Bennett, P.C., M.P., Minister of Mental Health and Addictions).
[153] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 29 September 2022 (Stephanie Priest, Director General, Centre for Mental Health and Well-being, Health Promotion and Chronic Disease Prevention Branch, Public Health Agency of Canada).
[154] Sean Krausert, *Canadian Association for Suicide Prevention Brief*, Brief submitted to the Standing Senate Committee on Social Affairs, Science and Technology, 24 October 2022.
[155] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 20 October 2022 (Nitika (Rewari) Chunilall, Director, Prevention and Promotion Initiatives, Mental Health Commission of Canada).

- Unlike the Framework, the action plan is being designed "using an evidence base to determine what works and what does not work, as well as how we scale up appropriately."[156]
- A key focus of the action plan is intended to "map access challenges" in terms of both access to care, and to quality mental health supports.[157]
- The development of the national action plan considers best practices in other countries, and will benefit from an upcoming global mental health summit.[158]
- Like the Framework, the proposed action plan will not have financial resources attached to it. An official from PHAC observed that has the funding to continue doing what they currently are, "while we have funding to do what we are currently doing, there is always a need for additional funding if it is something that is deemed a priority."[159]

> "The most important thing in an action plan is that we need to be focusing on accountability for outcomes. We have to fund what works and stop funding what doesn't work but maybe makes us feel good."
>
> The Honourable Carolyn Bennett, Minister of Mental Health and Addictions

Rhonda Kropp confirmed that the Canadian Institutes of Health Research will be working with PHAC to ensure "that we look at different methodologies for evaluation and how best to do those so that the information on what is working and what isn't is collected very rapidly and can be put into practice really quickly, like the learning health system model, in terms of the research that we fund."[160]

National Suicide Prevention Strategy

While the proposed national action plan for suicide prevention may be more concrete than the Framework, witnesses also spoke of the need for Canada to develop a national suicide prevention strategy. In a brief submitted to the committee, the Canadian Association for Suicide Prevention stated that "Canada needs a national strategy for suicide prevention and is the only G-7 nation

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[156] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 29 September 2022 (Candice St-Aubin, Vice-President, Health Promotion and Chronic Disease Prevention Branch, Public Health Agency of Canada).
[157] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 29 September 2022 (Heather Jeffrey, Associate Deputy Minister, Health Canada).
[158] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 29 September 2022 (Heather Jeffrey, Associate Deputy Minister, Health Canada).
[159] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 29 September 2022 (Candice St-Aubin, Vice-President, Health Promotion and Chronic Disease Prevention Branch, Public Health Agency of Canada).
[160] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 29 September 2022 (Rhonda Kropp, Associate Vice-President, Research – Strategy, Canadian Institutes of Health Research).

without one."[161] The Centre for Suicide Prevention echoed this statement, adding that "a wealth of evidence indicates that having, resourcing and implementing a national suicide prevention strategy reduces suicide."[162] They further characterized the relationship between strategy, framework and action plan as "ideally, a strategy contains a framework; subsequent action plans are then developed to implement the work."[163]

Allison Crawford stated that "Canada is one of the few high-resource countries that does not have one, yet we know that national strategies are an effective approach."164 She added that the proposed national action plan, "is not a national suicide prevention strategy, because a national suicide prevention strategy would take on the complexities across different pillars–public health approaches, clinical approaches."[165]

The Canadian Association for Suicide Prevention shared various recommendations for a national strategy including that it introduce national guidelines on means safety and restrictions; that it promote better integration of services and culturally-appropriate training by partnering with Indigenous communities; and that it establish national surveillance and reporting standards for better data collection.[166]

Allison Crawford also recommended that the design of a national suicide prevention strategy could be based in part on the National Inuit Suicide Prevention Strategy, stating that:[167]

> It does a very good job of marrying health care evidence and also Inuit knowledge in its approaches. It is a very good example of how general principles derived from evidence can also be applied locally effectively, through Inuit leadership in that case. It also takes a lifespan approach in quite a systematic way, and it has evaluation built into it. It exemplifies some of the things that a national suicide prevention strategy could do.

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[161] Sean Krausert, *Canadian Association for Suicide Prevention Brief*, Brief submitted to the Standing Senate Committee on Social Affairs, Science and Technology, 24 October 2022.
[162] Centre for Suicide Prevention, *Suicide Prevention Initiatives in Canada*, Brief submitted to the Standing Senate Committee on Social Affairs, Science and Technology, 28 October 2022.
[163] Centre for Suicide Prevention, *Suicide Prevention Initiatives in Canada*, Brief submitted to the Standing Senate Committee on Social Affairs, Science and Technology, 28 October 2022.
[164] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 5 October 2022 (Dr. Allison Crawford, Associate Chief of Virtual Mental Health and Outreach, and co-chair of ECHO Ontario and ECHO Ontario Mental Health, Centre for Addiction and Mental Health).
[165] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 5 October 2022 (Dr. Allison Crawford, Associate Chief of Virtual Mental Health and Outreach, and co-chair of ECHO Ontario and ECHO Ontario Mental Health, Centre for Addiction and Mental Health).
[166] Sean Krausert, *Canadian Association for Suicide Prevention Brief*, Brief submitted to the Standing Senate Committee on Social Affairs, Science and Technology, 24 October 2022.
[167] Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 5 October 2022 (Dr. Allison Crawford, Associate Chief of Virtual Mental Health and Outreach, and co-chair of ECHO Ontario and ECHO Ontario Mental Health, Centre for Addiction and Mental Health).

Lived and Living Experiences with Suicide and Suicide Prevention

The committee received testimony regarding lived and living experiences with suicide and suicide prevention.[168]

A Waterloo family shared the story of their daughter, J:

My daughter J, who is 27 years old, has been suffering with mental health issues for most of her life and has been in and out of hospitals for the past 12 years. She goes into the hospital when in crisis and is discharged with limited resources or plans for treatment or support, which inevitably leads to another crisis that ultimately send her back to the hospital. This is the cycle that has been going on for years with so many 911 calls for suicide attempts. J has been admitted over 30 times and each time it for a much longer stay. It has caused a great deal of trauma for J as well as our family for witnessing our daughter being dragged out of our home in hand cuffs because she wants to die. This has been the pattern for many years.

J is currently in the hospital where she has been for the past 56 days. She is in full restraints with a helmet on, to protect her from hurting herself. Along with her strong suicidal thoughts and self-harm thoughts, she also has an eating disorder that has progressed to the point where she was medically unstable. Her malnutrition caused problems with her heart and fractures in her bones. Over the few months, prior to her admission to the hospital she saw 12 different medical doctors in emergency and family care practises. Despite my pleading and J's initial willingness, no one would admit her to the hospital. Finally, after much persuasion, the family doctor "formed" her for medical reasons, and she was admitted to hospital.

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[168] For J's story, please see Waterloo Area Family, *Family Story*, Brief submitted to the Standing Senate Committee on Social Affairs, Science and Technology, 14 November 2022.

For Senator Brazeau's comments, please see Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 29 September 2022 (The Honourable Senator Patrick Brazeau).

For Alex's story, please see Senate, Standing Committee on Social Affairs, Science and Technology, *Evidence*, 19 October 2022 (Wendy Stewart, Director, Community Wellbeing Branch, Métis Nation of Ontario, Métis National Council).

For Kaitlyn's story, please see Michael and Fiona Roth, *Kaitlyn Roth's Story*, Brief submitted to the Standing Senate Committee on Social Affairs, Science and Technology, 2 November 2022.

Senator Brazeau shared his story:

I tried to commit suicide on August 2, 2014, and again on January 18, 2016. Just because I am a man and I'm an Indigenous person—because of those two facts—I have more chances of committing suicide than anyone else in this room.

I am a senator of Canada. I was hurting. I tried to commit suicide. But I'm lucky because I'm here talking to you today about an issue that is very important to me. What is your government going to do for those Indigenous peoples, once and for all? It is time to stop with your bureaucratic bull crap about what we need to do for outcomes. No. What are we going to do?

Senator Brazeau added that we are slowly getting better at destigmatizing suicide:

We are not where we should be yet, because, let's face it, it is an uncomfortable discussion. I'll admit: it has even been an uncomfortable discussion within my own family, with my father, brothers and the rest of the family, because it has severely impacted not just my life but the lives of others. I have had to do a great deal of work to try to rebuild a lot of relationships.

Some people have lost cherished ones to this and just can't handle it, but for those who can handle it, it is very important that they share their voices and stories. We need them; we simply need them to tell others who are having problems. There are many people having problems in Canada today.

There is hope, but it takes work. There is hope and there is help. Help is everywhere. Anybody who is having problems can ask for help, not only from a friend or family member but from a complete stranger on the street. Sooner or later, they are going to get help.

The Honourable Senator Patrick Brazeau

Wendy Stewart shared the story of Alex, "a Métis teenager who was sent to 17 different care homes and seen by 23 different social workers over a span of 11 years. Throughout his time in care, Alex was subjected to abuse and neglect. He was also denied access to mental wellness supports or any meaningful connection to his family or Métis culture. At the end of his life, Alex was placed alone, unsupported in an Abbotsford, B.C., hotel room for 49 days. He ended his life by jumping out the window from that very room."

Michael and Fiona Roth shared their daughter, Kaitlyn's story:

Kaitlyn was a bright young woman who tragically died by suicide on April 28, 2022.

In the months preceding her death, Kaitlyn and our family worked diligently to access care and supports for Kaitlyn only to discover that services either did not exist or Kaitlyn was not able to qualify. At the time of her death, Kaitlyn was on wait lists for skills programs, including counselling, and she did not have a regular psychiatrist to assess treatment options. We know that you would agree with us that it takes great courage to ask for help, as Kaitlyn did, and that courage should be honoured with timely access to quality care. Undoubtedly, the system failed Kaitlyn.

She received inconsistent and insufficient options of care, which left her incredibly vulnerable. It is also worth noting that by the end of her experience with the Ontario mental health services, she had been in contact with 27 police officers. The case can easily be made for early investment into care options, to prevent the challenges of police intervention. We are sharing this story with you because as a province/country, we need to do better.

Appendix 1: List of Witnesses

Thursday, September 29, 2022

The Honourable Carolyn Bennett, P.C., M.P., Minister of Mental Health and Addictions

Candice St-Aubin, Vice-President, Health Promotion and Chronic Disease Prevention Branch, Public Health Agency of Canada

Stephanie Priest, Director General, Centre for Mental Health and Well-being, Health Promotion and Chronic Disease Prevention Branch, Public Health Agency of Canada

Heather Jeffrey, Associate Deputy Minister, Health Canada

Suki Wong, Director General, Mental Health Directorate, Strategic Policy Branch, Health Canada

Rhonda Kropp, Associate Vice-President, Research – Strategy, Canadian Institutes of Health Research

Dr. Tom Wong, Chief Medical Officer of Public Health, Indigenous Services Canada

Wednesday, October 5, 2022

Dr. Tyler Black, Clinical Assistant Professor, Department of Psychiatry, University of British Columbia, A s an Individual

Dr. Allison Crawford, Chief Medical Officer, Talk Suicide Canada, Centre for Addiction and Mental Health

Dr. Joanna Henderson, Director, Margaret and Wallace McCain Centre for Child, Youth and Family Mental Health; Senior Scientist, Child, Youth and Emerging Adult Program, Centre for Addiction and Mental Health

Mara Grunau, Executive Director, Centre for Suicide Prevention

E. David Klonsky, Professor, Department of Psychology, University of British Columbia, As an Individual

Thursday, October 6, 2022

Dr. Sidney Kennedy, Professor, Department of Psychiatry, University of Toronto, As an Individual

Dr. J. John Mann, Director, Conte Center for Suicide Prevention, Columbia University, As an Individual

Dr. Gustavo Turecki, Professor and Chair, Department of Psychiatry, McGill University, As an Individual

Wednesday, October 19, 2022

Natan Obed, President, Inuit Tapiriit Kanatami

Daniel Afram, Senior Policy Advisor, Inuit Tapiriit Kanatami

Dr. Polina Anang, Assistant Professor of Psychiatry, Max Rady College of Medicine, University of Manitoba, As an Individual

Jocelyn W. Formsma, Executive Director, National Association of Friendship Centres

Wendy Stewart, Director, Community Wellbeing Branch, Métis Nation of Ontario, Métis National Council

Thursday, October 20, 2022

The Honourable Senator Patrick Brazeau

Nitika (Rewari) Chunilall, Director, Prevention and Promotion Initiatives, Mental Health Commission of Canada

Kimberly Fairman, Executive Director, Institute for Circumpolar Health Research

Appendix 2: List of Briefs

The committee received the following briefs and follow-up information during this study:

- *Suicide Prevention and Mental Health Needs Among Canadian Boys and Men: Research Programs and Services*, written by Sophie Roy, at the direction of Senator Brazeau
- Brief from Dr. Rob Whitley, Associate Professor of Psychiatry at McGill University
- Brief from the Canadian Association for Suicide Prevention
- Brief from Michael and Fiona Roth
- Brief from a Waterloo Area Family
- Follow-up information from Nitika (Rewari) Chunilall, on behalf of the Mental Health Commission of Canada
- Follow-up information from Dr. Polina Anang, Assistant Professor of Psychiatry, Max Rady College of Medicine
- Follow-up information from E. David Klonsky, Professor, Department of Psychology, University of British Columbia
- Follow-up information on suicide data gaps in Canada from Mara Grunau, on behalf of the Centre for Suicide Prevention
- Follow-up information on suicide prevention initiatives in Canada from Mara Grunau, on behalf of the Centre for Suicide Prevention
- Follow-up information from Cassidy Caron, on behalf of the Métis National Council
- Follow-up information from Dr. Joanna Henderson, on behalf of the Centre for Addiction and Mental Health
- Follow-up information from Dr. Allison Crawford, on behalf of Talk Suicide Canada and the Centre for Addiction and Mental Health
- Follow-up information from the Public Health Agency of Canada
- Follow-up information from the National Association of Friendship Centres
- Follow-up information from the Mental Health Commission of Canada
- Follow-up information from Health Canada
- Follow-up information from Health Canada

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