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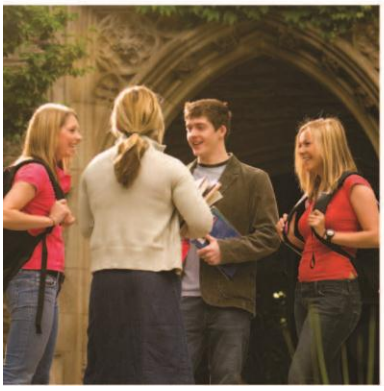
McMaster HEALTH FORUM

DIALOGUE SUMMARY

PREVENTING SUICIDE IN CANADA



9 NOVEMBER 2012

EVIDENCE >> INSIGHT >> ACTION

Dialogue Summary:
Preventing Suicide in Canada

9 November 2012

McMaster Health Forum

For concerned citizens and influential thinkers and doers, the McMaster Health Forum strives to be a leading hub for improving health outcomes through collective problem solving. Operating at the regional/provincial level and at national levels, the Forum harnesses information, convenes stakeholders, and prepares action-oriented leaders to meet pressing health issues creatively. The Forum acts as an agent of change by empowering stakeholders to set agendas, take well-considered actions, and communicate the rationale for actions effectively.

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Conflict of interest

The authors declare that they have no professional or commercial interests relevant to the dialogue summary. The funder reviewed a draft dialogue summary but the authors had final decision-making authority about what appeared in the dialogue summary.

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Dialogue

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SUMMARY OF THE DIALOGUE

The deliberation about the problem initially focused on the challenge of making suicide prevention a high priority public issue in Canada. Several dialogue participants suggested that the lack of political will at different levels of government and the lack of broader societal leadership contributes to this challenge. Dialogue participants identified several key features of the problem that also contributed to the challenge: 1) the complex nature of the problem; 2) the stigma associated with suicide; 3) the limited capacity to trigger meaningful societal transformation; 4) the fragmentation of efforts across the country; and 5) the lack of applied and community-driven research. On the other hand, several dialogue participants expressed cautious optimism about the priority being accorded to suicide prevention, citing the recent introduction of a bill in Canada's federal parliament calling for a federal suicide prevention framework, the Mental Health Commission of Canada's promotion of a national mental health strategy across the country, and the plan for creating a national collaborative on suicide prevention.

Dialogue participants generally supported all three potential elements of a comprehensive approach to address the problem. They primarily focused on the first and second elements: 1) developing and implementing suicide-prevention strategies in ways that build on strengths, resilience and protective factors (element 1); and 2) fostering integration and coordination of new and ongoing efforts to prevent suicide within and across sectors and jurisdictions (element 2). Dialogue participants focused on the importance of celebrating and building on successes, which include those provincial/territorial strategies that exist and are being implemented. Most participants agreed about the importance of developing and supporting the implementation of a national suicide prevention strategy, although they grappled with who should lead the development of the strategy, who should be the client(s) for the strategy, and who could play a coordinating role in the execution of the strategy. The deliberation focused to a lesser extent on providing education and training in suicide prevention (element 3), which was felt to be handled within the other two elements. Two additional elements emerged during the deliberation, namely developing a path forward for societal transformation in relation to suicide prevention, and ensuring that research evidence gets used in policymaking and in decision-making more generally.

Many dialogue participants voiced their optimism and some expressed feelings of re-invigoration. Dialogue participants agreed that each of them as individuals could take steps given their respective roles, although some indicated that they could only make modest contributions given their lack of capacity, resources or both. Examples of potential contributions included: undertaking more advocacy efforts for a national strategy and ensuring that all of the existing strategies talk to each other; reaching out beyond traditional partners and taking advantage of serendipitous opportunities to address the issue; giving more strategic direction to what research gets funded and engaging communities in supporting its use; and keeping the conversation going to reflect on what can be done collectively, to showcase promising practices and to give a voice to particular communities.

SUMMARIES OF THE FOUR DELIBERATIONS

DELIBERATION ABOUT THE PROBLEM

The deliberation about the problem initially focused on the challenge of making suicide prevention a high priority public issue in Canada. Several dialogue participants suggested that contributors to this challenge include the lack of political will at different levels of government, and the absence of "political champions of the cause" that other countries have had. Other participants emphasized the lack of broader societal leadership as a key factor. One participant noted the "pervasive silence among society." This resonated with a second participant who said that "you don't see people rallying publicly around the issue." A third participant argued that the lack of public voice from survivors and those affected by suicide in Canada may have contributed to the silence as well as the lack of attention and sense of urgency brought to the issue. This participant cited the intense mobilization of survivors in the United States in the mid-1990s as being critical in getting suicide prevention on the U.S. federal government's agenda.

While agreeing that there was a general lack of public awareness, one dialogue participant observed that the suicide prevention community is often "preaching to the converted," and this individual took low membership numbers in suicide-prevention organizations as an indication of this. Several participants acknowledged the need to undertake more public-outreach activities to raise awareness about suicide and to mobilize people to take action about suicide prevention. Another participant argued that everyone must be engaged in defining the problem, developing a shared understanding and vision about how to address the problem, and addressing the stigma associated with mental illness and suicide. This individual said: "We have a responsibility, as a society, to own this issue."

Dialogue participants identified a number of key features of the problem that also contributed to the challenge: 1) the complex nature of the problem; 2) the stigma associated with suicide; 3) the limited capacity to trigger meaningful societal transformation; 4) the fragmentation of efforts across the country; and 5) the lack of applied and community-driven research.

The complex nature of the problem was the first of the features of the problem to be discussed. One participant argued that the "challenge in defining the problem is that we do not want to miss anything. There are so many entry

Box 1: Background to the stakeholder dialogue

The stakeholder dialogue was convened in order to support a full discussion of relevant considerations (including research evidence) about a high-priority issue in order to inform action. Key features of the dialogue were:

1) it addressed an issue currently being faced in Canada;
2) it focused on different features of the problem, including (where possible) how it affects particular groups;
3) it focused on three elements of a comprehensive approach (among many) for addressing the policy issue;
4) it was informed by a pre-circulated evidence brief that mobilized both global and local research evidence about the problem, three elements of what could be a comprehensive approach for addressing the problem, and key implementation considerations;
5) it was informed by a discussion about the full range of factors that can inform how to approach the problem and possible options for addressing it;
6) it brought together many parties who would be involved in or affected by future decisions related to the issue;
7) it ensured fair representation among policymakers, stakeholders and researchers;
8) it engaged a facilitator to assist with the deliberations;
9) it allowed for frank, off-the-record deliberations by following the Chatham House rule: "Participants are free to use the information received during the meeting, but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed"; and
10) it did not aim for consensus.

Participants' views and experiences and the tacit knowledge they brought to the issues at hand were key inputs to the dialogue. The dialogue was designed to spark insights – insights that can only come about when all of those who will be involved in or affected by future decisions about the issue can work through it together. The dialogue was also designed to generate action by those who participate in the dialogue, and by those who review the dialogue summary and the video interviews with dialogue participants.

points." A few participants cautioned the group against conflating mental illness and suicide, and expressed the need to consider the broader determinants of health to fully grasp the problem. One participant illustrated this complexity by stating that suicide rates among First Nations, Inuit and Métis may be rooted in the process of colonization and acculturation: "It's a process when two cultures collide. We need to understand how to deal with this. We need to face the problem head on. We have tended to dance around the issue."

The stigma associated with suicide was also identified by several participants as a key feature of the problem. According to one participant, stigma has not only been observed within the general public, but also in the healthcare sector. This participant argued that some health system decision-makers may also have their own prejudices about suicide, and hence are perhaps not as sensitive to issues of timely access to mental health services for people with suicide-related behaviours as they are to access problems in other healthcare domains such as cancer screening or diagnosis. This individual commented: "I never get a call from people in the mental health area.… In no other domain is it acceptable for a three-year delay."

Reflecting back on the complexity of the issue and the pervasive stigma associated with suicide, one dialogue participant observed that there was limited capacity to trigger meaningful societal transformation. This individual commented: "Our [health] system doesn't have the capacity to transform everything on its own."

Dialogue participants also argued that suicide-prevention efforts are fragmented across the country. One participant pointed out that there are a lot of promising initiatives across the country, but that current institutional arrangements posed communication and coordination challenges: "There is a lot of great stuff happening. We need to communicate with governments, stakeholders and non-governmental organizations who are passionate about this issue, but who do not have the resources and mechanisms to address this on their own." A second dialogue participant argued that Canada's federal government could play a similar role to the World Health Organization, which in this case would mean supporting the creation of a vision for provinces and territories, making strategic investments to support this vision, developing guidelines, and fostering inter-provincial/territorial communication, but without telling provinces and territories how to achieve the vision or becoming involved in the delivery of programs and services. A third dialogue participant mentioned that there are simple policy levers available at the federal level that "don't cost a penny," such as developing regulations that mandate the erection of suicide barriers on new bridges.

The lack of applied and community-driven research was also identified as a key feature of the problem. A few participants expressed the need to articulate more clearly shared beliefs, values and principles that could guide research, but also to conceptualize "success" more explicitly. One individual said: "It would be great to talk more openly about what we could expect. How can we make positive contribution? This ideation is the linchpin to all of this. We need a path that a group of people can look to for success." However, beyond seeking more applied and community-driven research, participants were clear that the related challenge was identifying how to get research evidence accessed, understood and used.

While significant attention was given to the problems and its many features, several dialogue participants expressed cautious optimism about the priority being accorded to suicide prevention, citing the recent introduction of a private member's bill in Canada's federal parliament calling for a national suicide prevention framework, the Mental Health Commission of Canada's development and promotion of a national mental health strategy across the country (despite the jurisdictional fragmentation it faced), and the plan for creating a national collaborative on suicide prevention.

As one dialogue participant pointed out, the success of the Mental Health Commission of Canada rested on its ability to develop a strategy that is "framed as adaptable and non-interfering" and that relies on a constant dialogue with all relevant stakeholders. Reflecting on the experience of the Commission, this participant was enthusiastic about the groundbreaking work achieved, but remained cautious: "We may have broken some of the ground, but it's not going to change fundamentally the constitutional landscape of this country."

The collaborative was identified as a promising initiative to support greater coordination and communication across the country in the specific area of suicide prevention. The idea of a "collaborative" resonated with many participants, with one individual mentioning that the concept was more alive than a "strategy" or a "framework."

In concluding the deliberation about the problem, one participant noted: "I'm encouraged by the tone of discussion. In the past, there was a lot territoriality."

DELIBERATION ABOUT ELEMENTS OF AN APPROACH TO ADDRESS THE PROBLEM

The deliberation about elements of what could be a comprehensive approach to address the problem focused primarily on developing and implementing suicide-prevention strategies in ways that build on strengths, resilience and protective factors (element 1), and fostering integration and coordination of new and ongoing efforts to prevent suicide within and across sectors and jurisdictions (element 2). The deliberation focused to a lesser extent on providing education and training in suicide prevention (element 3), which was felt by some dialogue participants to be handled within the other two elements. Two additional elements emerged during the deliberation, namely developing a path forward for societal transformation in relation to suicide prevention, and ensuring that research evidence gets used in policymaking and in decision-making more generally.

Element 1 – Develop and implement suicide prevention strategies in ways that build on strengths, resilience and protective factors

The deliberation about the first potential element of a comprehensive approach to addressing suicide initially focused on the importance of celebrating and building on successes, which include those provincial/territorial strategies that exist and are being implemented. Most participants agreed about the importance of developing and supporting the implementation of a national suicide prevention strategy. However, one participant argued nobody could be against such a proposal, but that the problems are determining who is going to lead the development of the strategy, and what interventions should be incorporated in the strategy. This participant cautioned the group about re-inventing the wheel and argued that a dozen key documents and strategies already existed. This individual instead advocated for a national process to develop a new "shopping list" of suicide-prevention interventions, mentioned having a "déjà vu feeling", and was worried about getting involved in preparing a "nice document" that would ultimately lead nowhere.

The deliberation about the first element also focused on finding a client for a national strategy and a lead government or organization that could play a coordinating role in the execution of the strategy. One participant mentioned the need to develop such a strategy through a meaningful partnership with federal, provincial and territorial partners to ensure that they "see themselves" in the strategy, and that their own work is given momentum - not undermined - by it.

A few dialogue participants expressed the need to "catch the current wave" of interest in suicide prevention. For example, several participants wanted to see the group build on the momentum created by recent federal initiatives such as the sponsorship of the Mental Health Commission of Canada and the Canadian Institutes of Health Research's Pathways to Health Equity for Aboriginal Peoples. A few participants were also encouraged by the recent federal private member's bill calling for a national framework for suicide prevention. One participant said: "If the government didn't want the private bill to go further, it would have been abandoned. So I'm encouraged by that. At a minimum, it calls for a consultation and a federal framework, and for best practices that need to be shared. That kind of leadership is important. It is a signal." While acknowledging that the bill's introduction is a step forward, one participant pointed out that the bill fails to identify a coordinating body to support the development and implementation of a national strategy. Another participant expressed skepticism about the capacity of the Mental Health Commission of Canada to

tackle suicide as an issue given that it only has four and a half years remaining in its mandate and no dedicated funding to take on this issue as a priority.

Finally, one dialogue participant emphasized the need to attach clear targets to a national suicide prevention strategy. This participant noted that initiatives in Canada rarely have suicide prevention targets like they do in the United States where strategies regularly aim for a 15-20% reduction in suicide rates.

Element 2 – Foster integration and coordination of new and ongoing efforts to prevent suicide within and across sectors and jurisdictions

Two themes emerged during the deliberation about the second potential element of a comprehensive approach to address the problem. First, several dialogue participants expressed the need to establish a coordinating body that could develop and maintain a well-functioning collaborative on suicide prevention. As one participant observed: "A collaborative is one approach to deal with the fragmentation." A second participant illustrated this fragmentation by describing the difficulty encountered when trying to identify who, if anyone, is the suicide prevention coordinator in many provinces and territories. A third participant noted that the proposed collaborative could support greater knowledge translation and exchange within and across jurisdictions. While a new national collaborative for suicide prevention could play such a coordinating role, some participants expressed doubt that it would be adequately resourced to play this role effectively. One idea floated by a dialogue participant was to consider the possibility of extending the mandate, term and funding for the Mental Health Commission of Canada to enable it to take on this role.

Second, a few dialogue participants argued for a key first step to be identifying the clients who may be interested in initiatives to foster integration and coordination. Two participants suggested engaging private sector partners as actors in their own right and as potential funders for integration and coordination initiatives. These participants believed that some Canadian companies could make a significant commitment to a public/private collaborative.

By the end of the deliberation about element 2, one participant was still grappling with who could or should assume leadership for integration and coordination, and what type of process would be needed to get there. This participant observed that the group was still hesitating between two options for how to move forward: one where the federal government appoints a department or agency to take on this role, and a second where an organization steps forward and assumes a leadership role.

Element 3 – Provide education and training in suicide prevention

Many dialogue participants argued that the third potential element of a comprehensive approach – providing education and training in suicide prevention – was essential. As one participant said: "Regardless of what happens with a strategy and coordinating body, education is essential."

Several participants supported the idea of engaging people through a number of different channels (e.g., Canadian Association of Retired Persons and survivors' networks). Such engagement could equip individuals with the tools to identify and respond meaningfully to suicide-related behaviours, but also help them navigate the system. Public engagement initiatives could also familiarize people with some of the key risk and protective factors, and consequently reduce the stigma associated with suicide. One participant emphasized the need to learn from other jurisdictions, like Scotland, that have implemented successful anti-stigma campaigns.

This element was also perceived as essential to create demand among citizens, health workers and others for effective programs and services, and for well-functioning and responsive health systems and supportive public policies.

One dialogue participant emphasized the need for better engagement and mobilization of existing survivors' networks, and for the creation of a speakers' bureau so that survivors can play a key role in education and training. This participant pointed out that it was unacceptable that suicide survivors and many health professionals were left on their own to learn about suicide, and emphasized the need to be proactive in reaching out to survivors instead of leaving them on their own: "Those survivors are not reached out to at the beginning of their journey." This resonated with another participant who reiterated that some of the accomplishments in the United States resulted from survivors who were passionate about making a difference, and mobilized a movement by reaching out to other survivors.

Considering the full array of options

Dialogue participants generally supported all three potential elements of a comprehensive approach to addressing the problem, although, as noted previously, element 3 (education and training) was argued by several participants to be covered by elements 1 and 2. Greater survivor engagement was described as a cross-cutting priority that could support the development and implementation of suicide prevention strategies, foster greater integration and coordination of new and ongoing efforts, and be a key part of education and training in suicide prevention.

Most dialogue participants also supported new, complementary elements of a comprehensive approach, namely developing a path forward for societal transformation in relation to suicide prevention, and ensuring that research evidence gets used in policymaking and decision-making more generally. Several dialogue participants argued that the societal transformation needed to address the full spectrum of contributors to suicide risk. One participant remarked: "Our society has normalized suicide. We need to de-normalize suicide as a precondition to address suicide prevention." Other dialogue participants argued that getting research evidence used in decision-making requires many distinct sub-elements, such as: 1) sponsoring more community-driven research (so that the research is relevant to the communities who need it); 2) establishing the principle of shared ownership for the research produced with community input (so that the research is done with and for community members and not "to them"); 3) requiring evaluation as a condition of funding (so that the research identifies which innovations warrant continued or broader use and which require modifications or replacement); 4) acknowledging explicitly the equal importance of different sources of knowledge, such as tacit knowledge and Indigenous knowledge (so that the place of research knowledge alongside other forms of knowledge is appropriately recognized); 5) articulating shared beliefs, values and principles within which research and other forms of knowledge will be considered (so that decision-making can begin with a shared understanding of what are and are not considered broadly acceptable ways forward); and 6) ensuring a place for research evidence in decision-making and better supporting its use in decision-making (so that there is more knowledge application).

DELIBERATION ABOUT IMPLEMENTATION CONSIDERATIONS

Dialogue participants identified three main barriers to implementing the key elements of a comprehensive approach to preventing suicide in Canada: 1) absence of strong leadership; 2) absence of a clear client; and 3) difficulty in articulating what constitutes success.

In deliberating about addressing the first barrier – absence of strong leadership – a few dialogue participants argued that Bill C-300, while opening a window of opportunity to bring about change, does not specify who should take leadership, or in other words, who should be "behind the wheel." Participants debated about who should play a leadership role and who should play a coordinating role. One participant said it would be difficult for a primarily volunteer-based organization to assume a leadership or coordinating role, which are better suited to an organization with sustainable funding and a reasonably sized permanent staff. A second participant suggested that if the goal is to have funds attached to any initiative then it should be a

governmental body playing a leadership and coordinating role. A third participant disagreed with the idea that leadership and coordination should be based within a government department or a government-supported agency. This participant argued that much can be accomplished with existing structures and grassroots organizations, and noted: "Leadership can happen in very different ways. And it doesn't always involve funding. Sometime it does, but not always. Some things may be built from grassroots."

For the second main barrier – absence of a clear client – a few dialogue participants commented that, in the absence of a clear client who could take ownership of the issue, the focus should turn to identifying key partners (e.g., health charities, professional associations, faith-based organizations, industry and unions) who could be brought to the table and who could push forward the suicide-prevention agenda. While acknowledging the need to involve industry partners, one participant believed that it could be a "hard sell" since some companies may not want their products associated with suicide.

Finally, some participants argued that the third main barrier to implementing a comprehensive approach for suicide prevention – difficulty of articulating what constitutes success – is made particularly challenging by how different partners often don't share the same beliefs and values. One participant illustrated the challenge by stating that "for political leadership, success means more than numbers." Another participant suggested that to overcome this barrier, it may be necessary to convene a smaller executive group that could steer the development of a strategic plan that articulates what constitutes success, and identifies priorities for achieving success in the next five years.

DELIBERATION ABOUT NEXT STEPS FOR DIFFERENT CONSTITUENCIES

When the focus of deliberation turned to next steps for different constituencies, many dialogue participants voiced their optimism and some expressed feelings of re-invigoration. One participant noted: "We are at this tipping point. We can't let that momentum pass by." Dialogue participants agreed that each of them as individuals could take a number of steps given their respective roles, although some participants indicated that they could only make modest contributions given their lack of capacity, resources or both. As one participant said: "I can't take grandiose steps.… I can only take small steps." Examples of individuals' potential contributions, given their organizational roles, included:

1) undertaking more advocacy efforts for a national strategy in order to reach the general public and decision-makers, and placing greater emphasis on ensuring that all existing strategies talk to each other and that all existing initiatives (even within a given jurisdiction) are well coordinated ;
2) reaching out beyond traditional partners to raise awareness and understanding about the magnitude and complexity of the issue (and to address stigma), and taking advantage of "serendipitous opportunities" to address the issue (such as the new Québec Health minister's call for a new public health policy in which mental health promotion and suicide prevention could be integrated);
3) giving more strategic direction to what research gets funded, attracting more investigators to the area, and engaging communities using effective knowledge-translation mechanisms; and
4) keeping the conversation going (possibly through the national collaborative for suicide prevention, and through one-off events such as the workshop on suicide prevention that is being convened by the Canadian Institutes of Health Research, and the youth summit on suicide prevention that is being considered) to reflect on what can be done collectively, to showcase promising practices, and to give a voice to particular communities.