Preventing and Reducing the Risk of Suicide

A Framework for Nova Scotia

NOVA SCOTIA

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January 2020

Health and Wellness

ISBN: 978-1-989654-29-3

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Executive Summary

Over 100 Nova Scotians lose their lives annually to suicide and hundreds more make a suicide attempt. It is an issue that impacts individuals, families, and whole communities throughout the province. Suicide and attempted suicides typically result from a combination of factors, the most significant of which are severe mental illness, including substance use disorders. As with other health issues, risk for suicide is also impacted by a range of social and economic factors such as income and education.

Preventing and Reducing the Risk of Suicide: A Framework for Nova Scotia is intended to provide a guiding framework under which collaborative action can occur across sectors to reduce the burden of suicide in the province. The objectives of the framework are as follows:

- Build on the implementation of the 2006 Framework to Address Suicide to provide a renewed approach based on current evidence and opportunities.
- Enhance understanding of suicide in Nova Scotia by providing an updated statistical picture.
- Recommend an action-oriented approach to suicide prevention and risk reduction for Nova Scotia that is informed by data monitoring, evaluation, and research.
- Highlight work already underway that can further contribute to suicide prevention and risk reduction in Nova Scotia.
- Identify gaps in services, supports, and knowledge with respect to suicide prevention and risk reduction.
- Recommend steps forward for stakeholders to find or strengthen their role in working together to reduce the risk of suicide in Nova Scotia.

Development of this framework was informed by several guiding documents, literature reviews, key informant interviews, and input from academic advisors. The framework builds on previous and current efforts of community, government, and the health care system to prevent and reduce the risk of suicide and suicide attempts. Significant efforts are already underway in areas that support the objectives of this framework including, but not limited to, integrated service delivery, improved data sharing, investments in youth health and mental health and addictions services, and support for community programming.

The framework has 20 recommendations organized within 6 areas of action which are summarized in Appendix A. The areas of action span the individual, health system, community, and societal levels along with improved surveillance and evaluation. Implementation will require a phased approach and collaboration across sectors including various government departments, community organizations, and the health care system. Specific actions, programs, and policies to implement the recommendations in this framework will be identified in collaboration with key stakeholders. Collectively and collaboratively we will address suicide risk factors and strengthen supports to reduce the rate of suicide in Nova Scotia.

Introduction

Suicide is a serious public health issue[i] in Nova Scotia. Each death and attempted suicide is a tragedy that impacts individuals, families, and our communities. Yet many suicides are preventable.

What causes suicide? There is no easy answer. A combination of biological, psychological, social, cultural, and environmental factors can influence suicidal thoughts and behaviours. Stressful situations or experiences that cause emotional pain, such as death of a loved one, financial problems, trauma, or change in health, are associated with risk of suicide.[1] In Canada, suicide affects certain segments of the population disproportionately, such as some Indigenous communities, 2SLGBTQQIA (Two-Spirit, Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Intersex, Asexual) communities, veterans, and youth.[2]

Suicide is often the result of emotional pain combined with hopelessness.[3] People who have suicidal thoughts may not see any other option for resolving the hopelessness or adversity they are experiencing.[4]

Evidence is clear that severe mental illness (specifically clinical anxiety and depression in Nova Scotia) is one of the most significant risk factors for suicide; substance use disorders pose a more significant risk in suicide attempts.[5,6] Risk increases for people who experience more than one illness or multiple psychiatric conditions.[7] Evidence also shows that it is often the influence of multiple factors that leads someone to die by suicide. Other risk factors for suicide are a prior suicide attempt, substance abuse or gambling, job loss, chronic pain or illness, hopelessness, family history of suicide, family violence or neglect, and/or self-harming behaviour.[8,9]

There are interventions at the individual, health system, community, and societal levels that can help prevent or reduce the risk of suicide. Some interventions are specific to the health care system, such as quality standardized training of doctors, nurses, and other primary health care professionals for suicide screening.[10,11] Other interventions provide community-based capacity to assess, treat, and provide follow-up care to people at-risk of suicide.[12] Non-government organizations also help to prevent suicide in Nova Scotia by providing clinical services, support groups, and resource hubs.

[i] Suicide prevention requires working at a population level to reduce disparities with interventions that address the social determinants of health while promoting health care equity, quality, and accessibility.

Upstream interventions at a population level are also needed to address social issues that correlate to higher risk of suicide including poverty, racism, discrimination based on gender identity or sexuality, and/or the legacy of marginalization and colonization. These whole-of-society challenges necessitate a response that goes well beyond the parameters of health care. Effective programs, services, and policies require collaboration of communities, the justice sector, the media, schools, workplaces, and social services.[13]

This framework is intended to guide the implementation of evidence-informed interventions at the health system, community, and societal levels, as well as support data collection and evaluation to demonstrate effectiveness of interventions. It outlines six Areas of Action:

1. Improve suicide-related data monitoring and evaluation;
2. Identify and support people at risk;
3. Strengthen health system capacity,
4. Extend access to services and supports in the community;
5. Address targeted social issues identified as increasing risk; and,
6. Strengthen upstream prevention.

These categories span a whole system of influences, including the individual, community, and societal levels, as well as the intersections between them. Collectively and collaboratively we will address suicide risk factors and strengthen supports to reduce the rate of suicide in Nova Scotia.

Background

In 2006, *Nova Scotia's Strategic Framework to Address Suicide* was developed and released by the provincial government following consultation with individuals and organizations dedicated to addressing suicide. This framework served as a guide for the collective work of stakeholders and government. A steering committee provided ongoing advice and direction to the implementation of the framework from 2007–2012. The strategic goals of the framework focused on six key areas: leadership, infrastructure, and partnerships; awareness and understanding; prevention; intervention; postvention; and knowledge development and transfer.[14]

Key initiatives were completed in the years following the release of the framework, including research into postvention,[15] a data report on suicide and suicide attempts,[16] and support for community programming. In May 2012, the Province of Nova Scotia launched its first mental health and addictions strategy, *Together We Can: The plan to improve mental health and addictions care for Nova Scotians*. This five-year plan further elevated the focus on suicide prevention for the Department of Health and Wellness.[17]

In 2017, the Province of Nova Scotia accepted recommendations from the Cape Breton Situation report[18] and committed to renew the Strategic Framework to Address Suicide. In 2018, the Department of Health and Wellness began working on this renewed strategic framework by reviewing strategies, frameworks, reports, and research from Canada and around the world.

The actionable steps and principles set out by the World Health Organization's (WHO) *Preventing Suicide: A Global Imperative* (2014)[19] and the Government of Canada's *Working Together to Prevent Suicide in Canada – The Federal Framework for Suicide Prevention* (2014, 2016)[20] play a key role in guiding the areas of focus for the renewal of the Nova Scotia Framework. To ensure a suicide prevention and risk reduction framework for Nova Scotia is effective in supporting the suicide prevention efforts of Indigenous communities, this framework also draws on the First Nations Mental Wellness Continuum Framework[21] and the National Aboriginal Youth Suicide Prevention strategy (NAYSPS)[22] in addition to the knowledge held by Elders and community members.

The Nova Scotia Health Authority (NSHA) and IWK's joint report *Milestones on our Journey*[23] also informed the development of this framework. It describes the full continuum of care that parallels the Mental Health and Addictions stepped care model, from universal population health approaches (in Tier 1) to highly specialized care for those with complex needs (in Tier 5).

In addition to establishing working groups focused on the areas of action, the Department of Health and Wellness (DHW) conducted interviews with key informants from academia, health care services, community-based organizations, cultural groups, and individuals who provide care to populations at higher risk. Information gathered through this engagement process informed this document and sets the stage for further cross-sector collaboration on suicide prevention and risk reduction in Nova Scotia.

Objectives of this Framework

The purpose of this framework is to guide the implementation of evidence-based actions to reduce the rate of suicide in Nova Scotia. The overall objectives of this framework are to:

- Build on the implementation of the 2006 Framework to Address Suicide to provide a renewed approach based on current evidence and opportunities.
- Enhance understanding of suicide in Nova Scotia by providing an updated statistical picture.
- Recommend an action-oriented approach to suicide prevention and risk reduction for Nova Scotia that is informed by data monitoring, evaluation, and research.
- Highlight work already underway that can further contribute to suicide prevention and risk reduction in Nova Scotia.
- Identify gaps in services, supports, and knowledge with respect to suicide prevention and risk reduction.
- Recommend steps forward for stakeholders to find or strengthen their role in working together to reduce the risk of suicide in Nova Scotia.

Specific actions, programs, and policies to implement the recommendations in this framework will be identified in collaboration with key stakeholders.

Understanding Suicide in Nova Scotia

Statistical information about suicide in Nova Scotia is available, including data from provincial sources (described below) as well as Statistics Canada at the federal level. Key points are summarized below to describe suicide and suicide attempts in the province, as well as trends over time. For further statistical information beyond this summary, please refer to Appendix B.

Suicide mortality in Nova Scotia between 2007–2016[24] indicates:

- 1,124 Nova Scotians lost their lives to suicide, an average of 112 per year.
- Suicide rates fluctuate each year, but the overall trend is upward.
- The majority of suicides (77%) were by males, with 23% of suicides by females. However, in an earlier 10-year period (1994-2004), only 16% of suicides were by females.
- 65% of suicides occurred in urban areas, where 69% of the population lives, compared to 35% of suicides in rural areas where 31% of the population lives.
- The following populations had the highest rates of death by suicide:
  - Individuals between the ages of 45–59 years;
  - Males across all age groups except 10–14 years;
  - Individuals with an annual income of $30,000 or less;
  - While rates are highest among those with higher educational attainment, actual numbers of deaths are highest among those with no certificate, diploma, or degree.
- The most commonly used method for suicide is hanging/strangulation/suffocation, followed by poisoning and firearms for men, and poisoning and drowning/submersion for women.
- 68% of those who died by suicide had a diagnosed mental illness in the two years prior to their death. In that group, anxiety and depression were the most prevalent conditions.[ii]

[ii] Some individuals without a mental illness diagnosis may have been living with an undiagnosed mental illness.

Data on suicide attempts in Nova Scotia, specifically for 2011–2016 reveals:[25]

- 13,746 Nova Scotians attempted suicide, 2,979 of these were hospitalized.
- Attempts were more common among males, but hospitalizations for attempts were more common among females (59%);
- 75% of suicide attempts occur in urban areas, compared to 25% in rural areas.
- The populations with the highest rates of suicide attempts were:
  - Individuals over the age of 80, followed by those aged between 45–49 years, however, number of attempts were highest for those 50–54 years old.
  - Individuals with an annual income of $30,000 or less;
  - Individuals with higher educational attainment, however, actual number of attempts are highest among those with no certificate, diploma, or degree.

Specific hospitalization data regarding suicide attempts in Nova Scotia, 2007–2016[26] indicates:

- There were 4,848 hospitalizations for suicide attempts. While there was some variability each year, the rate of hospitalizations due to suicide attempts has not changed significantly over time.
- Poisoning is the most common method of attempted suicide, followed by cutting/piercing, for both males and females. Youth aged 10–19 years are more likely to use anti-inflammatory, pain relief, or arthritis drugs, while adults are more likely to use antiepileptic, sedative-hypnotic, anti-parkinsonism, and psychotropic drugs.
- Among those hospitalized for a suicide attempt during this time period, 38% had been diagnosed with a mental illness (based on their health records for the two years before attempt). Among that cohort, substance use disorder and anxiety were the most prevalent diagnoses.

Little data related to diversity and inclusion of specific population groups and suicide, such as non-binary gender statistics or ethnicity, is available for Nova Scotia. While these statistics are only a snapshot of suicide in Nova Scotia, the upward trends noted over the past decade demonstrate that suicide is a public health issue of concern.

Areas of Action

This framework is organized into six Areas of Action where interventions have been demonstrated to be effective at preventing or reducing the risk of suicide. Each Area of Action contains recommendations for moving forward.

The individual, community, and societal factors that lead to suicide are complex and cannot be resolved with a single strategy or approach. Recommendations in this framework stand on their own as necessary pieces of work, however each is insufficient on its own to create broad-based, impactful change. It is important that work within all Areas of Action move forward in an intentional, collaborative way for suicide prevention and risk reduction to occur in Nova Scotia.

Improve Suicide-Related Data Monitoring and Evaluation

Suicide research is growing, helping to develop a better understanding of suicidal behaviours and how best to prevent and reduce the risk of suicide. Consistent and on-going data monitoring and timely evaluation of interventions for suicide prevention are essential to ensure that good data and information guide program delivery, policy development, and decision-making.

Studies on suicide interventions often rely on self-reported information such as suicidal thoughts, but stigma may lead to response bias and limitations to the validity of the results. Other forms of research depend on quantitative data tracking deaths, hospitalizations, and interactions with the health system, while others examine circumstances that may lead an individual to be at risk of suicide. There are limitations and gaps in the data available regarding suicide in Nova Scotia that require attention.

As data and information become easier to access in Nova Scotia, there is potential to improve our understanding of death by suicide and suicide risk factors. Currently, data that is relevant to suicide in Nova Scotia is housed within separate information systems with different access policies among Department of Health and Wellness, NSHA and IWK, the departments of Community Services, Education and Early Childhood Development, Justice, and Labour and Advanced Education, academic researchers, and non-government organizations. There is work underway across government to establish data-sharing agreements, which will help ensure that departments and stakeholders with a role in suicide research, evaluation, and policymaking are able to access data and develop a more comprehensive picture of the issue.

The evaluation of interventions for suicide prevention can provide valuable information about their effectiveness and can help to determine whether interventions are likely to be impactful if scaled up and spread across the province. Consistent evaluation provides information that should be shared among all stakeholders for a more comprehensive understanding of how best to address the issue. Programs that build monitoring and evaluation into their development and implementation are better poised to collect, analyze, and share important information on suicide; gaps and/or limitations in existing data may also be uncovered through robust evaluation efforts. Importantly, these principles also apply to the evaluation of this framework.

Globally, it is well understood how to establish an effective system that gathers and shares information about suicide.[27] To better understand the pathways to suicide in Nova Scotia, there is a need to collect, share, and examine relevant data and information about Nova Scotians at risk of suicide, as well as evaluate interventions aiming to prevent or reduce the risk of suicide.

Recommendations

SM1: Leverage existing efforts to ensure data is easily shared across government and readily available and accessible to suicide prevention stakeholders.

SM2: Identify and resolve gaps in clinical and non-clinical suicide-related data and information, with a focus on better understanding the factors that affect populations and communities in Nova Scotia where there is greatest risk of suicide.

SM3: Ensure all programs, interventions, and policies that intend to prevent or reduce the risk of suicide include a plan for ongoing monitoring and evaluation, including this framework.

Identify and Support Populations at Risk

Risk and protective factors related to suicidal behaviour are summarized in the tables on pages 11 and 12. Each individual factor is complex, even more so when their interrelationships and individuals' highly personalized experiences with them are considered. It is also important to understand that even though risk factors in particular are important to understand and mitigate where possible, they are not necessarily predictive warning signs. However, both risk and protective factors exert a powerful influence on suicidal behaviour.

People who have previously attempted suicide and/or have experienced mental illness, harm from substance use or gambling, a recent loss, poor physical health, family violence, and trauma are at a higher risk of suicidal behaviour and death.[28] Suicidal thoughts and behaviour may arise with situations of adversity or stress, such as interpersonal conflicts, economic hardship, bullying, harassment, discrimination, issues with identity formation (e.g. personal, sexual, gender, cultural), or exposure to traumatic experiences such as abuse, war, or natural disasters. [29] Intergenerational trauma, cultural losses, systemic racism, discrimination, incarceration, and social upheavals are linked to higher levels of trauma and mental health conditions.[30]

An individual's physical, cultural, and social circumstances can result in greater risk of suicide.[31] A 2009 report released by the former Nova Scotia Department of Health Promotion and Protection showed that suicide mortality was highest among Nova Scotians in the lowest income quartile compared to other income quartiles[32] — this remains true today (see section on "Understanding Suicide in Nova Scotia"). At the national level, specific segments of the population have higher rates of suicide, including incarcerated people, Inuit populations, members or veterans of the Canadian Armed Forces, and people who have experienced trauma.[33]

Compared to the non-First Nations population, the rate of suicide is disproportionately higher for First Nations people in Nova Scotia; the rate is nine times higher for First Nations males aged 20–39 when compared to the same age/sex category in the non-First Nations Nova Scotia population.[34] Comprehensive research on other historically marginalized communities in Nova Scotia such as African Nova Scotian and 2SLGBTQQIA communities is needed.

Population change influenced by international immigration to Nova Scotia highlights another consideration related to suicide. Between July 2017 and July 2018, the province's population increased by 9,262, with international migration accounting for 80% of this increase.[35] Acculturative stress — stress usually experienced by immigrants resulting from the adaptation to new cultures, norms, values, lifestyles, and practices — is linked to risk of suicide.[36,37] Suicide-related considerations for this population group should also be examined.

Protective factors are the characteristics and skills within individuals, families, communities, and wider society that help people cope with stressful events or life circumstances. Protective factors can include positive socioeconomic status, loving parent-child relationship, social connectedness, sense of belonging, and access to treatment, among others.[38] Although important, protective factors cannot entirely mitigate risk factors for all individuals. Evidence from Scotland shows that it is critical to target and build protective factors for individuals at elevated risk of suicide and within populations known to have

elevated suicide risk.[39] The ability of the individual and their caregivers to build skills in problem solving and social-emotional resilience can be facilitated not only at home or clinical settings but in schools, workplaces, and community settings. This must be layered with supportive policy and community action so the burden of change is not on the individual alone.

There is more we can do to better understand what works and what more is needed to prevent and reduce the risk of suicide in Nova Scotia. A cross-departmental exploration of how people who are at-risk of suicide interact with the province's health, justice, and social services systems could help identify areas for improvement in research, evaluation, programs, and policies. Similarly, valuable insight can also come from an examination of system touchpoints for people who have died by suicide.

Community-based organizations hold a vast amount of knowledge about their clients' experiences with a variety of government and non-government support services. This information could improve our understanding of the barriers and other challenges within those systems and help develop supports for people at risk of suicide.

Recommendations

IS1: Advance collaboration among community-based organizations and government departments to develop integrated service delivery approaches that support populations at risk of suicide.

IS2: Initiate a collaborative exploration of how people at-risk of suicide have interacted with the health, justice, education, and social services systems to better understand opportunities and barriers related to preventing and reducing the risk of suicide.

IS3: Create, maintain, and evaluate interventions and policies designed to improve protective factors, with a focus on populations with elevated risk factors for suicide and groups experiencing major stressors.

IS4: Ensure that all targeted interventions apply a trauma-informed care approach and are grounded in the lived experience of people and communities for whom it is intended.

Risk Factors for Suicide[40]

Individual	Relationship	Community	Societal
Previous attempt(s)	Family history of suicide or self-harming behaviour	Local epidemics of suicide	Easy access to lethal methods
Mental illness, particularly clinical depression	Family history of violence (e.g. child abuse or neglect)	Barriers to accessing mental health treatment	Unsafe media reporting practices
Addiction (substance or gambling)	Isolation and feelings of being cut off from other people	Lack of access to recreational opportunities and barriers to resources	Cultural and religious beliefs (e.g., belief that suicide is a noble resolution of a personal dilemma, or belief that older people have little value to the community)
Feelings of hopelessness, of being alone, or a burden to others	Interpersonal conflicts		Unwillingness to seek help because of the stigma associated with mental health or substance abuse, or to suicidal thoughts
Impulsive or aggressive tendencies	Peer victimization		Economic disadvantage (poverty, unemployment, homelessness)
Poor physical health, chronic illness, and/or pain	Harassment and/or discrimination		Substandard housing
A recent loss (relational, social, work, or financial)	Exposure to trauma		Inadequate health care
Limited problem solving or coping mechanisms			Low levels of education and literacy
Illness and disability, including loss of physical or mental functioning			
Problems with identity formation			

Protective Factors[41, 42, 43]

Individual	Relationship	Community	Societal
Strong self esteem Cultural identity Adaptive coping and problem-solving skills Identified reasons to live	Healthy relationship (i.e. familial and social connections)	Effective clinical care for mental, physical, and substance use disorders Easy access to a variety of clinical interventions and support for help-seeking	Responsible media reporting Restricted access to means of suicide Cultural and religious beliefs that discourage suicide and support self preservation

Strengthen Health System Capacity

Recent evidence from the United States demonstrates that many people who have died by suicide have had contact with health care providers in the months before their death.[44] The authors suggest that these interactions with the health care system may be considered opportunities to identify, assess, treat, and follow-up with individuals who may be at risk of suicide. It is important that health care providers have the tools and capacity to screen and assess the risk of suicide and appropriately treat, refer and follow up with people at risk.

Continued efforts to improve coordination in the delivery of health services in Nova Scotia are designed to enable better access to care, such as the coordination of Emergency Health Services (EHS), NSHA's Crisis Response Service, and 911; the shift towards team-based primary care, including circle of care and the circle of support programs; the vision for One Person One Record to track progress and share health information for individuals on their journey through different levels of care; expansion of e-Mental Health; and the initiation of Central Intake for NSHA and IWK Mental Health and Addictions, which seeks to improve access to community based mental health and addictions care through a single entry point, with consistent screening, assessment, and triage. These efforts are intended to enable the health system to respond to the needs of patients at risk of suicide more efficiently and effectively. In part, this work must involve a common language that provides clarity between mitigation of immediate and potential risk, as well as a population health approach, both of which are important and involve the health system in different ways. Realities within Nova Scotia's health system continue to cause significant challenges for those seeking support for mental health issues. These include insufficient integration across various sectors within the system

(e.g., acute care, primary care, urgent care, and mental health and addictions), as well as lengthy wait times for individuals to access non-urgent community-based mental health and addictions support — especially in rural areas of the province. Numerous efforts are underway to address these challenges within the system.

Suicide screening and assessment is a required organizational practice of Accreditation Canada for specific programs of care in Nova Scotia, including in Mental Health and Addictions Services, Emergency Departments, and some Long-Term Care facilities.[45] However, not all primary health care providers or allied health professionals are trained in suicide screening and assessment, which may result in patients being referred to care that is not the most accessible or appropriate for them. To ensure efficient and appropriate referral and care for people at risk of suicide, any gaps in capacity for suicide screening and assessment amongst health care professionals and allied health professionals should be identified and addressed.

Providers in other government sectors, such as Justice, Education, Community Services, and Labour and Advanced Education also support individuals at risk of suicide to access appropriate health system resources based on their mental health needs. An integrated, inter-sectoral approach to care is a system gap in Nova Scotia, but this type of coordination could help lead individuals at risk of suicide to access mental health and addiction supports in a more focused and timely way. Significant efforts are underway to improve integration of services, a goal that is shared across numerous government strategies, departments, and agencies. Examples of this include the Commission on Inclusive Education, the Restorative Inquiry into the Home for Coloured Children, and recommendations from the Truth and Reconciliation Commission of Canada.

For the health system to achieve the highest level of impact related to suicide prevention and risk reduction, it must be safe and comfortable for all Nova Scotians to use – especially for those who are at a higher risk of suicide. The Nova Scotia Department of Health and Wellness states that "a culturally competent health system provides services that respond to historical inequities, lived realities, diverse values, beliefs, and behaviours".[46] If Indigenous people, those who are 2SLGBTQQIA, or members of other marginalized groups do not feel that this level of cultural competence is available to them, significant barriers to help-seeking behaviour can result.[47] This is especially important as many historically marginalized communities also have an increased risk of suicide. An example of action in Nova Scotia is the recently released action plan *Count Us In* which is Nova Scotia's response to the UN's International Decade for People of African Descent. The *Count Us In Action Plan* includes an action for a collaborative approach between the Nova Scotia Health Authority, Department of Health and Wellness and other parts of government to co-develop a strategy with the African Nova Scotian community.[48]

It is important that people at risk of suicide can access health services that are trauma-informed.[49,50] This means that care providers take into account the possibility of past trauma and the resulting coping mechanisms when attempting to understand the patient and the urgency of care in the context of suicide risk. While some health service providers in Nova Scotia use trauma-informed approaches, further work is required to identify and address any gaps in how the health system delivers services with respect to this key concern.

Embedding services that directly support individuals at risk of suicide in 'non-traditional' settings such as community hubs, recreation centres, or educational centres improves access to support for clients and reduces the stigma associated with those services. There are examples in Nova Scotia of clinical resources being integrated into the suite of services offered by community-based organizations. A different approach has been taken in British Columbia with Foundry BC, a network of community-based access points for information and supports that uses a "storefront" approach to youth-focused service provision.[51] Approaches like this around the world have demonstrated promise in reducing barriers to service access amongst young people and improvement in clinical outcomes.[52] In Nova Scotia, health care providers are integrated into the education system to provide care for youth in the school setting. These include Youth Health Centres staffed by NSHA Public Health Services and school- and community-based mental health clinicians from NSHA and the IWK Health Centre as part of the SchoolsPlus model.

Other approaches leverage contacts made with primary health care providers who are trained on social prescribing: an intervention that seeks to link patients in primary care with local, non-clinical support targeted at meeting their social and psychological needs.[53] This kind of intervention can address some of the risk factors for suicide by assigning clients to appropriate services in their local communities. This is particularly relevant following discharge when there is increased risk of relapse of risk factors associated with suicide.[54]

The health system in Nova Scotia aims to provide high-quality service and has several important strengths that support people who are at risk of suicide. However, this system also has gaps related to capacity, accessibility, and safety that can have a significant impact on people at risk of suicide — including members of traditionally marginalized communities and people who have experienced harm from substance use and/or gambling. Further collaborative effort is needed to build on system strengths and work to address any inequities in access to care that exist among Nova Scotians at risk of suicide.

Recommendations

HS1: Identify and leverage opportunities to implement greater collaboration, communication, and integration of services for people at risk of suicide between the health system and other government departments (e.g., Justice, Education and Early Childhood Development, Community Services, Labour and Advanced Education).

HS2: Expand the capacity of health care providers to conduct suicide screening and assessment at appropriate system entry points that improves recognition of suicidal behaviours, conducts more effective referrals to supports within the health system, and informs appropriate treatment for people at risk.

HS3: Build on existing efforts to expand culturally competent and trauma-informed practice throughout the health system so all Nova Scotians, particularly those at higher risk of suicide, can access care that is safe, comfortable, and supportive.

HS4: Explore opportunities to implement more mental health and addictions service provision in non-traditional community settings.

HS5: Ensure that the assessment, treatment, and follow-up of individuals who have experienced harm from substance use and/or gambling includes suicide screening.

Extend Access to Services and Supports in the Community

Community is an important partner in the work towards the prevention of suicide and the mitigation of risk. Although research shows that many people at risk of suicide will turn to the health system for care,[55] we must also understand how to reach those who do not, including how and where they may seek help. It can be challenging for a person at risk to navigate the health system, especially those with low mental health literacy.[56] Often family, friends, and other supportive people and organizations in the community have a sense that someone may need help but are unsure about how to support them.

Typically, the term 'gatekeeper' has been broadly defined as the short-term psychoeducation programs that aim to build awareness and confidence among laypersons, or rather those without specialized training, to respond to those in crisis.[57] However, a lack of guidelines, consistency, and evaluation has left the concept of gatekeeping open to criticism and potential risk. Some research has offered a narrower

definition of gatekeeping that targets those who hold specialized training and may have regular interactions with individuals at risk.[58] This has included the school setting, military or veteran settings, and the medical setting, including nurses and physicians.

To ensure safety in the community, a consistent definition of gatekeeping should include robust guidelines focused on training for support persons who have a consistent connection to the individual at risk. For example, programs that identify and appropriately train a circle of support for an individual after a hospitalization related to suicide risk is also a practice that can prevent suicide.[59]

As mentioned in the previous section, the provision of community-based health services is particularly important for demographic groups that may have higher-risk of suicide and are less likely to access the health care system. Additional examples in Nova Scotia, like SchoolsPlus and the Fish Net Model in Eskasoni, have the capacity to identify, support, and follow up with at-risk individuals; they may also provide an environment that is more culturally or situationally comfortable and/or geographically easier to access for individuals at risk of suicide. Emerging evidence shows that youth-nominated circles of care and support, including community sources, are effective in reducing death.[60]

There may be other community sites and leaders that have the capacity to be a part of a broader approach to screening and follow-up of those at risk of suicide, particularly in communities that have lower rates of accessing health services. For example, faith-leaders[61,62] with counselling qualifications in African Nova Scotian communities provide an important extension of screening or care for individuals who may not otherwise feel comfortable accessing mental health and addiction services.

Other community roles involve education related to mental health literacy and stigma reduction programs, although these interventions do not show direct causal effect on the reduction of deaths, they are known to increase help seeking behaviours.[63]

These actions could potentially be implemented and evaluated as a part of layered approach modified from models like the Nuremburg Alliance for a customized Nova Scotian model that focuses on building strong relationships with health care to enhance screening and follow up.[64]

Recommendations

C1: Strengthen and extend community-based supports and services in support of individuals at-risk of suicide, particularly in communities that may have higher rates of suicide.

C2: Expand efforts to evaluate and provide targeted gatekeeping training as appropriate to community-based organizations and individuals who may regularly come into contact with people at risk of suicide.

Address Targeted Social Issues Identified as Increasing Risk

Several targeted, non-clinical interventions have emerged that show promise in reducing suicide risk at a societal level.

Access to lethal means, such as firearms, medications, and poisons increases the risk for suicide.[65] Information on the most common means for suicide and hospitalizations due to suicide attempts is available, but more can be done to use this information to guide effective means restriction in Nova Scotia.

Inappropriate media reporting, such as gratuitous coverage of celebrity suicides, unusual methods of suicide, suicide clusters, or normalizing suicide as an acceptable response to crisis or adversity, can increase suicidal behaviour among those at risk.[66] The availability of inappropriate portrayals of suicide and uncensored suicidal acts on social media and the internet are of particular concern, as controlling these sources is challenging.[67] Emerging research in these areas provides some insight, however, as promoting responsible media reporting of suicide and understanding the harms of social media can reduce suicide contagion and possibly reduce stigma for help-seeking behaviours.[68,69]

Alcohol and gambling are publicly regulated products, the use of which are risk factors for suicidal behaviour.[70,71] Public policy approaches that are effective in reducing harmful alcohol use can reduce the risk of suicide.[72] Although harm from gambling is considered a risk factor for suicide, less is known about the impact of policies aimed at reducing harmful gambling on suicide rates — in part because harm from gambling frequently occurs in combination with other mental health and addictions issues, and causal pathways between those factors have yet to be completely untangled.[73] However, a significant enough relationship has been established between alcohol, gambling, and suicide to warrant the inclusion of a suicide lens in the development of public policy related to both types of products.

The stigma and discrimination associated with mental illness and suicide makes many feel unable to seek help for fear of shame, guilt, and isolation.[74] Structural and systemic issues create challenges that are disproportionately faced by people who experience risk factors for suicide. Uneasiness with talking about suicide stems from cultural and religious norms and fear of worsening the problem by discussing it. People who have lost loved ones to suicide or are caring for individuals at risk of suicide are also impacted by this stigma.[75] They may fear or experience negative consequences or isolation due to their association with a person who has attempted or died by suicide. People are more likely to seek help if they do not experience stigma, which is an important step in preventing suicide from occurring.

Recent initiatives to address the stigma related to mental health problems have gained an increased public profile with a significant focus on raising awareness and funds. More academically-focused work around stigma related to suicide has been a focus of nationally-recognized organizations like the Centre for Addiction and Mental Health (CAMH).[76] In Nova Scotia, recent mental health-focused planning documents, such as the 2017 report "Milestones on our Journey", have included addressing stigma as a key principle and action. Nova Scotia can build on this momentum by engaging in visible, collaborative action to increase the understanding and acceptance of mental health and addictions issues across the province.

Recommendations

S1: Develop strategies to reduce access to the most common means of suicide and suicide attempts in Nova Scotia.

S2: Continue to work with media and community partners to promote appropriate reporting and language use on suicide and mental illness.

S3: Integrate suicide prevention into public policies aimed at reducing harmful alcohol use and gambling behaviour.

S4: Support broader collaborative, evidence-informed efforts to destigmatize and encourage dissemination of supportive messages on mental health and addictions issues and suicide on social media, including through national and global level policies for social media.

Strengthen Upstream Prevention

Upstream approaches focus on the social determinants of health, the conditions under which people are born, grow, live, work, and age. [77] At the population level this includes socioeconomic deprivation, income inequality, educational opportunity, labor market structure, affordable housing, access to healthy foods/nutrition, access to essential goods and services, physical and built environments, racial/ethnic population composition, and public spending on safety, social, and welfare services.[78] These mechanisms generate stratification and social class divisions within society that have been shown to have powerful influences on health and well-being at the individual and population levels.[79] In addition, targeted and universal approaches that support prevention and early intervention (i.e., "midstream" interventions) can contribute to improved health outcomes.

There is emerging evidence that these large, societal issues do have an association with suicide; a recent example in the United States has found an association between state-level minimum wage and rates of suicide, with the authors concluding that suicide rates have increased more slowly in states that increased their minimum wage.[80] There are income-related inequalities in suicidal behaviours among Indigenous peoples living off reserve in Canada;[81] programs and policies to address income and food insecurity targeted to off-reserve Indigenous people may help reduce risk of suicide.[82]

Population-level upstream interventions cannot be initiated or implemented by the health system alone. There are many sectors that influence the social determinants of health. Health and Wellness, Education and Early Childhood Development, Community Services, Justice, Labour and Advanced Education, and other departments and levels of government have a role to play in advancing these common issues. Upstream interventions can have a large effect on reducing the population incidence of illness and injury including suicide and can often result in improved health without any conscious awareness or participation by individuals. Upstream interventions can also support populations at increased risk of suicide because of geographic, cultural, and social isolation or marginalization. Individuals among these populations may not have suicidal behaviours; however, they may be at an elevated level of psychological or socioeconomic risk due to the adversity they may have experienced from being part of a marginalized group. These disadvantages begin before birth and continue throughout the lifespan. Enhancing the conditions in which individuals live, play, work, and grow is crucial to supporting positive mental health. Examples of upstream approaches are ensuring quality and livable incomes for all, removing barriers to access to healthy, affordable food, quality education, and safe and affordable housing.

Exposure to adverse childhood experiences such as abuse, family violence, harassment, and other risks that arise early in life such as bullying and aggression, are linked to later morbidity and mortality including suicide.[83] Suicide interventions that only target

people at high-risk of suicide behaviour (e.g., mental illness, previous suicide attempt) are unlikely to prevent suicide among children and youth who do not demonstrate these risk factors. In addition to upstream approaches, prevention and early intervention initiatives are also important. Improving the capacity of individuals to get through situations of adversity, and to reduce hopelessness and feelings of isolation while increasing the capacity of families, communities, and social systems to meet the social and emotional needs of children and youth, can set the stage for lower suicide rates later on.[84] For example, children with aggressive behaviour issues are more likely to have problems later in life that include substance abuse, school dropout, and delinquency which increase risk for suicide behaviour.[85] Efforts to reduce risk factors that may lead to aggressive behaviour (e.g. bullying, abuse, neglect) and strengthen protective factors (e.g. social inclusion, self-esteem and access to health services) can help prevent those children and youth from developing multiple problems linked to suicide risk.

An example in the Nova Scotia context is the Enhanced Home Visiting program run by NSHA's Public Health Services. Enhanced Home Visiting is a voluntary home-based program for families with identified risk factors known to impact healthy child development such as substance use and mental health issues. The program focuses on promoting healthy parent-child relationships, fostering healthy child development, connecting families with community supports and resources, and promoting positive mental health and coping skills.

Upstream approaches that apply a broad focus on large populations, such as entire communities or schools, are designed to minimize suicide risk by strengthening protective factors for everyone. The effect of such policies on suicidal behaviours requires further evaluation but strengthened social and emotional capacities also reduces other problem outcomes such as substance abuse and fortifies protective factors such as social connectedness and inclusion.

Recommendations

U1: Coordinate a comprehensive provincial approach to suicide prevention focused on the structural and social determinants of health, inclusive of all levels of government and other related organizations.

U2: Identify opportunities to strengthen and extend policies, programs, and services that reduce suicide risk factors and support the development of protective factors for children and youth, as well as for target populations at increased risk of suicide because of geographic, cultural, and social isolation or marginalization.

Conclusion

The Government of Nova Scotia is committed to working with all levels of government, the health care system, clinicians, workplaces, education and corporate sectors, community groups, and the media, along with family, friends, and peer networks to prevent harm and death by suicide.

This framework builds on successful work already being done in Nova Scotia and provides foundational recommendations to align efforts across sectors. It is intended to guide the implementation of evidence-informed interventions in the health system and the community, as well as support data collection and evaluation. These actions will improve coordination and alignment of efforts to achieve greater impact.

Many suicides can be prevented. Collectively and collaboratively we will address suicide risk factors and strengthen supports to prevent and reduce the risk of suicide in Nova Scotia.

Appendix A – Framework Recommendations

Improve Suicide-Related Data Monitoring and Evaluation

Recommendations

SM1: Leverage existing efforts to ensure data is easily shared across government and readily available and accessible to suicide prevention stakeholders.

SM2: Identify and resolve gaps in clinical and non-clinical suicide-related data and information, with a focus on better understanding the factors that affect populations and communities in Nova Scotia where there is greatest risk of suicide.

SM3: Ensure all programs, interventions, and policies that intend to prevent or reduce the risk of suicide include a plan for ongoing monitoring and evaluation, including this framework.

Identify and Support Populations at Risk

Recommendations

IS1: Advance collaboration among community-based organizations and government departments to develop integrated service delivery approaches that support populations at risk of suicide.

IS2: Initiate a collaborative exploration of how people at-risk of suicide have interacted with the health, justice, education and community services systems to better understand opportunities and barriers related to preventing and reducing the risk of suicide.

IS3: Create, maintain, and evaluate interventions and policies designed to improve protective factors, with a focus on populations with elevated risk factors for suicide and groups experiencing major stressors.

IS4: Ensure that all targeted interventions apply a trauma-informed care approach and are grounded in the lived experience of people and communities for whom it is intended.

Strengthen Health System Capacity

Recommendations

HS1: Identify and leverage opportunities to implement greater collaboration, communication, and integration of services for people at risk of suicide between the health system and other government departments (e.g., Justice, Education and Early Childhood Development, Community Services, Labour and Advanced Education).

HS2: Expand the capacity of health care providers to conduct suicide screening and assessment at appropriate system entry points, improve recognition of suicidal behaviours, and conduct more effective referrals to supports within the health system for people at risk.

HS3: Build on existing efforts to expand culturally competent and trauma-informed practice throughout the health system so that all Nova Scotians, particularly those at higher risk of suicide, can access care that is safe, comfortable, and supportive.

HS4: Explore opportunities to implement more mental health and addictions service provision in non-traditional community settings.

HS5: Ensure that the assessment, treatment, and follow-up of individuals who have experienced harm from substance use and/or gambling includes suicide screening.

Extend Access to Services and Supports in the Community

Recommendations

C1: Strengthen and extend community-based supports and services in support of individuals at-risk of suicide, particularly in communities that may have higher-rates of suicide.

C2: Expand efforts to evaluate and provide targeted gatekeeping training as appropriate to community-based organizations and individuals who may regularly come into contact with people at risk of suicide.

Address Targeted Social Issues Identified as Increasing Risk

Recommendations

S1: Develop strategies to reduce access to the most common means of suicide and suicide attempts in Nova Scotia.

S2: Continue to work with media and community partners to promote appropriate reporting and language use on suicide and mental illness.

S3: Integrate suicide prevention into public policies aimed at reducing harmful alcohol use and gambling behaviour.

S4: Support broader collaborative, evidence-informed efforts to destigmatize and encourage dissemination of supportive messages on mental health and addictions issues and suicide on social media, including through national and global level policies for social media.

Strengthen Upstream Prevention

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U1: Coordinate a comprehensive provincial approach to suicide prevention focused on the structural and social determinants of health, inclusive of all levels of government and other related organizations.

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Appendix B – Detailed Figures, Suicide in Nova Scotia

Figure 1. Age-standardized rate of suicide completion per 100,000 population (with trendlines), Nova Scotia & Canada, 2007–2017.

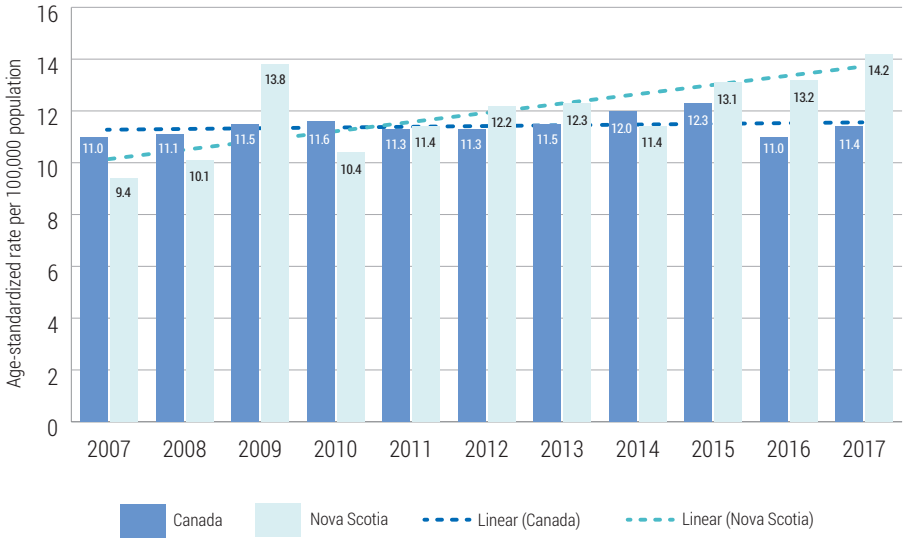


Figure 2. Number of completed suicides by age and sex, 2007–2016.

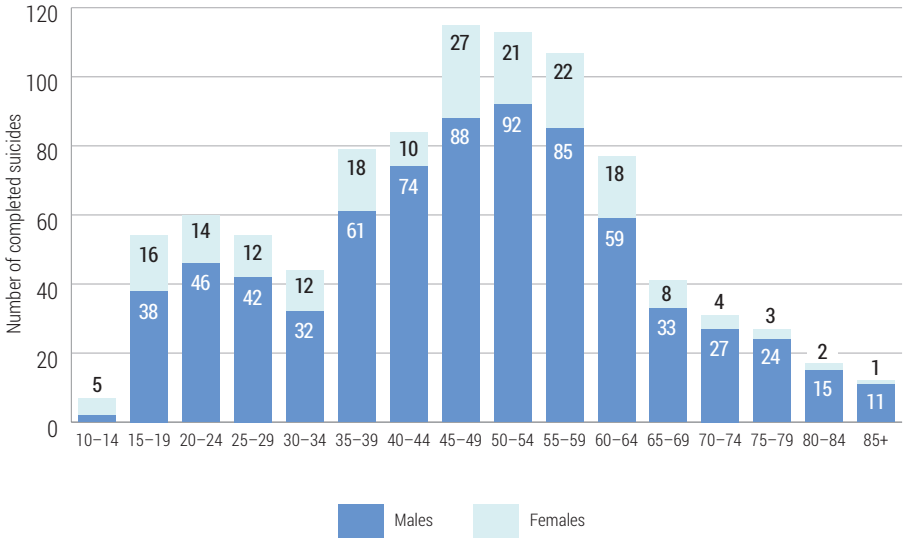


Figure 3. Rate of completed suicides by age and sex, 2007–2016.

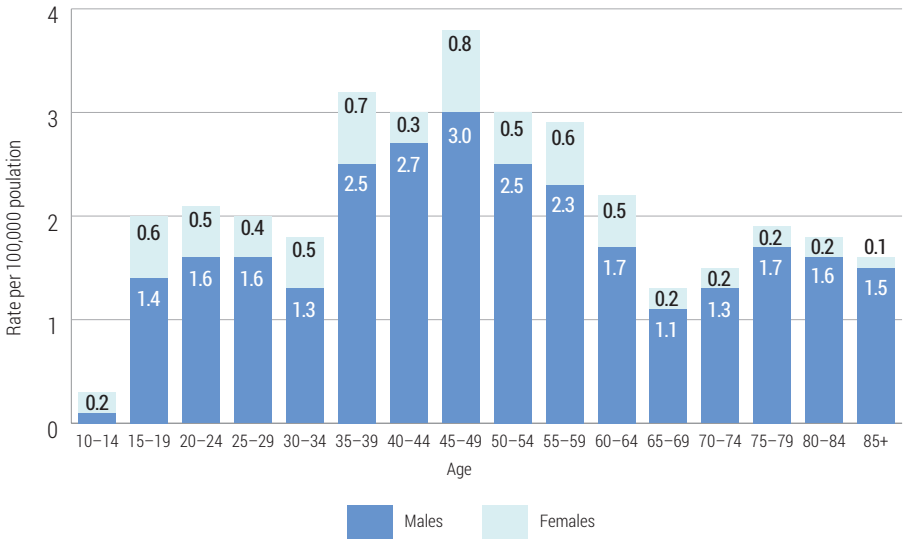


Figure 4. Crude rate of suicide completion per 100,000 population by health zone, 2008–2017 (red bars indicate the zone with the highest rate each year).

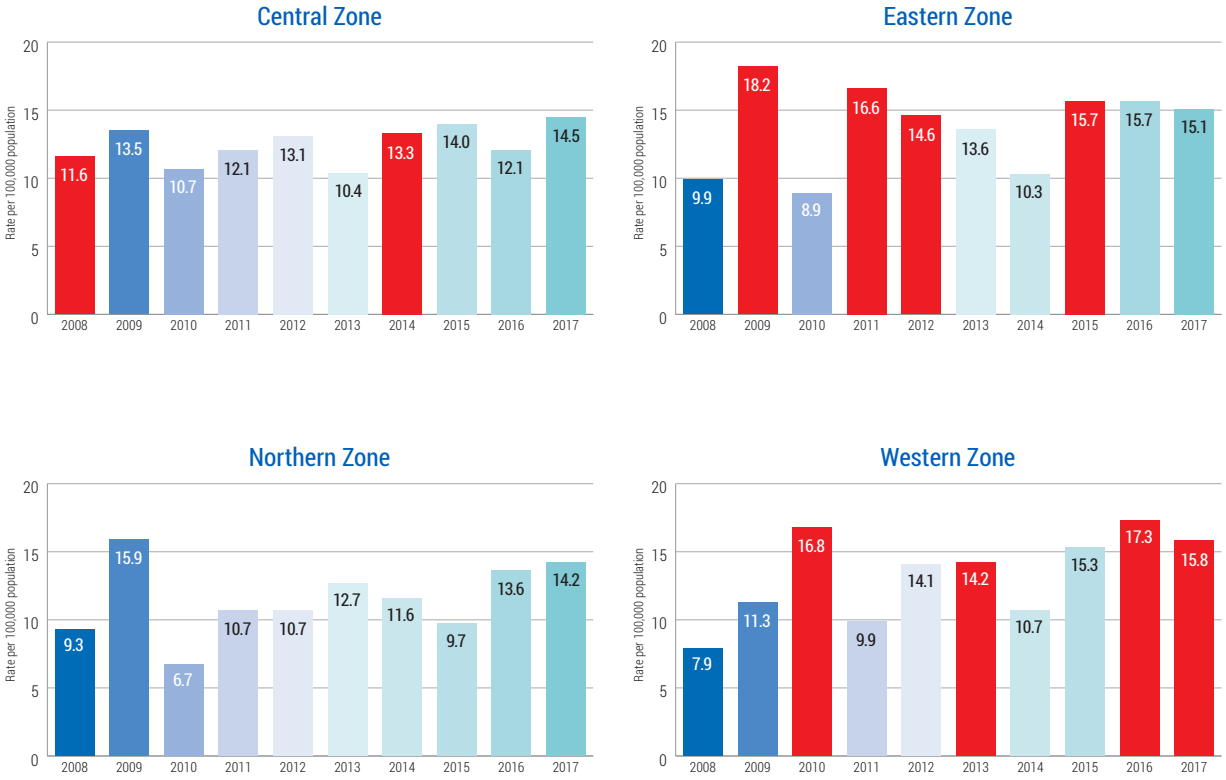


Figure 5. Rate of attempted suicides by age and sex, 2011–2016.

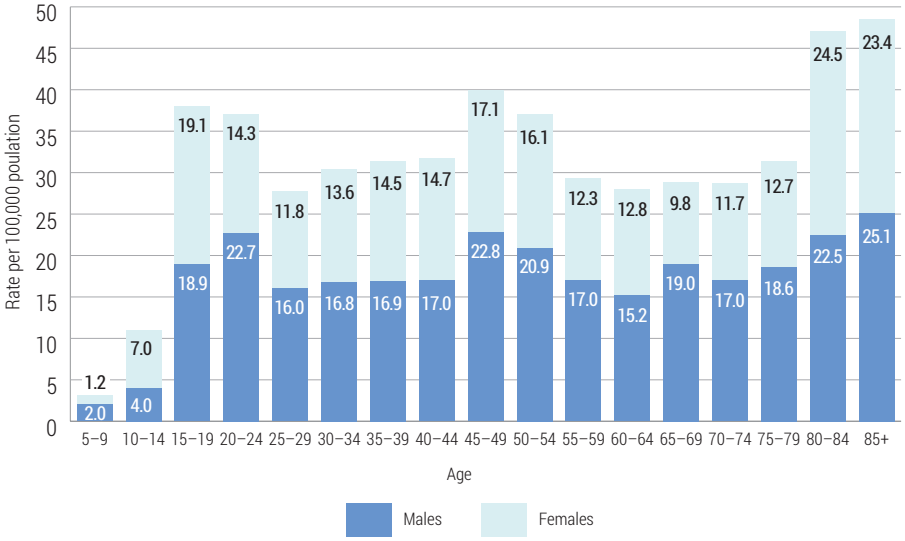
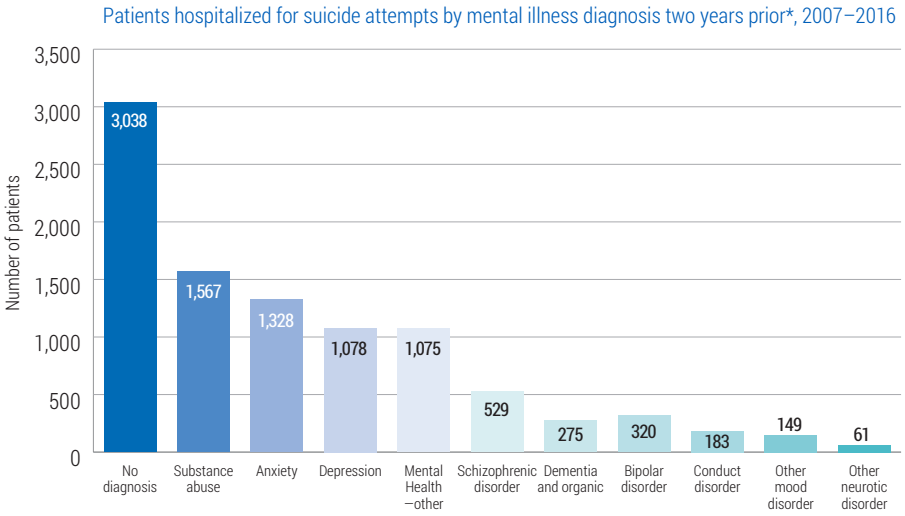


Figure 6. Mental Health Diagnoses in those Hospitalized with a Suicide Attempt



Substance abuse, anxiety, and depression were the most common mental illness diagnoses in patients hospitalized for suicide attempts

References

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

[2] Mental Health Commission of Canada. (2018). Research on suicide and its prevention: What the current evidence reveals and topics for future research. Ottawa, ON. Retrieved from: https://www.mentalhealthcommission.ca/sites/default/files/2018-12/Research_on_suicide_prevention_dec_2018_eng.pdf

[3] Klonsky, E. D., & May, A. M. (2015). The three-step theory (3ST): A new theory of suicide rooted in the "ideation-to-action" framework. *International Journal of Cognitive Therapy*, 8(2), 114-129.

[4] World Health Organization (2014). Preventing suicide: A global imperative. Geneva, SW: World Health Organization

[5] Mental Health Commission of Canada. (2018). Research on suicide and its prevention: What the current evidence reveals and topics for future research. Ottawa, ON. Retrieved from: https://www.mentalhealthcommission.ca/sites/default/files/2018-12/Research_on_suicide_prevention_dec_2018_eng.pdf

[6] CIHI Discharge Abstract Database, CIHI National Ambulatory Care Reporting System, NS Physician Billing Database, 2007-2016. *Patients could have multiple diagnoses.

[7] Cavanagh JT, Carson AJ, Sharpe M, Lawrie SM. (2003). Psychological autopsy studies of suicide: a systematic review. Psychol med.;33(3):395?405

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

[9] Shead, N. W., Derevensky, J. L., & Gupta, R. (2010). Risk and protective factors associated with youth problem gambling. *International journal of adolescent medicine and health*, 22(1), 39.

[10] Ramberg, I. L., Di Lucca, M., & Hadlaczky, G. (2016). The impact of knowledge of suicide prevention and work experience among clinical staff on attitudes towards working with suicidal patients and suicide prevention. International journal of environmental research and public health, 13(2), 195.

[11] Coppens, E., Van Audenhove, C., Gusmão, R., Purebl, G., Szekely, A., Maxwell, M., ... & Hegerl, U. (2018). Effectiveness of General Practitioner training to improve suicide awareness and knowledge and skills towards depression. Journal of affective disorders, 227, 17-23.

[12] Fountoulakis, K. N., Gonda, X., & Rihmer, Z. (2011). Suicide prevention programs through community intervention. Journal of affective disorders, 130(1-2), 10-16.

[13] Suicide Prevention Resource Center. (2012). Upstream Youth Suicide Prevention Expert Panel Meeting Summary. https://www.sprc.org/sites/default/files/migrate/library/Upstream_Youth_Suicide_Prevention_Expert_Panel_Meeting%20Summary.pdf

[14] Provincial Strategic Framework Development Committee. (2006). Nova Scotia Strategic Framework to Address Suicide. Retrieved from: https://novascotia.ca/dhw/healthy-communities/documents/Nova-Scotia-Strategic-Framework-to-Address-Suicide.pdf

[15] Kutcher, S. P., & Chehil, S. (2007). Suicide risk management: A manual for health professional. Blackwell Publishing. Retrieved from: https://www.ipsepa.com/content/uploads/Suicide-Risk-Management_-A-Manual-for-Health-Professionals-Stan-Kutcher-Sonia-Chehil.pdf

[16] Province of Nova Scotia. (2009). Suicide and Attempted Suicide in Nova Scotia 1995–2004. https://novascotia.ca/dhw/healthy-communities/documents/Suicide-and-Attempted-Suicide-in-Nova-Scotia.pdf

[17] DHW (2016) Together We Can. Retrieved from: https://novascotia.ca/dhw/mental-health/reports/ProgressReport-Jan2016.pdf

[18] Kutcher, S. (2017). Cape Breton Situation Recommendations. Retrieved from: https://novascotia.ca/dhw/publications/Kutcher_CB_-_Ministers_Recommendations.pdf

[19] World Health Organization (2014). Preventing suicide: A global imperative. Retrieved from: https://apps.who.int/iris/bitstream/handle/10665/131056/9789241564779_eng.pdf;jsessionid=6CB09FB48D4E23D2FFE8A224B445A343?sequence=1

[20] Government of Canada (2016). Working together to Prevent Suicide in Canada: The Federal Framework for Suicide Prevention. Retrieved from: https://www.canada.ca/content/dam/canada/public-health/migration/publications/healthy-living-vie-saine/framework-suicide-cadre-suicide/alt/framework-suicide-cadre-suicide-eng.pdf

[21] Tui'kn Partnership (2016). Strength in numbers Bulletins (Mental Health and Addictions, Mortality). Retrieved from: http://www.tuikn.ca/health-information/strength-in-numbers-project/

[22] Health Canada (2013). National Aboriginal Youth Suicide Prevention Strategy (NAYSPS). Retrieved from: https://www.canada.ca/content/dam/hc-sc/migration/hc-sc/fniah-spnia/alt_formats/pdf/pubs/promotion/_suicide/strat-prev-youth-jeunes-eng.pdf

[23] MHA (Aug 2017) Milestones on our Journey http://www.nshealth.ca/sites/nshealth.ca/files/milestones_on_our_journey_-_1.8mb.pdf

[24] Vital Statistics Nova Scotia, Statistics Canada Census 2016

[25] CIHI Discharge Abstract Database, NS Physician Billing Database 2011-2016; Statistics Canada Census, 2016.

[26] CIHI Discharge Abstract Database, CIHI National Ambulatory Care Reporting System, NS Physician Billing Database, Vital Statistics Nova Scotia, 2007-2016.

[27] World Health Organization. (2016). Practice manual for establishing and maintaining surveillance systems for suicide attempts and self-harm. Retrieved from: https://www.who.int/mental_health/suicide-prevention/attempts_surveillance_systems/en/

[28] McLean J, Maxwell M, Platt S, Harris F, Jepson R. (2008). Risk and protective factors for suicide and suicidal behaviour; A literature review. Edinburgh: Scottish Government Social Research. Retrieved from: https://dspace.stir.ac.uk/bitstream/1893/2206/1/Suicide%20review%5B1%5D.pdf

[29] World Health Organization (2014). Preventing suicide: A global imperative. Retrieved from: https://apps.who.int/iris/bitstream/handle/10665/131056/9789241564779_eng.pdf;jsessionid=6CB09FB48D4E23D2FFE8A224B445A343?sequence=1

[30] Government of Canada (2016). Working together to Prevent Suicide in Canada: The Federal Framework for Suicide Prevention. Retrieved from: https://www.canada.ca/content/dam/canada/public-health/migration/publications/healthy-living-vie-saine/framework-suicide-cadre-suicide/alt/framework-suicide-cadre-suicide-eng.pdf

[31] ibid.

[32] Province of Nova Scotia. (2009). Suicide and Attempted Suicide in Nova Scotia 1995–2004. https://novascotia.ca/dhw/healthy-communities/documents/Suicide-and-Attempted-Suicide-in-Nova-Scotia.pdf

[33] Government of Canada (2016). Working together to Prevent Suicide in Canada: The Federal Framework for Suicide Prevention. Retrieved from: https://www.canada.ca/content/dam/canada/public-health/migration/publications/healthy-living-vie-saine/framework-suicide-cadre-suicide/alt/framework-suicide-cadre-suicide-eng.pdf

[34] Tui'kn Partnership (2018) Strength in Numbers Project Mortality Bulletins. Mortality in NS Mi'kmaq Communities. Retrieved from: http://www.tuikn.ca/wp-content/uploads/2015/03/Mortality-bulletin-FINAL.pdf

[35] Department of Finance and Treasury Board (2018). Retrieved from: https://novascotia.ca/finance/statistics/news.asp?id=14204

[36] Wyatt, L. C., Ung, T., Park, R., Kwon, S. C., & Trinh-Shevrin, C. (2015). Risk factors of suicide and depression among Asian American, Native Hawaiian, and Pacific Islander youth: A systematic literature review. *Journal of health care for the poor and underserved*, 26(2 0), 191.

[37] Demetry, Y. (2014). Suicidal Ideation and Attempt among Immigrants in Europe: A Literature Review.

[38] Centres for Disease Control and Prevention, (2015). Injury Center: Violence Prevention: Suicide: Risk and Protective Factors. Atlanta, GA: Centres for Disease Control (2015) [Cited 2019 July 17] https://www.cdc.gov/violenceprevention/suicide/riskprotectivefactors.html Atlanta, GA: Centres for Disease Control. Retrieved from: (2015) [Cited 2019 July 17] https://www.cdc.gov/violenceprevention/suicide/riskprotectivefactors.html

[39] McLean J, Maxwell M, Platt S, Harris F, Jepson R. Risk and protective factors for suicide and suicidal behaviour; A literature review. Edinburgh: Scottish Government Social Research; 2008. Retrieved from: https://dspace.stir.ac.uk/bitstream/1893/2206/1/Suicide%20review%5B1%5D.pdf

[40] Centres for Disease Control and Prevention, (2015). Injury Center: Violence Prevention: Suicide: Risk and Protective Factors. Atlanta, GA: Centres for Disease Control (2015) [Cited 2019 July 17] https://www.cdc.gov/violenceprevention/suicide/riskprotectivefactors.html Atlanta, GA: Centres for Disease Control. Retrieved from: https://www.cdc.gov/violenceprevention/suicide/riskprotectivefactors.html Centres for Disease Control and Prevention. Injury Center: Violence Prevention: Suicide: Risk and Protective Factors. Atlanta, GA: Centres for Disease Control (2015) [Cited 2019 July 17] https://www.cdc.gov/violenceprevention/suicide/riskprotectivefactors.html

[41] Centres for Disease Control and Prevention, (2015). Injury Center: Violence Prevention: Suicide: Risk and Protective Factors. Atlanta, GA: Centres for Disease Control (2015) [Cited 2019 July 17] https://www.cdc.gov/violenceprevention/suicide/riskprotectivefactors.html Atlanta, GA: Centres for Disease Control. Retrieved from: https://www.cdc.gov/violenceprevention/suicide/riskprotectivefactors.html Centres for Disease Control and Prevention. Injury Center: Violence Prevention: Suicide: Risk and Protective Factors. Atlanta, GA: Centres for Disease Control (2015) [Cited 2019 July 17] https://www.cdc.gov/violenceprevention/suicide/riskprotectivefactors.html

[42] Government of Canada (2016). Working together to Prevent Suicide in Canada: The Federal Framework for Suicide Prevention. Retrieved from: https://www.canada.ca/content/dam/canada/public-health/migration/publications/healthy-living-vie-saine/framework-suicide-cadre-suicide/alt/framework-suicide-cadre-suicide-eng.pdf

[43] Bakhiyi, C. L., Calati, R., Guillaume, S., & Courtet, P. (2016). Do reasons for living protect against suicidal thoughts and behaviors? A systematic review of the literature. *Journal of psychiatric research*, 77, 92-108.

[44] Ahmedani, B. K., Simon, G. E., Stewart, C., Beck, A., Waitzfelder, B. E., Rossom, R., … & Operskalski, B. H. (2014). Health care contacts in the year before suicide death. Journal of general internal medicine, 29(6), 870-877. Retrieved from: https://link.springer.com/article/10.1007/s11606-014-2767-3

[45] Suicide Risk Assessment, Intervention (SRAI), Monitoring and Management for Mental Health and Addictions, Policy MA-SA-005.

[46] NS Department of Health and Wellness. Diversity, Social Inclusion and Cultural Competence. Retrieved from: https://novascotia.ca/dhw/diversity/

[47] Gahagan, J., & Subirana-Malaret, M. (2018). Improving pathways to primary health care among LGBTQ populations and health care providers: key findings from Nova Scotia, Canada. International journal for equity in health, 17(1), 76.

[48] Government of Nova Scotia. (2019). Count Us In: Nova Scotia's Action Plan in Response to the International Decade for People of African Descent 2015-2024. Retrieved from: https://novascotia.ca/international-decade-for-people-of-african-descent/Action-Plan-international-decade-for-people-of-african-descent.pdf

[49] Trauma-informed approaches: An Introduction and Discussion Guide for Health and Social Service Providers (2015). Retrieved from: https://novascotia.ca/dhw/addictions/documents/TIP_Discussion_Guide_1.pdf

[50] Pepler, D. & Milton, P. (June 13, 2013). External review of the Halifax Regional School Board's Support of Rehtaeh Parsons: Final Report. Province of Nova Scotia.

[51] Foundry BC. Retrieved from: https://foundrybc.ca/

[52] Hetrick, S. E., Bailey, A. P., Smith, K. E., Malla, A., Mathias, S., Singh, S. P., ... & Moro, M. R. (2017). Integrated (one?stop shop) youth health care: Best available evidence and future directions. Medical Journal of Australia, 207(S10), S5-S18. Retrieved from: https://www.mja.com.au/system/files/issues/207_10/10.5694mja17.00694.pdf

[53] Bickerdike, L., Booth, A., Wilson, P. M., Farley, K., & Wright, K. (2017). Social prescribing: less rhetoric and more reality. A systematic review of the evidence. BMJ open, 7(4), e013384.

[54] Loch, A. A. (2014). Discharged from a mental health admission ward: is it safe to go home? A review on the negative outcomes of psychiatric hospitalization. *Psychology research and behavior management*, 7, 137.

[55] Ahmedani, B. K., Simon, G. E., Stewart, C., Beck, A., Waitzfelder, B. E., Rossom, R., … Solberg, L. I. (2014). Health care contacts in the year before suicide death. Journal of general internal medicine, 29(6), 870–877. doi:10.1007/s11606-014-2767-3

[56] World Health Organization (2014). Preventing Suicide. Retrieved from: https://apps.who.int/iris/bitstream/handle/10665/131056/9789241564779_eng.pdf;jsessionid=6CB09FB48D4E23D2FFE8A224B445A343?sequence=1

[57] Yonemoto, N., Kawashima, Y., Endo, K., & Yamada, M. (2018). Gatekeeper training for suicidal behaviors: A systematic review. Journal of affective disorders.

[58] Burnette, C., Ramchand, R., & Ayer, L. (2015). Gatekeeper Training for Suicide Prevention: A Theoretical Model and Review of the Empirical Literature. Rand health quarterly, 5(1), 16.

[59] King, C. A., Arango, A., Kramer, A., Busby, D., Czyz, E., Foster, C. E., & Gillespie, B. W. (2019). Association of the youth-nominated support team intervention for suicidal adolescents with 11-to 14-year mortality outcomes: secondary analysis of a randomized clinical trial. JAMA psychiatry, 76(5), 492-498.

[60] King CA, Arango A, Kramer A, et al. (2018). Association of the Youth-Nominated Support Team Intervention for Suicidal Adolescents With 11- to 14-Year Mortality Outcomes: Secondary Analysis of a Randomized Clinical Trial. JAMA Psychiatry. Published online February 06, 201976(5):492–498. doi:10.1001/jamapsychiatry.4358

[61] Suicide Prevention Competencies for Faith Leaders: Supporting LifeBefore, During, and After a Suicidal Crisis https://www.sprc.org/sites/default/files/resource-program/fhl_competencies_v8_interactive.pdf

[62] Hegerl, U., Rummel-Kluge, C., Värnik, A., Arensman, E., & Koburger, N. (2013). Alliances against depression–a community-based approach to target depression and to prevent suicidal behaviour. Neuroscience & Biobehavioral Reviews, 37(10), 2404-2409.

[63] Clement, S., Schauman, O., Graham, T., Maggioni, F., Evans-Lacko, S., Bezborodovs, N., ... & Thornicroft, G. (2015). What is the impact of mental health-related stigma on help-seeking? A systematic review of quantitative and qualitative studies. Psychological medicine, 45(1), 11-27.

[64] Hegerl, U., Rummel-Kluge, C., Värnik, A., Arensman, E., & Koburger, N. (2013). Alliances against depression–a community based approach to target depression and to prevent suicidal behaviour. Neuroscience & Biobehavioral Reviews, 37(10), 2404-2409.

[65] World Health Organization (2014). Preventing Suicide. Retrieved from: https://apps.who.int/iris/bitstream/handle/10665/131056/9789241564779_eng.pdf;jsessionid=6CB09FB48D4E23D2FFE8A224B445A343?sequence=1

[66] World Health Organization (2014). Preventing Suicide. Retrieved from: https://apps.who.int/iris/bitstream/handle/10665/131056/9789241564779_eng.pdf;jsessionid=6CB09FB48D4E23D2FFE8A224B445A343?sequence=1

[67] Robinson, J., Cox, G., Bailey, E., Hetrick, S., Rodrigues, M., Fisher, S., & Herrman, H. (2016). Social media and suicide prevention: a systematic review. Early intervention in psychiatry, 10(2), 103-121.

[68] DHW (2016). Recommended Media Reporting Guidelines on Mental Illness. Retrieved from: https://novascotia.ca/dhw/mental-health/reports/Reporting-Guidelines-on-Mental-Illness-Jan2016.pdf

[69] Canadian Psychiatric Association. (2017) Media Guidelines for Reporting on Suicide: Update of the Policy Paper. Retrieved from: https://www.cpa-apc.org/wp-content/uploads/Media-Guidelines-Suicide-Reporting-EN-2018.pdf

[70] Norström, T., & Rossow, I. (2016). Alcohol consumption as a risk factor for suicidal behavior: a systematic review of associations at the individual and at the population level. Archives of Suicide Research, 20(4), 489-506.

[71] Black, D. and Shaw, M. (2019). The Epidemiology of Gambling Disorder. In: Heinz, A., Romanczuk-Seiferth, N., Potenza, M. (eds) Gambling Disorder. Spring, Cham.

[72] Babor T.,Caetano R.,Casswell S.,Edwards G.,Giesbrecht N., Graham K. et al. (2010). Alcohol: No Ordinary Commodity—Research and Public Policy. Oxford, UK: Oxford University Press

[73] Browne, M., Langham, E., Rawat, V., Greer, N., Li, E., Rose, J., … Best, T. (2016). *Assessing Gambling Harm in Victoria: A Public Health Perspective*. Melbourne, AU.

[74] World Health Organization (2014). Preventing Suicide. Retrieved from: https://apps.who.int/iris/bitstream/handle/10665/131056/9789241564779_eng.pdf;jsessionid=6CB09FB48D4E23D2FFE8A224B445A343?sequence=1

[75] Sheehan, L., Corrigan, P. W., Al-Khouja, M. A., Lewy, S. A., Major, D. R., Mead, J., … Weber, S. (2018). Behind Closed Doors: The Stigma of Suicide Loss Survivors. *OMEGA - Journal of Death and Dying*, 77(4), 330–349. https://doi.org/10.1177/0030222816674215

[76] Addressing Stigma (2019). Centre for Addiction and Mental Health. Retrieved from: https://www.camh.ca/en/driving-change/addressing-stigma

[77] CSDH (2008). Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health. Geneva, World Health Organization.

[78] Singh GK, Daus GP, Allender M, et al. Social Determinants of Health in the United States: Addressing Major Health Inequality Trends for the Nation, 1935-2016. Int J MCH AIDS. 2017;6(2):139-164. Retrieved from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5777389/ Singh GK, Daus GP, Allender M, et al. (2017). Social Determinants of Health in the United States: Addressing Major Health Inequality Trends for the Nation, 1935-2016. Int J MCH AIDS. 2017;6(2): 139-164. Retrieved from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5777389/

[79] Hajizadeh, M., Bombay, A. and Asada, Y. "Socioeconomic inequalities in psychological distress and suicidal behaviours among Indigenous peoples living off-reserve in Canada", CMAJ: The Canadian Medical Association Journal, 91 (12), E325-E336. Retrieved from: http://www.cmaj.ca/content/cmaj/191/12/E325.full.pdf
Hajizadeh, M., Bombay, A. and Asada, Y. (2019). "Socioeconomic inequalities in psychological distress and suicidal behaviours among Indigenous peoples living off-reserve in Canada", CMAJ: The Canadian Medical Association Journal, 91 (12), E325-E336. Retrieved from: http://www.cmaj.ca/content/cmaj/191/12/E325.full.pdf

[80] Gertner, A. K., Rotter, J. S., & Shafer, P. R. (2019). Association between state minimum wages and suicide rates in the US. American journal of preventive medicine, 56(5), 648-654. https://www.sciencedirect.com/science/article/abs/pii/S0749379719300285

[81] Hajizadeh, M., Bombay, A. and Asada, Y. (2019). "Socioeconomic inequalities in psychological distress and suicidal behaviours among Indigenous peoples living off-reserve in Canada", CMAJ: The Canadian Medical Association Journal, 91 (12), E325-E336. Retrieved from: http://www.cmaj.ca/content/cmaj/191/12/E325.full.pdf

[82] Ibid

[83] World Health Organization (2014). Preventing suicide: A global imperative. Retrieved from: https://apps.who.int/iris/bitstream/handle/10665/131056/9789241564779_eng.pdf;jsessionid=6CB09FB48D4E23D2FFE8A224B445A343?sequence=1

[84] Suicide Prevention Resource Center. (2012). Upstream Youth Suicide Prevention Expert Panel Meeting Summary. https://www.sprc.org/sites/default/files/migrate/library/Upstream_Youth_Suicide_Prevention_Expert_Panel_Meeting%20Summary.pdf

[85] Ibid.