A SUICIDE PREVENTION TOOLKIT

About suicide prevention

centre *for* suicide prevention

IN THIS TOOLKIT

Introduction

Suicide is complex because people are complex – each person who considers suicide does so for reasons unique to them. We do know that people who think about and attempt suicide don't want to die: they want a way out of their psychological pain or their deep sense of burdensomeness. This is why suicide is preventable.

What to expect

The purpose of this toolkit is to introduce the topic of suicide including warning signs, risk and protective factors, statistics, and myths and facts. You'll also learn about suicide prevention best practices and how to have a conversation with someone you're worried about.

If you or someone you know is actively thinking about suicide, call Talk Suicide Canada at 1-833-456-4566. In an emergency, call 911.

This toolkit offers a brief introduction to suicide prevention. For more information, visit togethertolive.ca/about.

Statistics

EVERY YEAR AROUND THE WORLD OVER

700,000

PEOPLE DIE BY SUICIDE (WORLD HEALTH ORGANIZATION, 2021A)

APPROXIMATELY

4,500

PEOPLE DIE BY SUICIDE IN CANADA ANNUALLY

THE GLOBAL SUICIDE RATE IN 2019 WAS

9 per 100,000

PEOPLE (WORLD HEALTH ORGANIZATION, 2021B)

MEN DIE BY SUICIDE

3 times

MORE THAN WOMEN (STATISTICS CANADA, 2022A)

WOMEN ATTEMPT SUICIDE

1.5 to 2 times

MORE OFTEN THAN MEN (PUBLIC HEALTH AGENCY OF CANADA, CENTRE FOR SURVEILLANCE AND APPLIED RESEARCH, 2019)

IN 2019, MORE THAN

1 in every 100

DEATHS (1.3%) WERE CAUSED BY SUICIDE (WORLD HEALTH ORGANIZATION, 2021B)

The most current and complete statistics are available at www.suicideinfo.ca/resource-type/statistics/.

Economics of suicide

- Suicide and self-harm accounted for $2.9 billion of the total cost of injuries in Canada in 2018 (Parachute, 2022).
- A Canadian report estimated the cost of a suicide in Canada for 2018 to be $636,244 (Parachute, 2021).

Myths and facts

Fact

MALE SUICIDE RATES ARE HISTORICALLY HIGHER THAN FEMALE RATES.

Males die by suicide at 3 times the rate of females; females attempt suicide 1.5 to 2 times more than men (Statistics Canada, 2019; Public Health Agency of Canada, Centre for Surveillance and Applied Research, 2019). Middle-aged men die by suicide most often; in Canada in 2019, 1169 of 4011 suicides were males aged 45-64. Older men have the highest rates of suicide, while middle-aged men die by suicide in the greatest numbers (Statistics Canada, 2022b).

The difference between male and female suicide rates is described as the 'gender paradox' and can be explained by a few different factors: men use more lethal means of suicide, they are less likely to seek help, and they are socialized to 'get things done' (Canetto & Sakinofsky, 1998; Barrigon & Cegla-Schvartzman, 2020).

Myth

PEOPLE WHO TALK ABOUT SUICIDE ARE JUST ATTENTION-SEEKING – NOT TRULY THINKING OF SUICIDE.

If you think someone is telling you that they're thinking of suicide so that you will give them attention – they are. A major warning sign for suicide is talking about wanting to hurt or kill oneself (American Association of Suicidology, 2019). Everyone who talks about suicide needs to be taken seriously and connected to necessary and appropriate supports.

Myth

TALKING ABOUT SUICIDE CAN CAUSE SUICIDE.

Talking about suicide with someone who is considering suicide reduces the risk that they will attempt suicide. Asking people directly if they are having suicidal thoughts or if they have a plan to die by suicide takes the burden off of the person in crisis. A caring conversation can often de-escalate a suicidal crisis by providing an opportunity to talk, diminishing the likelihood that the person will carry through with suicide (Eynan et al., 2014; Reynolds et al., 2006; Deisenhammer et al., 2009). Simply talking about suicide will not cause someone to think about suicide (Dazzi et al., 2014).

Myth

MOST PEOPLE WHO DIE BY SUICIDE LEAVE NOTES.

People who die by suicide rarely leave notes. Approximately 18% of people who die by suicide leave a note (Cerel et al., 2014).
Many believe a note must be present to deem a death a suicide. This can be especially important to those bereaved by a suicide. If a death is not accepted as a suicide, the grieving process can become more difficult, and closure will become elusive.

Myth

ONLY PEOPLE WITH MENTAL ILLNESSES DIE BY SUICIDE.

Anyone can have thoughts of suicide – not everyone who dies by suicide has a mental illness (Bryan, 2022). External and systemic factors can increase the likelihood a person may think about and die by suicide, and these factors can affect those with or without mental illness. Factors like houselessness, racism, food insecurity, trauma, and other stressors are associated with suicide (National Alliance on Mental Illness, 2022).

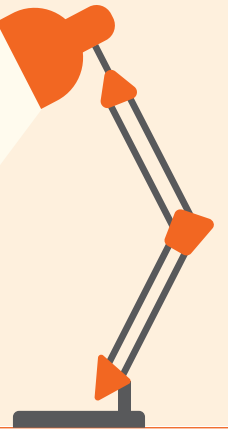
Warning signs

People who are considering suicide often show warning signs. Any significant change in behaviour can be a warning sign for suicide.

We can be more alert to warning signs when we are sensitive to the people around us, and when we appreciate that anyone can have thoughts of suicide. Active listening can help us tune in to comments people make that indicate they're struggling.

WARNING SIGNS OF SUICIDE INCLUDE:

- Statements that indicate hopelessness or being a burden
- Threats of suicide or comments about wanting to die*
- Looking for ways to die*
- Suicide attempt
- Increased substance use
- No sense of purpose in life or evident reason for living
- Withdrawal from friends and family
- Rage, anger, irritability
- Recklessness
- Dramatic mood changes



* **These warning signs indicate immediate suicide risk.** Stay with the person who is exhibiting these signs and connect them to help (American Association of Suicidology, 2019). In Canada call the national crisis line, Talk Suicide Canada, at **1-833-456-4566.**

Risk and protective factors

Even before a person displays warning signs, we can learn something about their suicide risk by considering different factors in their lives. We all have characteristics or traits that may contribute to or diminish our risk of suicide: risk factors and protective factors.

Risk Factors

Suicide cannot be predicted by a single cause. Risk factors are a combination of personal, cultural, and social factors that may contribute to an increased possibility of suicide (Government of Canada, 2016).

RISK FACTORS INCLUDE:

- Previous suicide attempt
- Suicide loss (someone close to them has died by suicide)
- Mental illness (especially if untreated, including depression and postpartum depression)
- Unresolved traumatic experiences (including childhood trauma, intergenerational trauma, and racism-related trauma)
- Access to lethal means
- Reluctance to seek help
- Belief that showing emotion means showing weakness
- Risk-taking behaviours
- Aggression and impulsivity
- Social isolation
- Substance use that disrupts everyday functioning

(Pearlstein et al., 2009; Houle et al., 2008; Ogrodniczuk & Oliffe, 2011; American Psychological Association, 2005)

Protective factors

Certain factors or circumstances can guard a person against thinking about suicide and increase their resiliency.

SOME PROTECTIVE FACTORS THAT CAN BUILD RESILIENCY INCLUDE:

- Close, positive, and supportive relationships with family, friends, and others
- Tendency to look for support when needed
- Positive coping strategies, including emotional regulation
- Comfort expressing emotion
- Easy access to mental health care; the 'right care' at the 'right time' (It's important that this care is stigma-free, culturally appropriate and trauma-informed)

(Government of Canada, 2016; Centers for Disease Control and Prevention, 2021)

Why do people think about suicide?

Suicide is complex because people are complex – there is never any one reason a person will think about suicide, and each person who considers suicide does so for reasons unique to them.

We do know that people who think about and attempt suicide don't want to die: they want a way out of their intense, psychological pain or their deep sense of burdensomeness. They describe feelings of being overwhelmed, being stuck, or not being able to see a way out. They're experiencing conflict (or ambivalence): they want to live but they want the unbearable pain to end. Suicide is not inevitable.

Stigma and language

One of the biggest barriers to suicide prevention is *stigma*.

Misunderstanding and fear are factors that perpetuate stigma. Therefore, learning more about suicide, listening to stories of people who have been impacted by suicide, and collaborative community work towards suicide prevention can help break down the stigma (Public Health Agency of Canada et al., 2018).

The use of specific language, such as people-first, safe, and strengths-based language, is crucial to help destigmatize suicide.

Through the use of this language we can create non-judgmental environments where suicide and its prevention can be talked about openly and safely and where people can feel supported and are more likely to seek and offer help (Public Health Agency of Canada et al., 2018).

EXAMPLES OF DESTIGMATIZING LANGUAGE INCLUDES:

"Died by suicide" instead of "committed suicide"

"Person considering suicide" instead of "suicidal person"

The term 'committed' is stigmatizing – it implies someone has committed an offence, however, suicide is not a crime. 'Suicidal person' is stigmatizing because it emphasizes a person's condition or diagnosis and doesn't put the person first (Public Health Agency of Canada et al., 2018).

Caring conversations

People who are thinking about suicide are desperate for human connection.

People in suicidal crisis report feeling more hopeful after being in conversation with someone who actively listens, reserves judgment, and promotes self-empowerment (Gould et al., 2013). Therefore, a simple caring conversation with someone thinking about suicide could be enough to show them that people do care and that their life does matter.

Studies have shown that 90% of people who were in the process of acting on their plan to die by suicide but were stopped before attempting – either by a passerby, security staff, or police – did not go on to attempt suicide ever again (Seiden, 1978).

Other studies have found that people who regularly receive letters or texts with caring messages following discharge from psychiatric care have fewer suicide attempts than those who do not (Motto & Bostrom, 2001; Luxton et al., 2013).

Priority populations and intersectionality

Anyone can have thoughts of suicide, however, some groups of people, 'priority populations', experience suicide more.

Just because someone is a part of a priority population does not mean they themselves carry increased suicide risk. However, priority populations as groups experience higher rates of suicide. It is important to understand the unique risk factors facing these groups so that prevention efforts can be tailored in meaningful ways. Priority populations in suicide prevention include but are not limited to: 2SLGBTQ+ youth, men and boys, Indigenous people, newcomers, racialized populations, and older adults.

> *People sometimes belong to more than one of these groups – this is called intersectionality. Intersectionality describes the ways in which various identity categories intersect with one another and create distinct experiences of inequality (Steinmetz, 2020).*

Understanding the complexity of the various identities of members of priority populations is crucial to addressing the disparities in suicide prevention.

Best practices

Suicide is complex, therefore, there are few best practices in suicide prevention.

Certain strategies are best implemented at the community level, while others are designed for individuals. Ultimately, a multipronged approach is needed, that is, a coordinated range of efforts needs to be co-implemented to reduce the suicide rate.

EFFORTS NEED TO BE DRAWN FROM THESE FOUR KEY CATEGORIES:

- Responsible suicide reporting, e.g., publishing news stories about people recovering from thoughts of suicide
- Means safety and access reduction, e.g., building barriers on bridges
- Foster socio-emotional life skills in adolescents
- Early identification, assessment, management, and follow-up for anyone who is affected by suicidal behaviours, e.g., ensuring community members and health care workers are trained to identify people thinking about suicide

(World Health Organization, 2021a)

How to talk to someone about suicide

1

Pay Attention.

Any noticeable change in someone's behaviour is a warning sign that they might not be doing well. This includes:

- Not texting or calling as much
- Drinking or smoking more than usual
- Appearing tired or distant
- Talking about how much life sucks
- Being more irritable or angry

2

Start a conversation.

Create a safe, open, and non-judgmental environment to have a conversation with the person you care about. For example:

- Over the phone
- While driving in the car
- Over food or drinks at a favourite hang out
- While working on a project

Mention what you've noticed; be specific:

"I haven't heard from you much these days. Is everything okay?"

3

Keep the conversation going.

- Ask questions and listen to what the person is saying.
- Resist the urge to offer solutions.
- Validate them. Acknowledge their feelings are valid and let them know that you're there to support them:

> *"That sounds really hard. But thank you for telling me. Can you tell me more about it? I'm here for you."*

4

Stick to your role.

- You're a friend, stranger, family member, co-worker, etc. – not a counsellor.
- Who else have they told? Encourage them to reach out to others.

5

Still worried? Ask directly: "Are you thinking about suicide?"

- If they say yes, **don't panic.**
- Let them know you are there for them and connect them with readily accessible mental health supports.
- Call the crisis line together; in Canada, Talk Suicide Canada at **1-833-456-4566.**
- If they have imminent plans to die, call **911** and ensure they are not left alone.

After a suicide

Exposure to a suicide can increase the likelihood that a person who has lost someone to suicide will consider suicide themselves if they:

- View suicide as a normal or common reaction to life circumstances
- Are still in the process of grieving a suicide; this may instill feelings of hopelessness in the individual and reinforce the idea that suicide is an option or is 'normal'
- Are currently struggling with mental illness, considering suicide, or have a past suicide attempt

It is critical to ensure counselling opportunities are available for those affected by suicide because of this increased risk (Erbacher et al., 2015; Carson J. Spencer Foundation et al., 2013).

Typical suicide grief responses include shock and numbness, guilt, profound sadness, anger, shame, relief, and denial (Canadian Association for Suicide Prevention, 2018).

Grieving the death of someone we know is normal. However, suicide grief is unique and can be more intense and complicated in contrast to other types of loss.

It is crucial for people who have been impacted by a suicide loss to understand that it is not their fault, to allow themselves to express emotions, and to reach out for support.

The Canadian Association for Suicide Prevention has resources for people who have experienced a suicide loss. https://suicideprevention.ca/resources/

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We are the Centre for Suicide Prevention, a branch of the Canadian Mental Health Association. For 40+ years we have been equipping Canadians with knowledge and skills to respond to people considering suicide.

We educate for life.

Canadian Mental Health Association
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