SUICIDE PREVENTION IN CANADA: A HISTORY OF A COMMUNITY APPROACH

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ABSTRACT

Suicide is a major mental health and public health problem in Canada. Canada's suicide rate ranks above average in comparison to countries around the world. The prevention of suicide predates the European presence in Canada and much can be learned from these endeavours. Current efforts grew largely from the grass roots, with little government support or initiative (with a few provincial/territorial exceptions). Canada's community efforts have been diverse and inclusive. Among such efforts have been: (a) traditional approaches among Native peoples, (b) the establishment of the first crisis centre in Sudbury in the 1960s, (c) the development of a comprehensive model in Alberta, (d) the beginning of a survivor movement in the 1980s, and (e) the national prevention efforts of the Canadian Association for Suicide Prevention. There are, however, striking lacks—most notable among them the paucity of support for research in Canada. Future efforts will call for even greater community response to prevent suicide and to promote wellness.

INTRODUCTION

Suicide is a major mental health and public health problem in Canada. The impact of suicide in terms of expected years of life lost is enormous. Canada's suicide rate (of approximately 13.5 per 100,000 yearly) ranks above those of many countries around the world, including that of the United States (National Task Force, 1987, 1994; Leenaars, 1995; Schmidtke et al., 1999). Males are especially at risk; indeed, for young Canadian males (ages 15-30), the suicide rates are 50 to 60% higher than their American counterparts (Leenaars, 1995). Indeed, suicide is so prevalent in Canada, especially among youth, that UNICEF has called it one of the world's major tragedies (UNICEF, 1994).

Suicide and suicidal behaviour are multi-faceted events which involve biological, psychological, sociological, cultural, and philosophical/existential aspects (Leenaars, 1999). Because suicide cannot be reduced to a single factor, a parallel complexity of solutions is necessary. Canada's response to its high suicide rate reflects such a comprehensive approach and can, in fact, be characterized by diversity and inclusiveness (Trainor, Pomeroy, & Pape, 1997).

A historical account depends on the knowledge and memory of many people; I would especially like to thank John Benjafield, Pat Harnisch, Karen Kiddey, Isaac Sakinofsky, Ed Shneidman, and Susanne Weneckstern for this account. The editorial assistance of John Benjafield and his editors vastly improved the final product. Grateful acknowledgement is made to the University of Toronto Press for permission to quote from Leenaars et al. (1998, pp 3-34).

The study of suicide and its prevention has a long history. Plato and Aristotle, for example, discussed the topic and, at the turn of the 20th century, Emile Durkheim and Sigmund Freud began empirical (quantitative and qualitative) work in the field. The practice of contemporary suicidology, however, is even more recent. It began with Edwin Shneidman's 1949 discovery of several hundred suicide notes in a Los Angeles coroner's vault (Leenaars, 1997; Shneidman, 1973; Shneidman & Farberow, 1957). The "fulcrum moment," as Shneidman himself called it, came a few moments after the discovery when he had a glimmering that the vast potential value of the notes could be increased immeasurably if he did not read them, but instead used John Stuart Mill's method of difference to compare them blindly, in a controlled experiment, with simulated suicide notes. From this insight, the seeds for the contemporary study of suicide and its prevention were sown.

Even though the contemporary study of suicidology is now just over 50 years old (Leenaars, 1999), its practice in Canada is even more recent. Despite the fact that the concern about suicide and its prevention predated the arrival of Europeans in Canada, Canadian contemporary suicidology only began in the last 30 years. This fact of history is critical; there are distinct differences between Canadian and American responses to suicide and its prevention.

It is the intent of this paper to outline Canada's distinct history of suicide prevention. However, this review is by no means exhaustive (and may be somewhat like a self-directed prayer, calling a blessing on oneself). Clare Brant—whose premature death of a heart attack was a deep loss to the field of Canadian suicidology—wrote:

> One of the favourite phrases is, 'We look back to find a new direction.' If you get lost, you try to find out where you came from. Look back to find a new direction . . . (1987, p. 181)

This reflection attempts to meet Brant's challenge, to look back at the Canadian history of suicide and its prevention—with Aboriginal peoples, in government action, through community-based initatives, and in research endeavours—in order to find a new direction for suicide prevention in Canada.

SUICIDE PREVENTION AMONGST ABORIGINAL PEOPLES

There are conflicting opinions about the suicide rate within Aboriginal communities before European contact. Weyer (1962), for example, suggested that suicide was a cultural trait in one group of Aboriginal people, the Inuit. However, Weyer likely exaggerated his reports and loosely grouped data from various sources which went beyond self-inflicted death (Kirmayer, Fletcher, & Boothroyd, 1998). The general consensus is that self-inflicted events among Aboriginal people were, at the time of European contact, extremely limited (Connors, 1998). This consensus is supported by evidence which appears to indicate similar low suicide rates among Indigenous people worldwide (Leenaars, Anawak, Brown, Hill-Keddie, & Taparti, 1999).

Certainly, suicide did occur (albeit rarely) within pre-contact Aboriginal communities (Royal Commission on Aboriginal Peoples, 1995). Most recorded cases, however, appear to have occurred within a traditional social structure and set of

beliefs: a warrior who was facing death in battle would forfeit his life, or an older Inuk (singular for Inuit), during times of food scarcity, would walk out into the snow. Durkheim (1897) called such deaths altruistic suicides. There were, of course, incidents when individuals who were physically, mentally, emotionally, or spiritually unbalanced might take their own lives. Such events evoked very different community responses: whereas the warrior's death would become part of the folklore in a community, totems and taboos were in place to strongly discourage other self-inflicted events.

Since contact with European society, however, epidemics of suicide among Indigenous peoples have occurred. In Nunavut, for example, there have been reports of suicide rates as high as 59.5 to 73.4 per 100,000 (Abbey, Hood, Young, & Malcolmson, 1993), compared to rates of around 13.5 in the general Canadian population. Although Aboriginal youth suicide rates were once almost non-existent (Taparti, 1998), the rates for youth are now especially high in the Arctic. Wotton (1985), for example, reported a rate as high as 295 per 100,000 for 15 to 25-year-olds in one community. There is mounting support that this epidemic is related to *genocide* of the Aboriginal peoples, including cultural genocide (where the intention is to destroy not only the people but the culture of the people) (Royal Commission on Aboriginal Peoples, 1995). This trend appears to be true worldwide among Indigenous peoples (Leenaars et al., 1999).

We are, however, seeing healing changes, as was prophesized by the ancestors of the peoples (Connors, 1996). Once more, the communities are becoming places of healing. Culture, "the way of the people," is again being seen as the solution to the imbalance: "Culture is the whole complex of relationships, knowledge, languages, social institutions, beliefs, values and ethical rules that bind a people together and give a collective and its individual members a sense of who they are and where they belong" (Royal Commission on Aboriginal Peoples, 1995, p. 25). Prior to contact with Europe, the traditional culture offered Native peoples a complex and effective system of healing (Vogel, 1970). This healing system was based on an holistic approach which attempted to balance the physical, mental, emotional, and spiritual aspects of people (Connors, 1996). The Sweat Lodge of the Ojibway people in Northwestern Ontario, for example, fostered a cultural embodied approach to wellness. As an example,Taparti (1998) offers the meaning attached to snow to explicate such healing:

> I'll use snow as an example: it is worked on by different people—some are very good with snow and some are able to work with it but not as well—that's why we use different types of snow to work with. Snow was our means of survival, even when we were young and even when we became adults. I wasn't worried at all, knowing that we'll get an igloo, even when there was going to be a blizzard. That was one of the laws and I followed it. So that was our life and the igloos were where our lives were. That's how we used to live in the wintertime (p. xiii).

The problem is that many Aboriginal peoples do not know what the Aboriginal culture was all about (Sinclair, 1998). Only now are many people recognizing that there is merit in Native culture. Sweat lodges, the sun rise ceremony, trips to the land, the drum dances, the sun dances, lodge gatherings, community feasts, and so on offer healing within a cultural frame. Thus, "Aboriginal

peoples, individually and collectively, must—if they are to come to terms with the tremendous problems they face—take control of who they are to be, and they will have to feel and to believe that they are in control of their destiny" (Sinclair, 1998, p. 177).

GOVERNMENT APPROACHES

Canada has a major suicide problem and there is much work to do. The recognition of both these facts, however, is quite new. In the White Paper—a study commissioned by Marc LaLonde, Minister of Health in the 1970s—the Canadian government first identified suicide as a major health problem (LaLonde, 1974). LaLonde's study found that suicide was a primary cause of early death (i.e., death before age 70) and, most alarmingly, that it was the second highest cause of death for people under the age of 35. Although the credibility of LaLonde's data has since been questioned, in the 1970s these findings, which were a surprise both to the government and to most Canadians, caused Canada to awake to its malaise and to begin, for the first time, discussing suicide as a public health problem. Unfortunately, however, at the same time the deep taboo on the topic continued.

Recognizing the problem, Health and Welfare Canada established the National Task Force on Suicide in the 1980s "to investigate and better define the dimensions of suicide, and to consider effective strategies of response to the problem" (National Task Force, 1987, p.1). The National Task Force first met on March 7, 1980, and in 1987 released the document *Suicide in Canada* (National Task Force, 1987). The Task Force concluded that Canada's suicide problem was indeed at an epidemic level, well above that of many nations. There are major problems in the report, however. Canada's elderly, for example, are identified as a high-risk group, but the document provides little Canadian content on older adults. Most of the document cited American studies on the elderly, with exceptions of the work of Sakinofsky (1976a, 1976b, 1982, & 1983) and Syer-Solursh and Wyndowe (1981). The problem is not only that we do not know much about suicide in the Canadian elderly, but also that the government document does not cite the Canadian literature that was available. Thus, we are left to understand suicide in Canada based on American data. A recent update (National Task Force, 1994) does no better, despite an array of professional studies on the topic of the elderly available then that were not cited (i.e., Agbayewa, 1993; Jarvis & Boldt, 1980; Bagley & Ramsay, 1993; Sendbuehler & Goldstein, 1977; Leenaars, Saunders, Balance, Wenckstern, & Galgan, 1991; Evans, Fogle, & McDonald, 1987).

There is, however, a deeper problem. Canada, at a federal level, has done little to address the problem of suicide—with the notable exceptions of the decriminalization of attempted suicide and the implementation of tighter gun control measures—and one is left to wonder if this relative inactivity is a reflection of the larger Canadian taboo. At the release of *Suicide in Canada*—which took place at the meeting of the International Association for Suicide Prevention in San Francisco in 1987—I predicted, as the invited responder to the document (Tanney, Lakaski, Leenaars, & Syer-Solursh, 1987), that few, if any, of its important recommendations would be implemented. Subsequently, Bryan Tanney (Leenaars, Mishara, Sakinofsky, & Tanney, 1990) and Roger Tierney (1998) have expressed

the same reservations. The Royal Commission on Aboriginal Peoples (1995), in releasing its document, *Choosing Life*, also called for strong action to address suicide. And yet, Brant-Castellano, Tizya, and Connors (1995) have expressed grave concern about the lack of action which has resulted from that report.

Throughout the last millennium, suicide has been seen as a crime against society, and there have been major sanctions and penalties imposed upon those who attempted suicide and their families. Indeed, attempted suicide remained a crime in Canada (punishable by 6 months in jail and/or a fine) until 1972 when efforts to repeal the law—such as by those by Rev. Bernd Osborg (who in 1969 submitted a brief to John Turner, then Minister of Justice)—succeeded, with the passing of Bill C-2, in removing section (213) from the Criminal Code of Canada. Since then, suicide has been seen as a mental health and public health problem. Unfortunately, however, research (Lester, 1992) has not shown any measurable impact upon suicide rates.

Although never intended to address suicide, Bill C-51 (of 1977, implemented in 1978) introduced stricter gun control in Canada. Since firearms are the preferred method for suicide in Canada, it was proposed, first by Stengel (1964), that restricting access to firearms would reduce the incidence of suicide. And, as research—first by Lester and Leenaars (1993)—has shown, Bill C-51 has had a preventive impact (see Leenaars & Lester, 1998 for a full review).

These small efforts, however, fall far short of the action for which Canada's own recommendations (National Task Force, 1987, 1994) called. Consequently, advocacy for Canadian action continues. In June of 1991, Perrin Beatty (then Minister of Health and Welfare) met with a group of suicide preventionists from the Canadian Association for Suicide Prevention (CASP). CASP, of which I was then president, had conducted surveys across Canada and subsequently presented the peoples' ideas about suicide prevention in Canada. These included: (a) setting a realistic goal of percentage reduction in the overall suicide rate, (b) addressing the problem of unreliable reporting of suicide, (c) establishing the means for surveillance of clinically treated suicide attempters, and (d) addressing the problem of Aboriginal suicide.

Unfortunately, there has been no further meetings at this level of government and, regrettably, these same recommendations from the community could be made again. Once more, little has been done, and one continues to wonder if the secrecy of suicide that LaLonde discovered 30 years ago continues, or if the lack of government response to the problem is the result of other mundane factors, such as bureaucratic and political inactivity, competing priorities, lack of money, or racism.

Mental health and public health problems are, of course, not only a federal responsibility; they also must be addressed at provincial and territorial levels. A review of provincial/territorial efforts by Ron Dyck and Jennifer White (1998) provides the most recent, albeit mixed, report.

The Province of Alberta has been in the forefront of provincial/territorial approaches. In 1974, the government of Alberta established a Task Force on Suicide to study and make recommendations to prevent suicide (Boldt, 1976). Arising out of the Task Force's report, the position of a provincial suicidologist—

first held by Mark Solomon and then by Ron Dyck—was established in 1978. In 1981, with strong support of Bob Bogle, Minister of Community Health and Social Services, the government of Alberta established the Suicide Prevention Provincial Advisory Committee (SPPAC). Under the leadership of Menno Boldt, SPPAC set out to develop a comprehensive suicide prevention program. The Alberta Model, as the program became known, was developed with four objectives: (a) to provide education and training, (b) to offer outreach services, (c) to establish an information centre, and (d) to support a research centre (Boldt, 1985a, 1985b, & 1998). Although Alberta itself fell short of these intended objectives—the research centre, for example, was never established and the position of provincial suicidologist, a cornerstone of the model, all but disappeared with budget cuts in the 1990s—this model continues to be historically the best in Canada. The efforts by numerous people in Alberta deserve the commendations and national honours which they have received.

British Columbia, Quebec, New Brunswick, and the Northwest Territories (including the newly established Nunavut (April 1, 1999)) all received good grades in the provincial survey (Dyck & White, 1998). The poorest grade went to Ontario, which has done nothing to date to address the problem (except a lone "Think Tank" meeting on January 10, 1992 which resulted in the usual recommendations, but no action). Thus, with some exceptions at provincial/territorial levels, it is easy to extend the conclusion made by Jack Anawak (1994), an Inuit leader, about suicide prevention in the Arctic to Canada as a whole:

> We need to own this problem. We cannot give it over to the government . . . We own this problem. Say it . . . Believe it. We are part of the problem, if we do not acknowledge this fact and take both individual and collective actions to address it.

COMMUNITY APPROACHES

The classical approach to the prevention of mental health and public health problems is that of Caplan (1964), who differentiated primary, secondary, and tertiary prevention. The more commonly used concepts for these three modes of prevention are prevention, intervention, and postvention, respectively. All three modes of response have a place in helping the suicidal person in the community in a reasonably prudent fashion. Briefly, the three modes refer to the following:

1. Prevention relates to the principle of good mental hygiene in general. It consists of strategies to ameliorate the conditions which lead to suicide, to do something before the event occurs. Preventing suicide is best accomplished through primary prevention. Prevention is education. People and professionals must be educated about suicide. Such education—given that suicide is a multidimensional malaise—is enormously complicated, almost tantamount to preventing human misery.

2. Intervention relates to the treatment and care of a suicidal crisis or suicidal problem. Secondary prevention is doing something during the event. Since suicide is a multi-determined event and not solely a medical problem, many people can serve as lifesaving agents. Nonetheless, professionally trained people—psychol-

ogists, psychiatrists, social workers, psychiatric nurses, crisis workers, and so on—continue to play the primary roles in intervention.

3. Postvention, a term introduced by Shneidman (1973), refers to those things done after the event has occurred. Postvention deals with the traumatic aftereffects in the survivors of a person who has committed suicide (or in those close to someone who has attempted suicide). It involves offering mental health and public health services to the bereaved survivors. It includes working with all survivors who are in need.

Prevention

Although there exists a reasonably long history of prevention efforts in Canada on many topics (from parenthood preparation to stress-reduction training) (Lumsden, 1984), such is not the case for suicide prevention. A survey released by the Canadian Mental Health Association in 1981 noted that there was no program on the topic (CMHA, 1981) and little, if any, community activity. The situation has changed significantly since 1981, but not in all regions: there are still, for example, very few university studies on the topic (Maris, 1994), and professionals—psychologists, psychiatrists, medical doctors, and so on—still receive little, if any, education about suicide prevention (National Task Force, 1987). A community approach (as opposed to only a professional one) has, in fact, become the major focus of suicide prevention programs. Indeed, in *Suicide in Canada* (Leenaars et al., 1998), which was the first Canadian overview on the topic, the word most frequently indexed by some 60 authors was "community."

Although there are numerous local education programs, such as those administered by the Canadian Mental Health Association, the largest national efforts have been through the Canadian Association for Suicide Prevention (CASP). CASP had its early roots in a 1979 Ottawa meeting of the International Association for Suicide Prevention (IASP). The Ottawa IASP meeting, which was the first major event in suicide prevention in Canada, was organized by two important suicidologists, Jim Brown and Diane Syer. Although some people—such as Bernd Osborg, Sol Hirsch, and Gordon Winch—had been attending international IASP meetings for years, the Ottawa meeting gave great impetus to addressing the problem of suicide and its prevention in Canada. It paved the way for a first (albeit short-lived) attempt at a CASP which began, through the efforts of Diane Syer and Pat Harnisch, with its incorporation in 1985. However, shortly after 1986, CASP—because of factors such as the lack of the bylaw-mandated annual general meeting, the destructive impact of ongoing internal dynamics, and Diane Syer's premature move to the United States—ceased to exist.

At a June 1988 meeting, in response to increased recognition of suicide as a national problem, CASP was resurrected. At that meeting (which was skillfully hosted by Suicide Action, Montreal), I was elected to be the first President of the renewed CASP. The newly elected Board of Directors decided to dissociate the new organization from the earlier one and to develop a CASP which would meet its objective: "to promote within Canada activities designed to reduce the incidence and/or effects of suicide."

The real work of meeting that objective was undertaken within the peaceful and inspirational setting of Lake Louise, Alberta by the "group of six," Marcia Krawll, Antoon Leenaars, Brian Mishara, Linda Rosenfeld, Bob Sims, and Bryan Tanney. These people, and my constant consultant, Edwin Shneidman, became the true grandparents of suicide prevention in Canada, and Lake Louise—tribally known as Lake of Little Fishes—became CASP's spiritual home.

A constructive, five-year plan to meet CASP's objective was developed by the group of six. The plan focused on: (a) building membership, (b) networking and communication, (c) developing conferences, (d) increasing awareness, (e) establishing the first committee (the School Committee) to address suicide in youth, (f) addressing suicide in First Nations and Inuit People, (g) promoting research, and (h) improving operational structures.

CASP has undertaken many activities, including its main endeavour, a series of annual conferences. The first regional conference, chaired by Isaac Sakinofsky, was held at St. Michael's Hospital in Toronto in October of 1989. In October of 1990, CASP sponsored the first national conference, entitled "Lifting the Silence" (Krawll, 1998), which was held in Vancouver. It brought together over 500 people to learn from one another about suicide in Canada. Bryan Tanney was the conference program chair, Marcia Krawll and Linda Rosenfeld were the local conference co-chairs, and I was the President of CASP. The conference was opened by Bea Shawanda with a session entitled, "The Healing Power of Laughter and Play." Shawanda was only one of a long list of Aboriginal participants at the conference. Edwin Shneidman, as a personal favour, delivered the keynote address, entitled "Reflections on suicide and suicide prevention." The conference was successful in: (a) validating the need for a Canadian approach to understanding suicide, (b) placing the emphasis on the community's responsibility in preventing suicide, (c) lifting the silence (or taboo) of suicide on a national scale, and (d) securing a firm place for CASP in prevention. Subsequent conferences have continued this means of primary prevention nationally.

CASP's advocacy activities have been directed towards encouraging the government to engage in *national* primary prevention efforts. Recommendations to the federal government have focused on three areas: (a) health promotion, stressing the need both for Canadian information being available to caregivers and for a Canadian publication directed towards survivors; (b) research, highlighting the need for Canadian research on attempters and calling for a meeting in which Canadian researchers could establish research priorities; and (c) the task-force report, calling for a commitment to following the many recommendations made in *Suicide in Canada*.

There have been many other activities carried out through CASP. There have been many people since the group of six who deserve credit; to name any would be to omit too many. There was, and will be, a lot of work to do in suicide prevention. There will need to be new initiatives, not only by CASP, but other community organizations and institutions in suicide prevention.

Although there now are numerous efforts across Canada in prevention, one unique effort deserves special mention. In the 1970s, information about suicide was scarce. Alberta led the way to rectify this problem, and in 1981, under Menno

Boldt, a committee recommended the establishment of an information resource centre. The Suicide Information and Education Centre (SIEC) grew out of these efforts (Kiddey, Harrington, & Ramsay, 1998). SIEC, because of the work of many people, especially Bryan Tanney, Gerry Harrington, and Karen Kiddey, developed into Canada's—and the world's—largest information centre for English-language literature on the topic. Today, it continues to provide a basic of prevention—information.

Intervention

The first major attempt at suicide intervention came from the crisis centre movement. The first known centre in the world was established in Berlin in 1948 during the Airlift. The impetus for crisis centres came, however, largely from a centre established in Los Angeles which promoted the telephone as a way to reach out for help in a crisis. The Los Angeles Suicide Prevention Centre (LASPC) opened its telephones and its doors to people on September 1, 1958 (Leenaars, 1999; Shneidman, & Farberow, 1965). The trio responsible for this initiative were Edwin Shneidman, Norman Farberow, and Robert Litman—although the credit for the day-to-day work then, as now, goes to the volunteers who answered the telephones. Suicide prevention depends, in fact, worldwide on volunteerism.

The first telephone centre in Canada, Lifeline, was started in Sudbury, Ontario on October 4, 1965 by Rev. Bruce McDougall. The real push for telephone crisis lines came, however, from the Suicide Prevention and Distress Centre in Toronto, led by Gordon Winch, Pat Harnisch, and later, Karen Letofsky. The idea came from Graham Cotter, who had visited a Samaritan Centre in the United Kingdom in 1964. Cotter's experience prompted the Anglican Social Services Council of Toronto to establish a committee which, in May of 1967, incorporated as the Board of the Distress Centre (Winch & Letofsky, 1998). On November 1, 1967, 48 trained volunteers began to answer the telephone. The first three calls were from people in suicidal despair (Winch & Letofsky, 1998). Since then, the calls have increased to an estimated 800,000 calls per year.

Subsequent to the establishment of the Toronto Centre, more centres emerged across Canada. An umbrella group, the Canada Council of Crisis Centres, was established in the fall of 1972 under the direction of Pat Debridge although its life-span was short. Two Canadian centres merit special note: (a) Suicide Action in Montreal (started on May 1, 1984 under the direction of the late Rejean Marier), which provides the largest French-language service in Canada; and (b) Kamat-siaqtut, Baffin Crisis Line (opened on January 15, 1990 under Sheila Levy (Levy & Fletcher, 1998)), which provides an Inuktitut service to the vast Arctic region. The growth in the number of centres operating in Canada has been remarkable: in 1978, 92 centres had been established; by 1994, 210 centres were listed in CASP's records (CASP, 1994). The life-saving effects of these centres have been well established. Replicating a large-scale study in the United States (Lester, 1993), Leenaars and Lester (1995) demonstrated the preventive impact of crisis services on suicide in Canada. Crisis centres today continue to be a major effective avenue to intervention in Canada.

The treatment of suicidal people across Canada, prior to and following the arrival of Europeans, has been widespread and diverse. The first special psychiatric emergency program for suicidal people was established by Isaac Sakinofsky:

> It was to McMaster University, Hamilton and its cluster of teaching hospitals that I came to Canada in 1968, and fairly soon (with the help of an enlightened chief of medicine, Bill Goldberg) I was able to set up a special program for suicidal people at St. Joseph's Hospital (site of the regional psychiatric emergency services) that was modelled on the unit created in Edinburgh by Norman Kreitman and Henry Mathew. Although I knew of the Los Angeles Suicide Prevention Center I had only a hazy conception of how it worked. A few years later, when our unit was visited by Edwin Shneidman, I came to know more about it and about programs in Oxford and Australia from other visitors (Keith Hawton and Bob Goldney). Our unit which we euphemistically called the Liaison Unit (it had grown out of the hospital's psychiatric consultation-liaison service) took on a character that was its own and, for the times, untraditional. Although the team was led by its two psychiatrists (Emil Zamora and myself) the nurses functioned as primary therapists side by side with the psychiatric residents and medical students. The assessments of each case were comprehensive and included meetings with the family, judicious and protective contact with employers, and ongoing cooperation with the relevant social agencies, representatives of which were invited to the case conferences. Our goal was to do intensive crisis work and have the patient back in the community within 72 hours. We did not always achieve so tight a timetable, particularly with adolescents who had left home, but the goals of comprehensive evaluation and community orientation were always adhered to. Further detail on the philosophy of the program may be gathered from presentations made at the 1979 IASP meeting held in Ottawa by Anne Howe (Howe & Sakinofsky, 1979), an early head nurse, and June Miller (Miller, Sakinofsky, & Streiner, 1979), a psychiatric social worker (Sakinofsky, 1998, pp 11-12).

Subsequently, other university and hospital-based programs were developed (Sakinofsky, 1998). The most notable early ones were Jim Brown's unit in Winnipeg, Paul Termansen and Linda Rosenfeld's SAFER program in Vancouver, and Diane Syer's crisis program in Toronto. By the time that the IASP meeting occurred in 1979, there were, in fact, many intervention programs. At that meeting, Canada's professionals came together for the first time and networked to discuss and to share the comprehensive intervention programs across Canada.

Of course, there are today many professionals on the front lines. There were —and are—many people saving lives, too many to even attempt to name a few, although the education-based training in intervention by Bryan Tanney and the late Roger Tierney deserve to be noted. Ultimately, intervention takes the whole community; everyone in Canada needs to be involved in suicide intervention.

Postvention

The emotional pain of suicide ends up in the minds and hearts of the survivors (that is, in those people who have been left behind). Survivors of suicide (often the whole community) have only recently been treated with respect. During most of the last century, survivors were ostracized and were themselves treated as though they were mentally ill—most likely as a means of promoting the taboo of suicide. Public recognition of the pain experienced by survivors began in the 1970s, following the 1972 change to Criminal Code of Canada. The first efforts at

postvention were in the work of Albert Cain (1972) and Edwin Shneidman (1972). But it was not until the 1980s that survivors finally began to receive professional attention, to have access to self-help programs, to have their difficult experiences appropriately addressed, and to have their needs met.

The first program for survivors in Canada—started by Karen Letofsky in 1979 (Rosenfeld, 1998)—was developed out of a liaison between the Clarke Institute of Psychiatry and the Toronto Distress Centre (Rogers, Sheldon, Barwick, Letofsky, & Lancee, 1982). The model was derived from a survivor-group movement in California which had been spurred on by the work at the Los Angeles Suicide Prevention Centre. Survivor groups provide an opportunity, usually with other survivors, for sharing the pain, experiences, emotions, and aftershocks of suicide.

These groups have grown in number throughout Canada, and have been most beneficial (Cain, 1972). The Suicide Attempt, Follow-up, Education and Research program (SAFER) established a postvention program in Vancouver in 1980 under the direction of Linda Rosenfeld. SAFER is a multi-faceted suicide-intervention service which includes a postvention program. Other early postvention programs included that established in Edmonton by Mark Solomon, Alberta's first provincial suicidologist (following the publication of "The Bereaved and the Stigma of Suicide" (1982-83)) and that begun by Linda Delisle in Quebec City in 1982.

Notable among the many other postvention programs which have been developed are: (a) Anne Edmunds' program in Windsor, ON (in association, as in many communities, with the Canadian Mental Health Association); and (b) Barbara Moffat's program in Peterborough, ON. Suicide survivor programs are now plentiful in Aboriginal communities and elsewhere.

In recent years, Anne Edmunds, in association with CASP, established the first national survivor committee. The purpose of this effort is to work nationally for survivor needs. Activities of the committee include organizing special programs—both for healing (such as a candlelight vigil) and for education. These efforts promise to add to the well-being of many Canadians.

There also have been larger community approaches in postvention in Canada, namely in schools. The first known postvention program in schools began in Windsor, Ontario in 1980—first under my direction (Leenaars, 1985) and later under the direction of Susanne Wenckstern (Wenckstern, Leenaars, & Tierney, 1995). School suicide postvention essentially represents a synthesis of education strategies, consultative intervention, crisis intervention, and postvention in general. It is much more than debriefing or grief counselling (Leenaars & Wenckstern, 1998). Such programs, which strongly count on Canada's community approach to wellness, are now widespread.

Postvention also involves information. Although Cain's book (1972) was the first, Canada's most important book is *Left Alive*, by Linda Rosenfeld and Marilynne Prupas (1984), which has received international acclaim. The writings of Anne Edmunds, Jeannette Ambrose, and Lois Sapsford also have been influential. In our 1991 meeting with Perrin Beatty, CASP asked for a national publication for survivors; such a document has yet to be published. Nonetheless, since 1980 Canada has not only changed its perspective on survivors, but also has led the way in the development of postvention programs and information.

RESEARCH

Research is the basis for sound knowledge in a particular scientific community. In Canadian suicidology, the community has acknowledged research efforts as the foundations for prevention. Early (pre-1980) research was undertaken by Ken Adams in attachment theory, by Roger Bland in attempted suicide, by Jim Brown, Sol Hirsch, Isaac Sakinofsky, and Diane Syer in epidemiology, by Hugues Cormier and John Hoening in socio-economic correlates, by Al Evans in prevention, by Sol Littmann in means restriction, and by Mark Solomon in prevention. Among the many individuals undertaking contemporary research in suicidology (too many, indeed, to highlight), the following recipients of CASP's Research Award (for outstanding research in the field of suicide and its prevention) merit special mention: Isaac Sakinofsky for his work in epidemiology, Ken Adams for his contributions to attachment theory, Bryan Tanney for his research into training, Brian Mishara for his work on social correlates, Michael Kral for his Inuit research, and myself for work on suicide notes.

Unfortunately, though, there is inadequate support overall for suicide research in Canada. Indeed, only one large-scale study in attempted suicide has been undertaken. Following the model of the WHO/EURO multi-centre study, Roger Bland, Ronald Dyck, Stephen Newman, and Helene Orn (1998) studied a large sample of attempters in Edmonton, Alberta. Their work provides the only credible data on rates of attempts anywhere in Canada (with such details as age, sex, demographics, and method). The research began in November, 1990 with a 6-month pilot study; the large-scale work began in February, 1993 and continued for 1 year. These researchers (as well as CASP) have called for a national study to gain necessary information about Canadian suicide attempters. To date, no such study has been funded.

Similarly, evaluative research on Canadian suicide prevention and intervention programs is sparse. A recent review of the topic (focused primarily on young Canadians) was undertaken by Jean-Jacques Breton, Richard Boyer, and their colleagues (Breton et al., 1998). Out of 15 studies cited in this review, 11 had originated in Quebec. These studies showed a range of effective programs in Quebec (including government efforts, sensitizing youth towards suicide risk, and operating in hospital settings). Breton and his colleagues, noting the lack of similar research in the other provinces and territories, concluded that the government must give greater priority to research on the evaluation of programs in suicide prevention and treatment.

Clearly, the need for Canadian research is urgent. It is now a well-established fact that we cannot borrow, as a whole, studies from the United States (Leenaars, 1995). The transposing of American findings alone may well result in less-than-adequate conclusions within the Canadian context, and may even lead to suicidogenic mistakes. However, the lack of support for necessary research continues. Indeed, Canada's support for research on any topic is, on a per capita basis, among the lowest in major countries reporting to the Organization for Economic Cooperation and Development (Lipset, 1990). Canada has a paucity of research-intensive universities and private-funding institutions. Current government funding

is meager and support has declined. It was less in the 1990s than it was in the 1980s, and it was less in the 1980s than it was in the 1970s.

CONCLUSIONS

There are, of course, limitations to this account of the history of suicidology in Canada. The first comprehensive overview, "History: Vignettes of the Development in Suicide Prevention" appeared in *Suicide in Canada* (Leenaars et al., 1998). Beyond that chapter, little else has been written by way of an historical overview.

Many people have laid the early foundation for wellness in Canada. The Aboriginal peoples have done so for millennia. CASP has begun to recognize these people by awarding a Service Award to leaders in the field of suicide prevention. The service providers recognized to date are: Sheila Levy (crisis centres), SIEC (information), Gordon Winch (crisis centres), Pat Harnisch (crisis centres), Susanne Wenckstern (youth/schools), Roger Tierney (training), Anne Edmunds (survivorship), Errol Fletcher (crisis centres), Karen Letofsky (bereavement), Carol Perkins (volunteer), Barb Campbell (community programs) and SAFER (service).

The list of suicide preventionists is exhaustive. There are many people in our communities who are offering hope to our suicidal people. These front-line workers are the real heroes in the history of suicide prevention—even though they remain largely unnamed and unrecognized.

Hopefully, though, through the people, dates, and events chronicled in this account, it will be possible to review some of the crucial moments in the history of suicide prevention in Canada and, from that review, to determine the direction that we, as Canadians, will take in this millennium to address the issue of suicide.

RÉSUMÉ

Le suicide est un problème de santé mentale et publique majeur au Canada. Le taux de suicide au Canada dépasse la moyenne observée dans les autres pays du monde. La prévention du suicide existait avant l'arrivée des Européens en sol canadien et l'on peut tirer de nombreux enseignements de ces pratiques. Les mesures actuellement en cours sont surtout le fruit du travail des intervenants et intervenantes dans le milieu, qui n'ont bénéficié que d'un faible soutien et ont souffert du manque d'initiatives de la part des gouvernements (sauf quelques exceptions au niveau provincial et territorial). Les efforts déployés par les communautés canadiennes se démarquent par leur caractère varié et leur nature inclusive. Parmi ces efforts, notons: (a) les approches traditionnelles chez les autochtones, (b) l'établissement du premier centre de crise à Sudbury dans les années 1960, (c) le développement d'un modèle d'intervention complet en Alberta, (d) l'émergence du mouvement des survivants et survivantes au cours des années 1980 et enfin, (e) les campagnes pancanadiennes de prévention lancées par l'Association canadienne pour la prévention du suicide. Toutefois, il existe encore de sérieuses lacunes, notamment la pauvreté du soutien à la recherche en ce domaine au Canada. Il est à prévoir que les initiatives du futur feront encore plus largement appel à la contribution de la communauté afin de prévenir le suicide et de promouvoir la santé.

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