Subject: Preventing Deaths by Suicide on Public Infrastructure

Report to: Public Health & Social Services Committee

Report date: Tuesday, January 8, 2019

Recommendations

1. Regional Council as the Board of Health **RESOLVES** that current public discourse around suicide has caused contagion and **REQUESTS** local media and others with a public audience to adhere to the Canadian Psychiatry Association's 2017 "Media Guidelines for Suicide Reporting" to prevent further contagion of suicide
2. Regional Council as the Board of Health **ENDORSE** the proposed framework for preventing suicides on public infrastructure
3. Within this framework, Regional Council as the Board of Health **ENDORSE** the importance of considering a barrier at the location of multiple recent deaths by suicide and **DIRECT** staff to proceed with planning for such a barrier for installation in 2019, reporting back by spring 2019 with a final recommendation, detailed cost estimates, and budget options
4. To implement this framework, Regional Council as the Board of Health **DIRECT** staff to develop and report back in spring 2019 with detailed cost-estimates and budget options for:
    a. Suicide identification/intervention training
    b. Suicide risk assessment capacity-building
    c. Support for a Mental Health Hub/Clubhouse in St. Catharines
5. To implement this framework, Regional Council **DIRECT** staff to engage with the Ministry of Transportation on opportunities for provincial funding to support a possible infrastructure barrier as in recommendation #2
6. As part of this framework, Regional Council **DIRECT** staff to include consideration of barriers on any future major infrastructure projects, and to include details of their consideration in reports to Council for approval of such projects

Key Facts

- Deaths by suicides increase in the days and weeks after widespread discourse or coverage of the details of a death by suicide. This "contagion" is usually characterized by deaths from the same or similar means, and often in the same location. To prevent contagion, many specifics have been omitted from this report.

- Niagara-wide, there are approximately 44 deaths from suicide each year. Of these, an average of 3.8 deaths from suicide each year can be attributed to a fall from a height.
- Since October 2018, there have been three deaths by suicide from a single public infrastructure element in St. Catharines, as well as at least one death from an analogous infrastructure element elsewhere. The latter three deaths all occurred within days of significant public discourse of a prior death by the same means, and were likely due to contagion.
- Historically, the infrastructure implicated has not been associated with deaths from suicide, emphasizing that public discourse fueling contagion is likely responsible. It is unknown if this location may now become a “suicide magnet” longer term or not.
- Scientific research on suicide prevention in public places points to five areas of activities that should be taken in concert:
    - Restricting or deterring access to the means of suicide
    - Increasing opportunities for individuals to seek help
    - Increasing probability of human intervention
    - Redefining the public image of a place to no longer be attractive as a place to die by suicide
    - Improving integration and access of the mental health services
- Niagara Region staff and partners have escalated activity and plans in all five of these areas since October 2018 in order to reduce deaths by suicide Niagara-wide.
- Regarding the first area, barriers on infrastructure have relatively strong scientific evidence of preventing deaths by suicide from falls from a height, without a proportional increase in deaths elsewhere.
- The two infrastructure elements most strongly associated with deaths by suicide from a fall from a height are at locations other than where recent deaths have occurred, and where in discussion with the jurisdiction owner, barriers would not be feasible.
- Addition of a barrier to the infrastructure implicated recently in St. Catharines would cost upwards of $4 million and would take until late 2019 to be completed.

Financial Considerations

The proposed framework for suicide prevention on public infrastructure identifies several opportunities for enhanced work locally. The cost of such enhancements are included the table below.

Table 1. Framework to Prevent Suicides on Public Infrastructure and Possible Budget Implications

Area of Suicide Prevention	Activities	Local Enhancement	Estimated Capital Cost	Estimated Operating Cost
Restricting & Deterring Means	Barrier on public infrastructure	Barrier at location of recent suicides in St. Catharines	Approximately $4 million	
	Lighting	Review of lighting on infrastructure	$TBD	
Increasing Opportunities for Help Seeking	Signs & crisis phones	Signs		$TBD
	Staffed sanctuary	Implement HUB model or Clubhouse model in St. Catharines	$TBD	Contribution toward $700,000 cost
Increasing Probability of Intervention	Surveillance cameras	NRPS surveillance pilot	$TBD	
	Increased patrols	Increase in patrols		$TBD
	Suicide awareness & intervention training	ASIST & safeTALK training		$300,000 over 2 years (1.5 FTE)
Redefining the Public Image	Media Portrayal	Engagement with media Digital engagement campaign		$TBD
	Memorials	Relocation of memorials		$TBD
Mental Health System	Increasing suicide risk assessment	Public Health & CAMH-led capacity building		$67,500 over 2 years (0.5 FTE)
	Integration of mental health system	LHIN System Mapping		$500,000 implementation

Public Health could increase training for suicide awareness and intervention with 150 people who regularly interact with mental health clients as well as 500 members of the public. As well, Public Health has a plan to build capacity among health care providers for increased risk assessments. Together, this would require 2 FTEs of work over 2 years, production of supplies, reimbursement of the Niagara Distress Centre for services, and hosting a community forum at a total cost of $367,500.

Operating a mental health HUB or Clubhouse in St. Catharines would cost approximately $700,000. Niagara Region could support a portion of these operating

costs. Alternately, the Region could consider support through acquiring and donating a physical facility as a capital expenditure.

The LHIN is embarking on mapping the mental health system locally to identify gaps and opportunities for improvement. Niagara Region could contribute to implementation of improvements identified, particularly as they relate to current services. A possible future budget of $500,000 to implement these has been estimated. It is not recommended that any decisions be made to fund these until possible improvements have been identified.

None of the above estimates have been included in the 2019 operating or capital budgets, and/or previously approved budgets for Regional infrastructure. The Capital Variance Project provides funding for in-year capital project adjustments, and at this time $5.8 million in capital variance project funding is available to support priority projects, including the One District Police Facility, a number of transportation related projects and the low end estimate for the barrier on public infrastructure noted above.

Once the detailed cost estimates are determined, a report to Council with those estimates will be provided as well as recommended sources of funding. Council approval is a requirement of a Capital Variance Project draw greater than $1 million, and any further Capital Levy Reserve funding and/or an operating budget funding would required Council approval and a budget amendment.

Analysis

Contagion & Use of Language

Suicide “contagion” is the phenomenon where susceptible persons are influenced towards suicidal behaviour and certain suicide methods by learning of another’s suicide. This scientific finding has been validated many times: public discourse of a death, be it on social media, public fora, political debate, or traditional media can lead to an increase in deaths in the days and weeks after.[1] Additional suicides are most likely when there is/are

- greater volume or profile of discourse (e.g. front page coverage),
- descriptions that are specific and graphic (including the means of death and/or the location of death),
- descriptions of the victim in relatable terms,
- coverage of sympathy and concern towards the victim after the death, and
- ascribing simple or singular reasons for the death (e.g. was caused by bullying)

[1] Niederkrotenthaler T, Herberth A, Sonneck G. The "Werther-effect": legend or reality? *Neuropsychiatr*. 2007;21(4):284-90.

- language that implies action, control, or solution (e.g. “committed”, “successful” or “failed” attempt, “took their life”, prominent use of “suicide”)
- portrayal as achieving a result (e.g. relieving of pain/suffering; leading to peace or a “better place”; going to “heaven”; the act was quick, easy, and/or painless)

Research shows that when language and reporting avoids the above, contagion can be minimized (elimination of contagion requires there be no reporting).[2] As well, coverage that focuses on the opposite (e.g. other people who have overcome mental illness), it can lead to the opposite of contagion—a reduction in deaths by suicide in the days and weeks after.

In order to prevent this report, quotes taken therein, debate at Committee/Council, or subsequent coverage from contributing to contagion, language used in this report will sometimes be indirect and avoid specifics.

Statistics in Niagara

Statistics Canada’s Vital Statistics database is the established standard for examining causes of death. The most recent data release showed that in the 5 year period of 2008 to 2012, there were 222 deaths by suicide (average 44.4 deaths per year). Of these, on average,

- 18.2 deaths resulting from suspension from a cable,
- 9.8 deaths from a drug overdose,
- 3.8 deaths from a fall from a height,
- 3.2 deaths from chemical overdose,
- 3.0 deaths from firearms, and
- 1.8 deaths from sharp or blunt objects.

Examination of calls received by Emergency Medical Services data from 2016 to September of 2018 shows that call volumes related to suicide attempts and self-harm were stable from 2006 to 2015 (between 550 and 600 calls per year). There was an increase in calls thereafter with closer to 800 calls per year in 2016 to 2018. Part of this increase may be attributable to revised dispatch protocols during this time. It is unknown if more severe impacts from opioid use may be a contributor to this increase.

[2] Mark Sinyor, Ayal Schaffer, Yasunori Nishikawa, Donald A. Redelmeier, Thomas Niederkrotenthaler, Jitender Sareen, Anthony J. Levitt, Alex Kiss and Jane Pirkis. *CMAJ* July 30, 2018 190 (30) E900-E907; DOI: https://doi.org/10.1503/cmaj.170698

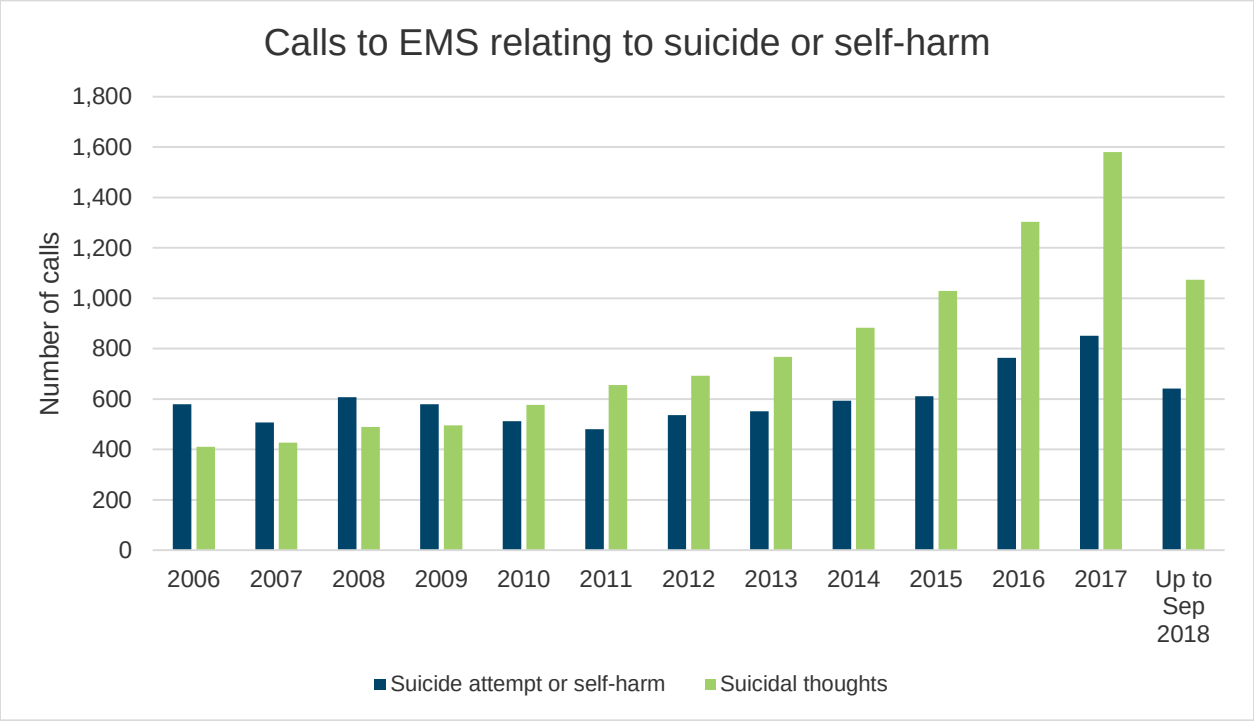

Figure 1 Calls to EMS relating to suicide or self-harm (2006 to September 2018)

Recent Events

In the three months since October 2018, there have been three deaths by suicide on an element of public infrastructure in St. Catharines, in addition to one reported attempt. As well, there has been at least 1 death at a similar infrastructure element elsewhere. Given the expected 3.8 deaths Niagara-wide per year from a fall from a height, 3 deaths in 3 months is unexpectedly high.

Under section 10 of the *Coroner's Act*, the Ontario Coroner's Office investigates every suspected death by suicide, and so has the most comprehensive and reliable data set. The coroner reported to us that they did not identify any deaths by suicide at this infrastructure between 2006 and 2017 (because the Coroner does not geocode investigations, their database query for deaths at this location was based on searching for place names, which is less accurate than geographical coordinates).

Data from Emergency Medical Services does not show any incident responses coded consistent with a death by or attempt of suicide at this infrastructure between 2010 and 2017 (EMS data is coded based on the 911 call, so if a response was not attributed to suicide or suicide attempt on the call, it would be missed by this database).

The lack of history of deaths by suicide at this location makes these recent deaths unusual. These deaths and the attempt all received significant discussion in the media, on-line, in political councils, and in public memorialization. This created significant risk of contagion. Indeed, all three of the later deaths occurred within 10 days of significant media coverage and public discourse of the earlier suicides, the highest risk period. The

reported attempt occurred within 18 days of such coverage. All of these are therefore likely attributable to a cycle of contagion, explaining the deviation from the historical norm.

In discussion with suicide experts, the three-month history is not enough to have confidence whether if this location will continue to have contagion-fuelled deaths by suicide, or if the cycle of contagion could end. However, there is certainly risk of the former.

Framework for Preventing Deaths by Suicide

Public Health England, the United Kingdom's scientific expert body on public health matters, published a guideline in November 2015 on preventing suicides in public places[3]. The guideline was based on a review of the scientific evidence, existing international guidelines, published and unpublished reports and policy documents, consultation with local governments worldwide, and interviews with survivors. The resulting guideline was pilot tested in local jurisdictions as well for revision prior to being published.

The guideline prioritizes action at the most frequently used places by individuals who die by suicide. A framework for prevention is outlined involving action in four areas of focus:

- Restricting and deterring individuals from the means of dying by suicide
- Increasing the opportunities for those in a public place who are contemplating dying by suicide to seek help
- Increasing the probability that persons can intervene with those intending to die by suicide in a public place
- Redefining the image of a public place where individuals die by suicide into one less attractive for this purpose

As suicide is complex, measures from multiple areas should be undertaken, ideally from all four, in order to be effective.

In addition, given the important role of the health care sector in diagnosing and treating mental illness before it progresses to suicidality, a fifth area of focus relating to this sector has been added to the framework

Below, the five areas are applied to publicly-accessible infrastructure in Niagara where deaths may occur from a fall from a height.

[3] Dr Christabel Owens, Rebecca Hardwick, Nigel Charles and Dr Graham Watkinson at the University of Exeter Medical School. *Preventing suicides in public places: A practice resource*. 2015.

Restricting/Deterring the Means

Restricting/deterring the means has been identified as one of the most scientifically-supported measures for suicide prevention[4]. When dealing with deaths on public infrastructure that occur from a fall from a height, the major means restriction is a barrier or netting. Additional deterrents would include lighting.

Research consistently shows that barriers (henceforth assumed to include netting) are effective at preventing deaths by suicide from falls on infrastructure, and that the majority of these deaths do not simply redistribute to other locations, but are completely prevented.[5][6]

The Ontario Coroner's Office was asked to identify the locations where deaths from suicide from a fall from a height are most common, and therefore where a barrier would be most impactful. The Coroner identified two locations (NF-1 and NF-2/NF-3 in Table 2). In addition, data was requested for the location of recent interest (StC-1). EMS responses for suicide and suicide attempts consistent with a fall from a height were also collected.

To supplement this, EMS data on responses to suicidal ideation by threatening to fall from a height was also reviewed. Data was limited to infrastructure widely used by the public (e.g. private residences, industrial buildings were excluded). Suicidal ideation rarely proceeds to death. Often it spurs individuals to treatment; other times it can be help-seeking for someone struggling to navigate the health care system. Nonetheless, suicidal ideation may highlight locations that are generally attractive for a suicide attempt.

A total of 44 locations had a suicide death, suicide attempt, or suicidal ideation associated with falling from a height from public infrastructure (Table 2).

As previously noted, location StC-1 has rarely seen deaths by suicide prior to 2018. Reviewing the EMS responses to suicidal ideation, however, StC-1 does seem to be the location with the most suicidal ideation, followed by NF-1 and NF-2.

It should be noted that after averaging less than 2 incidents per year at StC-1, in 2018 there have been 7 incidents up to December 14. This is likely due to contagion again.

With the history of the most deaths by suicides historically, NF-1 and NF-2/NF-3 are the best candidates for a barrier. Staff have informally engaged the jurisdiction owners for that infrastructure, however, barriers in those locations are deemed by them not to be feasible.

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[4] Jane Pirkis, Matthew J Spittal, Georgina Cox, Jo Robinson, Yee Tak Derek Cheung, and David Studdert. The effectiveness of structural interventions at suicide hotspots: a meta-analysis. *International Journal of Epidemiology 2013;42:541–548. doi:10.1093/ije/dyt021*

[5] Pirkis *et al*. 2013.

[6] Sinyor M, Schaffer A, Redelmeier DA, et al. Did the suicide barrier work after all? Revisiting the Bloor Viaduct natural experiment and its impact on suicide rates in Toronto. *BMJ Open* 2017;7:e015299. doi:10.1136/bmjopen-2016-015299

StC-1 has the most frequent suicidal ideation implying some greater potential for deaths from suicide to occur here, though only a 3 month history of frequent deaths.

The Region retained the original designer of the structure in St. Catharines to develop a barrier design that would be structurally and esthetically compatible. This work is ongoing. The order of magnitude cost estimate for a barrier along all exposed edges of the structure is $4 million based on conceptual design and market intelligence. The design work continues, along with the refinement of the cost estimate and will be subject to a subsequent report to Council.

Given that, after consulting with suicide experts, there is uncertainty whether deaths from suicide due to ongoing contagion can be expected to continue at this location. There is therefore also uncertainty whether a barrier would be the best mental health intervention and the best use of taxpayer dollars, since there is a possibility that contagion will dissipate and deaths will stop occurring as was the case prior to 2018. However, if a barrier is not built but contagion does not dissipate, preventable deaths will continue.

To balance these imperatives, and given that a barrier cannot be erected until late 2019 at the earliest, it is recommended that planning for a barrier to be erected in late 2019 continue as a contingency. In the next several months, other suicide prevention efforts will continue. Based on the pattern of any further deaths over those months, a final recommendation on whether to build a barrier will be brought to Council in spring 2019.

The other means deterrent to suicide, lighting, does not appear to be a concern at StC-1 or NF-1 and NF-2/NF-3. Review of lighting in other locations can be pursued as part of the larger framework.

Table 2. Suicide deaths, attempts, and ideation associated with falls from a height from public infrastructure

	Deaths & Attempts (2010-2017)		**Deaths & Attempts (2018)**		**Suicidal Ideation (EMS Responses)**	
Infrastructure Element	Coroner (To Nov. 20)	EMS Calls	Coroner (To Nov. 20)	EMS Calls	2006–2017	2018 (To Dec.14)
NF-1	11	1	1		16	2
NF-2	10		0		7	
NF-3		1			2	
NF-4					3	1
NF-5				1	3	
NF-6		1			2	
NF-7					2	
NF-8					3	
NF-9						2
NF-10					1	
NF-11					1	
StC-1	**0**		**3***	**1**	**22**	**7**
StC-2					1	
StC-3		1			4	
StC-4				1		1
StC-5					1	1
StC-6		1				1
StC-7					1	
StC-8		1			2	
StC-9		1				
StC-10					1	
StC-11		1			3	1
StC-12		1			2	4
StC-13		1			5	1
StC-14		1			1	
StC-15					2	
StC-16		1				
StC-17					1	
StC-18						1
Thorold-1					1	
Thorold-2		1				
Thorold-3						1
Thorold-4					1	
Thorold-5					1	3
Welland-1					4	1
Welland-2					2	
Welland-3					1	
Welland-4					1	
Welland-5					1	
Grimsby-1					1	
Grimsby-2					1	
Fort Erie-1					2	
NOTL-1					1	
PC-1						1

Increasing Opportunity for Help Seeking

Encouragement to seek help, even subtle ones, are often enough to help suicidal persons break from their plan. Research has shown this to be effective, though less so than means restrictions.[7]

Installing signs of where to seek help is one significant measure. In response to the deaths by suicide in October, signs were immediately put up in the area with the number to call the Niagara Distress Centre.

Crisis phones and automated messages are additional measures that have been effective in other jurisdictions.

One other opportunity for help seeking exists when there is a staffed "sanctuary" nearby to which individuals experiencing a crisis can attend. In downtown Welland, the Oak Centre has been developed according to the internationally-recognized Clubhouse Model. This model is predicated on those with mental illness helping each other, and then supplementing that with professional services to help clients build mental health and social integration skills. The International Centre for Clubhouse Development has found that admission to hospital, and hospital stays for clients are significantly reduced if someone is a Clubhouse member. Given the success of the model in Welland, there is interest by many in St. Catharines to develop a Clubhouse in this city as well. The Oak Centre is largely funded through the local LHIN and has a total budget of around $700,000.

Another model that is being discussed locally are regional mental health HUBs. HUBs of this nature accept individuals in crisis, who would normally be taken to an emergency department. Instead, in a HUB, with no competing patients needing to see a caregiver, people with acute mental health or addictions issues can get immediate help, in a setting tailored with services they need, while simultaneously relieving pressure on overcrowded emergency departments. HUBs also engage with the community and other groups to raise awareness, build the community's skills to foster social inclusion and mental wellness, and facilitate community-led responses to mental health issues.

The Suicide Prevention Coalition has recommended a HUB for St. Catharines as a top priority.

Increasing Probability of Persons to Intervene

Human interaction is very effective at deterring a person from dying by suicide. Where a location is having frequent deaths by suicide, human interaction can be increased by having additional patrols by emergency workers, as well as surveillance (e.g. by cameras) to trigger an intervention. The Niagara Regional Police Service (NRPS) has a raised level of awareness by front line patrol officers with respect to persons in crisis or experiencing suicidal thoughts, and has increased patrols in affected areas. The NRPS is piloting the use of closed circuit television (CCTV) to enhance its ability to respond to

[7] Jane Pirkis, Lay San Too, Matthew J Spittal, Karolina Krysinska, Jo Robinson, Yee Tak Derek Cheung. Interventions to reduce suicides at suicide hotspots: a systematic review and meta-analysis. *Lancet Psychiatry* 2015; 2: 994–1001

calls for service, including suicidal persons and persons in crisis in parts of St. Catharines where there have been recent deaths.

Research shows that there is no significant difference to interaction by a member of the public versus an emergency worker. However, given their greater numbers, it is usually more likely someone contemplating suicide will interact with a member of the public, rather than an emergency worker. However, people often lack the confidence to intervene, or the skill to recognize suicidal behaviour. Applied Suicide Intervention Skills Training (ASIST) is an internationally-recognized program for helping people gain the skills to recognize someone at risk of suicide, and to know how to intervene to support a suicidal person. A condensed version of this training is known as safeTALK.

Currently Public Health has staff who provide safeTALK in certain settings. As well, through the Niagara Distress Centre, Public Health has access to ASIST trainers. Public Health proposes to increase ASIST (targeting 150 of those working with mental health clients) and safeTALK training (targeting 500 members of the general public).

The Suicide Prevention Coalition currently ranks suicide identification/intervention training as one of its two key areas of focus.

Redefining the Public Image

The most important measure to decrease deaths by suicide in a public place is to end discourse that associates that location with suicide. This sentiment is reflected in how this report is written. Recognizing the disproportionate role the media play in spreading information, a half-day session was held with all local media outlets on November 16, 2018 to discuss the current public discourse and ways to shift it to better align with the Canadian Psychiatry Association's 2017 "Media Guidelines for Suicide Reporting". Public Health Communications along with Strategic Communications and the media are continuing to work on measures resulting from that meeting. The Suicide Prevention Coalition currently ranks shaping media report as its second key area of focus.

Mental health experts highlight that memorials and floral tributes after a death can associate a location's public image with suicide. This can lead to others dying by suicide in the same location. Experts recommended that memorials be removed "as quickly and sensitively as possible to prevent them building up, within two to three days at the most".[8]

In recognition of this, the memorials at the location where several recent deaths by suicide have occurred were removed in early December 2018 to reduce the risk of additional deaths by suicide. This, unfortunately, occurred much later than the "two or three days" recommended by experts. Attempts were made to remove the memorial at earlier dates. However, given public outpouring and attention prior attempts were aborted when it became clear their removal would generate controversy and more discussion of the location in association with suicide, exactly what would cause additional contagion. Going forward, staff hope to be able to adhere to the 2–3 day

[8] PHE

expert recommendation if there are any additional unfortunate deaths. As well, a permanent memorial site is being made available by Public Health at the Glenridge Naturalization Area where another memorial already exists for mental health clients who have died by suicide.

One other means of redefining the public image of a location associated with suicide is to redecorate or landscape in order to change the location's feel to be more hopeful, and to less visible sections where one may die by suicide in relative privacy. Staff plan to be mindful of opportunities to undertake such changes, though it is not anticipated that this will be a significant activity.

Improving Supports in the Mental Health System

As the mental health sector has the greatest contact with those at risk of suicide, particularly those with the greatest risk and most severe illness, deaths from suicide may be preventable through better support for these patients.

Niagara Region Mental Health has developed a Suicide Risk Assessment Strategy to strengthen health service providers' abilities to identify those at risk of suicide so that they can receive needed care earlier in their course of illness. This strategy will be delivered over the next several years, though it could be accelerated with additional investment.

The LHIN is also considering engaging a consultant to map the mental health system to address difficulties in navigating the system, to identify gaps in service, and to enable its many parts to work as a more cohesive whole. As Niagara Region serves mental health clients, there may be opportunities to implement recommendations from this exercise here. However, given that our mental health program is generally not supported through municipal levy funding, it would be a variation from past practice to do so. Until concrete proposals for change are available, staff do not recommend investing in this.

Alternatives Reviewed

As suicide affects all of Niagara and many means beyond falls from a height, the report has examined suicide holistically and Niagara-wide, rather than focused only on the location of recent interest.

Staff recommend a comprehensive approach to suicide prevention, rather than focusing on a single measure, as multi-factorial action has been shown in research to be most effective.

Recommending a barrier on the recent location of interest could have been proposed, but this was deemed to be premature given the lack of certainty that contagion will continue. However, recommending against a barrier would be imprudent given the risk that deaths by suicide might continue. The recommendation to continue working towards a barrier but deferring a final decision preserves the same opportunity to prevent suicide deaths, while also being fiscally prudent.

Relationship to Council Strategic Priorities

This report does not relate specifically to any of Council's strategic priorities. Nonetheless, it addresses a matter of current public interest.

Other Pertinent Reports

N/A

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Appendices

Appendix 1	Media Guidelines for Reporting on Suicide: 2017 Update of the Canadian Psychiatric Association Policy Paper	182–188

Canadian Psychiatric Association
Dedicated to quality care
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Dévouée aux soins de qualité

POLICY PAPER

Media Guidelines for Reporting on Suicide: 2017 Update of the Canadian Psychiatric Association Policy Paper

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This paper has been substantially revised by the Canadian Psychiatric Association's Research Committee and approved for republication by the CPA's Board of Directors on May 3, 2017. The original policy paper[1] was developed by the Scientific and Research Affairs Standing Committee and approved by the Board of Directors on November 10, 2008.

Summary

A substantial body of research suggests that media reports about people who have died by suicide, as well as the topic of suicide in general, can influence vulnerable people and is associated with higher subsequent rates of suicide. Emerging evidence also suggests that reports about people overcoming suicidal crises may lower suicide rates. The original 2009 Canadian Psychiatric Association (CPA) policy paper on media reporting of suicide[1] led to meaningful discussion between mental health professionals and journalists in Canada. This second iteration of the policy paper reviews the most up-to-date evidence relating to media reporting and suicide, and updates recommendations with more direct

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engagement and input from the journalism community. Recommendations are meant as a guide for all relevant stakeholders, including journalists, editors, producers, journalism educators, researchers, policy makers, mental health professionals, and social media platforms. The paper suggests a framework for approaching suicide-related coverage and outlines potentially harmful and helpful aspects of reporting that should be avoided and included, respectively. Recommendations include using appropriate language, trying to reduce the stigma around mental disorders, and providing information about alternatives to suicide. Pertinent resources for people contemplating suicide, such as crisis services, should also be provided and can be directly linked to reports that appear online. Simplistic or glorified depictions of suicide should be avoided, and suicide should not be presented as a way of solving problems. Reports should avoid details of suicide methods, particularly if they are novel or unusual. Recommendations also include that, where possible, suicide should be covered by or with the input of health reporters who are best positioned to contextualize suicide within the broader topic of mental health. The paper also makes preliminary recommendations for social media and suggests collaboration with online platforms to help establish organizational standards concerning the dissemination of information about suicide.

Introduction

Scientific evidence from numerous natural experiments worldwide demonstrates that media reporting of suicide can sometimes result in contagion, with increased suicide rates across a population.[2-12] The association has satisfied the criteria of consistency, strength, temporality, specificity, and coherence required to conclude that there is a causal relationship.[13-14] The research evidence indicates that, in general, more suicide deaths occur following repetitive reporting of suicide.[5-6] This relationship is widely known as the Werther Effect, a reference to a 1774 novella published by Goethe describing the death by suicide of a young man who was rejected by the young woman he loved.[2] This suicide contagion effect is thought to be mediated by social learning, whereby a vulnerable person identifies with people depicted in the media and may be more apt to copy their suicidal behaviour and subsequently die by suicide.[5-7,15-16] The effect may be particularly pronounced for youth, a group that can be more susceptible to social learning,[17-22] and in cases where the media report relates to a celebrity, whose behaviour people may be more prone to emulate.[4,12,16,23-27] In contrast, the effect does not seem to occur if the person who died by suicide was a criminal.[16] Although the best evidence in this area comes from large, population-based, natural experiments, where it is challenging to prove exposure to media reports, findings from psychological autopsy studies, reviews of suicide notes, and interviews with people who have attempted suicide show that many have or were exposed to suicide-related media content, which influenced suicidal behaviour.[8,28-34] More recently, Niederkrotenthaler et al. postulated a corollary effect to the Werther Effect called the Papageno Effect, whereby media reporting emphasizing a positive outcome of a suicidal crisis may be associated with lower subsequent suicide rates.[5] This was based on a latent class analysis examining media and suicide reporting in Austria. The authors found that articles stressing "mastery of crisis," in which people contemplating suicide employed adaptive coping strategies rather than suicidal behaviour, were associated with a subsequent decrease in the rates of suicide.[5] The "active ingredients" of reporting that mediate contagion of suicide and adaptive behaviour are not fully understood; however, there is general consensus on putatively harmful and protective aspects of media reporting, and these form the basis for media guidelines.

Guidelines for responsible media reporting of suicide have been developed across numerous countries and jurisdictions worldwide.[35-38] Several guidelines have been produced in Canada, including those from the Canadian Psychiatric Association,[1] the Canadian Association for Suicide Prevention (CASP),[39] and the Mindset guidelines developed by journalists themselves.[40] Media guidelines have demonstrable impact on the quality of reporting on suicide[41-44] and, in some cases, have been associated with lower suicide rates.[42,45] It is estimated that guidelines can prevent more than 1% of suicide deaths; such a reduction in Canada would translate to the prevention of more than 40 deaths per year across the country.[46-47] Canadian studies examining media reporting—in general and per the guidelines above—are limited. A recent study examining adherence to Mindset's 14 specific recommendations in the aftermath of a celebrity suicide found that most recommendations were followed (range of adherence was 65% to 99% of articles), except for the recommendation to tell people considering suicide how they can get help (present in only 27% of articles).[48]

The original CPA position paper on media reporting and suicide[1] garnered controversy from some who expressed scepticism about the evidence base for suicide contagion,[49] and argued that perceived efforts to suppress suicide-related stories are counter-productive.[50] In the interim, there has been increased engagement

between mental health professionals and the media via informal dialogue surrounding specific reports, through symposia at the CPA annual meeting, and during and after Canada's first media forum for suicide prevention, held in Toronto in November, 2015.[49] In part due to a greater public desire for information about mental health, journalists are increasingly interested in covering issues related to mental health, including suicide, in a respectful and destigmatizing manner.[49] Most suicide deaths are not newsworthy and the media are sensitive to concerns about contagion; however, deciding when and how to cover suicide is a delicate balancing act.[49] Rather than telling journalists how to do their jobs, consensus is that the mental health community needs to work collaboratively with the media and provide them with the best available information to make those difficult decisions, and to provide context and help mitigate risks of contagion when the decision is to proceed with a report.[36,39,49]

One relatively new aspect to this discussion is the proliferation of social media and the implications for media guidelines on reporting suicide.[51-52] There are significant concerns about pro-suicide content, which accounts for a substantial proportion of suicide related-information online,[53-54] and that users may use social media to learn about suicide,[55-56] disseminate suicide methods,[57-58] normalize and desensitize people to self-injurious behaviour,[59] and publish suicide notes.[60-61] Social media sites also provide opportunities for prevention through learning about alternatives to suicide, resources for getting help, and for access to peers who have mastered suicidal crises.[52,62] Some platforms have developed built-in responses in which, for example, queries about suicide prompt the display of prevention resources or where users can report concerns about people who may be expressing suicidal ideation.[52,62-64] It has been suggested that, in the age of the internet, media guidelines may be impractical or irrelevant given the difficulty inherent in trying to constrain or regulate billions of comments and postings.[65] However, there is general agreement that social media sites should facilitate access to health information and resources for people contemplating suicide.[65-66] Furthermore, studies show that the traditional media commonly uses social networking sites like Facebook and Twitter to inform their coverage and, likewise, their coverage can influence social media.[51] This bidirectional relationship suggests that the approach of the traditional media to covering suicide is likely to have some impact on how it is depicted in social media.

The goals of this updated policy paper are 1) to increase engagement with the journalism community and to adjust previous recommendations collaboratively with journalists; 2) where possible, to achieve consistency between CPA recommendations and recent Canadian and international guidelines; and 3) to address the challenging issue of recommendations in the context of new online and social media. The recommendations below stem from a careful review of the available literature and of Canadian and international guidelines, as well as discussion with journalists and mental health professionals.

Recommendations for Traditional Media Coverage

Table 1 outlines in detail the recommended approach to developing a suicide-related report. Table 2 describes specific elements to be avoided and included, respectively, in media reports. We highlight 3 of these recommendations for special attention:

1. Health reporters, not crime reporters, are best positioned to cover suicides.

A key element of these recommendations is that, as much as possible, suicide be covered by health reporters rather than crime reporters or other journalists. The notion that suicide is a crime rather than the result of a mental disorder is archaic. Crime reporting often includes graphic details of the suicide to make reports more exciting and sensationalistic. Such detailed reporting for suicide coverage is inappropriate and may promote contagion. Health journalists have the greatest awareness of the complex issues surrounding suicide reporting and are therefore best positioned to cover the topic. We acknowledge that there may be situations where other journalists, such as sports, entertainment, or financial reporters, may want to cover suicide deaths in their areas; however, we recommend that they do so cautiously, paying attention to these guidelines, and we suggest they consult with their health reporter colleagues about suicide-related content.

2. Reports should generally avoid details of suicide methods, especially when unusual or novel methods are involved.

There is growing evidence that media reporting on novel methods of suicide has led to dramatic increases in suicide deaths by these methods and in overall suicide rates in various areas of the world.[67-70] Whereas media reports should generally avoid details of suicide methods, as these can lead to contagion effects, such an effect may be particularly pronounced when unusual

Table 1. Factors for Journalists and Editors/Producers to Consider Before Covering Suicide-Related Content

1. Weigh the story's newsworthiness and the public's need to be informed with potential harm related to contagion.
   - Be familiar with your organizational guidelines relating to reporting on suicide.
   - If the decision is to proceed with coverage, plan and/or discuss how harm might be minimized.
   - Seek advice from suicide prevention experts.
   - Be especially cautious when reporting on celebrity or youth suicide deaths, as these currently have the strongest evidence for contagion.
   - Consider how a vulnerable person may identify with the suicidal behaviour/people depicted, and consider steps that might minimize this.
2. Consider the impact of the report on:
   - those thinking of suicide or potentially at-risk for suicide,
   - those bereaved by suicide, including attention to respect for their privacy and grief,
   - the journalist who is reporting the story.
3. Consider the appropriate approach/format.
   - Suicide reporting should generally be done by health reporters rather than other journalists (e.g., crime reporters), as they are best positioned to contextualize the issue within the broader topic of mental health; if other journalists do report, they should at least consult with guidelines and/or health reporter colleagues.
   - Where possible, long-form reporting is recommended, as it allows journalists the opportunity for nuanced discussion and may avoid presenting the causes of suicide in an overly simplistic fashion.

Table 2. Recommendations for Potentially Harmful Elements of Media Reporting that Should Be Avoided and Potentially Helpful Elements to Include

Avoid	Include
1. Prominent coverage, including • front page/lead story coverage • prominent photos of the deceased or loved ones or people engaged in suicidal behaviour 2. Graphic or sensational depictions 3. Excessive detail, including • details or photos of the method and/or location; particularly avoid reporting novel or uncommon methods • glorifying or glamourizing either the person or the act of suicide in a way that might lead others to identify with them • the content of suicide notes 4. Repetitive or excessive coverage[a] 5. Inappropriate use of language, including • the word "suicide" in the headline • "commit" or "committed" suicide[b] • "successful/unsuccessful" or "failed" attempts 6. Simplistic or superficial reasons for the suicide (i.e., suicide as arising from a single cause or event, such as blaming social media for suicide) 7. Portraying suicide as achieving results and solving problems • do not describe suicidal behaviour as quick, easy, painless, certain to result in death, or relieving suffering/ leading to peace ("in a better place")	1. Appropriate language (e.g., "he died by suicide" or "her suicide death") 2. Reporting that reduces stigma about mental disorders/ seeking mental healthcare, and that challenges common myths about suicide • refer to research linking mental disorders with suicide • highlight that mental disorders are treatable and therefore that suicide is preventable • highlight the tragedy of suicide (i.e., describe it in terms of a lost opportunity for someone suffering to have received help) • seek advice from suicide prevention experts and consider including quotes on causes and treatments 3. Alternatives to suicide (i.e., treatment) • include community resource information, such as websites or hotlines, for those with suicidal thoughts • where possible, list or link to a list of options including reaching out to a trusted family or community member, speaking to a physician or health care provider, seeking counselling/talk therapy, calling a hotline/911, or going to a nearby emergency department • where possible, cite examples of a positive outcome of a suicidal crisis (i.e., calling a suicide hotline) • embed emergency resource links/banners (for online content) 4. Information for relatives and friends, such as • warning signs of suicidal behaviour • how to approach, support and protect a suicidal person

[a]We acknowledge that suicide death of prominent figures will invariably result in serial coverage but urge journalists to nevertheless weigh the need for additional stories.

[b]"Commit" evokes a crime, since suicide was historically criminalized; however, this terminology is not consistent with the modern understanding of suicide evolving from a treatable disorder.

or novel methods of suicide are involved. Therefore, publicizing these details should be avoided.

3. Emergency resource links should be included in all articles that deal with suicide.

Guidelines universally advise the media to provide resources, such as crisis lines, to people contemplating suicide. Online platforms afford an opportunity to go a step further. Reports themselves can be accompanied by embedded links to crisis services to facilitate access, thereby decreasing barriers to help-seeking.

Recommendations for Social Media

As described, this is largely uncharted territory in Canada and throughout the world. The recommendations below are meant to be a starting point, with the intention that future iterations of the CPA policy paper will refine and expand on them with input from social media organizations.

We recommend:

1. A novel collaboration between Canadian mental health professionals and social media organizations. Just as journalists are the experts in their area and must take a leadership role in responsible reporting of suicide, those best positioned to address suicide on social media are the designers of the social media sites themselves. In replicating efforts that have been successful with the traditional media, the CPA and mental health professionals should organize meetings, symposia, and forums to address the topic of suicide collaboratively with social media stakeholders.
2. Social media organizations consider the degree to which they might be used as a platform for suicide prevention. Specific efforts may include 1) providing information and resources to people who make suicide-related queries or posts, 2) including "panic buttons" that allow for rapid access to crisis services/hotlines, 3) providing mechanisms for users to report if they are concerned about someone with the possibility for rapid intervention, and 4) moderating forums that frequently include suicide-related postings and making sure to remove inappropriate posts.

Recommendations for Dissemination of Guidelines

Evidence from other countries suggests that media guidelines work best when there is ongoing collaboration between suicide prevention experts, journalists, journalism schools, and public health policy experts.[39]

We recommend:

1. Ongoing collaboration between journalists and mental health professionals, acknowledging scientific evidence and the autonomy of journalists.
2. All journalism schools include teaching of how to report responsibly and respectfully on the topic of suicide, including attention to issues related to ethics and social justice.
3. Media training for mental health professionals who are likely to be called on to comment on suicide in the press.
4. Education for policy-makers and other prominent figures who may be asked to comment publicly on the topic of suicide.

Conclusions & Future Directions

These recommendations mainly rely on data from large, natural experiments, which must be interpreted with a note of caution. Nevertheless, the weight of evidence suggests that certain types of media reporting, particularly those that glamourize suicide or a person who has died by suicide, can and do influence some people to die by suicide. Similarly, reporting that describes people overcoming suicidal crises and finding other solutions may encourage help seeking and more adaptive coping strategies. Further high-quality research is needed to identify which putatively harmful and protective elements of media reports mediate risk and confer benefit, respectively. More studies on the influence of media reporting in Canada and the impact of social media on suicide are also needed. The Canadian Psychiatric Association and mental health professionals across Canada are committed to helping the media make informed decisions about when and how to report on suicide. These efforts will ideally involve collaborative partnerships among all stakeholders, including mental health professionals, members of the media, individuals with lived experience, and all those touched by suicide. These ongoing collaborations, and future efforts that also include social media platforms, will provide the best opportunity to address this important issue.

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