



# Community-Based Research Findings on Suicide Prevention Needs in Halton

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Prevention Coalition

# Acknowledgements

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# Introduction

Each year in Halton region, approximately 46 lives are lost to suicide and over 420 individuals are hospitalized due to attempted suicides. Halton Regional Police respond to approximately one suicide-related call per day.<sup>1</sup> These statistics underscore the critical need for effective strategies and collaborative efforts to enhance mental health and related support systems within the community.

The Halton Suicide Prevention Coalition (HSPC) is a collaborative of individuals and organizations in the Halton communities of Burlington, Oakville, Milton and Halton Hills, working together to provide leadership, advocacy and education in the areas of suicide awareness, prevention, intervention, and postvention. They have adopted a community-based approach to determining their organizational priorities through research grounded in local community knowledge. The HSPC contracted the Centre for Community Based Research (CCBR) to undertake this study from November 2023 to June 2024. This report captures what we have together learned about population trends, risks, protective factors, system needs, and data gaps in Halton. It is intended to guide HSPC's action-planning.

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<sup>1</sup>Halton Suicide Prevention Coalition, Suicide Statistics, accessed June 24 2024, <https://haltonspc.ca/suicide-facts/#suicide-statistics>



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# Approach

Community-based research (CBR) is defined as “a research approach that involves active participation of stakeholders, those whose lives are affected by the issue being studied, in all phases of research for the purpose of producing useful results to make positive changes.” As much as possible CBR should be community-driven, participatory, and action-oriented, while aiming to accomplish the three goals of knowledge creation, knowledge mobilization, and community mobilization (Ochocka C Janzen, 2014).

The present research project followed this approach in-part by collaborating with a Working Group of the HSPC to design and conduct the study. Members of the Working Group brought both professional and personal experience relevant to the project. The research partners met routinely to oversee and provide input into all aspects of the study. They jointly designed and conducted data collection and contributed to the analysis of findings. This partnership helped to ensure that research reflects local community perspectives and produces actionable results.

# Methods

The main research questions guiding this study are as follows:

1. Which populations in Halton are at greatest risk of dying by suicide?
2. What are the most common means of suicide?
3. What are the primary risks and protective factors in Halton?
4. What gaps and limitations exist in community services?
5. What gaps and limitations exist in community data?

CCBR conducted a grey literature review to understand the existing data in Halton region and to refine our approach to primary research. The HSPC Working Group identified local key informants to participate in data collection. In total, the research team conducted nine interviews and one focus group with these 21 key informants:

1. Five family members connected to **Heartache2Hope**, shared their experiences of losing a loved one to suicide, and provided critical insight into the gaps and limitations in community mental health services.
2. One representative from **Halton Public Health (HPH)**, who addressed the experience of public health educators in schools.
3. A physician from **Trafalgar Medical Clinic (Physician A)**, which serves 2000 patients, mainly women aged 40-50. She has also served on several mental health committees.
4. A physician from the **Halton Hills Family Health Team (Physician B)**, which is the largest Family Health Organization (FHO) in the area, serving 26,000 patients. This key informant is also clinical co-chair of the **Connected Care Halton Ontario Health Team (Physician B)**, involved in program planning and mental health service integration for both adolescents and adults.



5. Two representatives from **Support House**, who assist unhoused individuals living with mental health and addiction issues to secure shelter.
6. Three representatives from the **Halton Region Health Department (HRHD)**, who perform nursing assessments, connect parents to services, and work with the Healthy Babies Healthy Children (HBHC) program.
7. Two representatives of the **Mobile Crisis Rapid Response Team (MCRRT)**, including a member of the Halton Regional Police, and a social worker at St. Joseph's Healthcare. Operating from Oakville headquarters, they respond to crisis situations across Halton, focusing on immediate intervention and connecting individuals to available services.
8. Three representatives from **Halton Healthcare Mental Health (HHMH)**, who provide inpatient and outpatient care, emergency mental health services, and urgent care clinics in Milton and Georgetown, which support community members transitioning from inpatient units.
9. A representative from the **Distress Centre of Halton (DCH)**, which operate a distress hotline 24/7, 365 days a year. They also operate an outbound telephone support program that performs approximately 1200 calls a month. DCH further promotes mental health in the community through speaking engagements and courses related to mental health and active listening skills.
10. Two representatives from **CMHA Halton**, including the Manager of Crisis Services who oversees four crisis programs, and the Intake Coordinator who manages referrals and assigns people to necessary services.

This participatory research approach, involving both service providers and individuals with lived experience, offered the research team a broader understanding of the issues and contributed to the creation of actionable and impactful results. The research team also endeavoured to hold a focus group with people who have struggled with suicide ideation or attempted suicide but was unable to attract participants.

## Findings

This section presents findings from across the three research methods, organized according to the five main research questions. Findings are anticipated to assist HSPC to identify priority action areas for suicide prevention initiatives and advocacy.

### Which populations in Halton are at greatest risk of dying by suicide?

#### *Men*

In 2022 there were 45 confirmed deaths by suicide in Halton region. In the first half of 2023 (January-June), there were 21 deaths. The average number of deaths in the previous five-year period (2017-2021) was 46.4. These numbers suggest that the rate of suicide has remained consistent in recent years (Office of the Chief Coroner for Ontario [OCC], 2023). It has also consistently been the

case that the majority of these deaths have occurred amongst **men (37 or 82% in 2022), aged 20-64 (35 or 78% in 2022)** (OCC, 2023).

Provincially, there is evidence of higher suicide rates among men aged 40-59 compared to other age and sex groups (OCC, 2021, p.6). Across Canada, there is evidence that men die by suicide three times more often than women, and the gap between the sexes is larger among older age groups than younger age groups (Government of Canada, 2020, p.17). We also know that in Canada females are three to four times more likely than males to attempt suicide, but men prevalently use more lethal means (Mental Health Commission of Canada [MHCC], 2022, p.8).

Key informants in Halton largely reinforced what is seen in the literature, reporting higher suicide rates among men and their use of more lethal means. HHMH reported that **men over age 40 are at higher risk for adjustment disorders and suicide**. DCH elaborated further, highlighting that these men are especially vulnerable due to their **hesitancy to seek help**. They often lack a previous mental health diagnosis or support network and tend not to contact distress lines or other service providers during crises. However, both CMHA Halton and Support House have observed a recent increase in males aged 16 to 25 seeking support. CMHA Halton also noted an increase in the number of older adults 55+ (gender unidentified) seeking help with mental health issues, including suicidal ideation, because they are struggling with housing and food insecurity. <sup>2</sup>

### Seniors

Regardless of gender, most suicides in Halton occur within the 20-64-year age bracket. This is consistent regionally, provincially, and nationally. However, in 2022 there were nine confirmed deaths by suicide in Halton among seniors aged 65 and over, and the average over the preceding five-year period (2017-2021) was 6.2. Three research participants raised concerns about the unique challenges faced by the senior population. For instance, Support House reported that some seniors are struggling because they became accustomed to isolation during the COVID-19 pandemic, and it is **difficult for them to join in-person activities** that have resumed. Physician B added that for seniors, mental health vulnerabilities are often overshadowed or **obscured by other concerns**

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<sup>2</sup> Given the limited scope of this study, it is also relevant to consider the findings of studies in other jurisdictions. For instance, their review of the literature in 2020 led CAMH to conclude that the two populations most at-risk of suicide in Canada are Indigenous Peoples and trans people (Centre for Addiction and Mental Health [CAMH], 2020, p.4). CAMH found that priority populations internationally include “Indigenous Peoples; pregnant women; refugees and migrants; LGBTQ+ people; doctors; police; military members; prisoners; and those in high security hospitals.” (Bachman, 2018; MHCC, 2018; WHO, 2018, as cited in CAMH, 2020, p.4). Physician A identified transgender patients as potentially at higher risk for mental health issues; however, they were uncertain if the suicide risk is higher in this population in Halton, noting a lack of data and suggesting the need for further research to confirm. Additionally, no data was found that discerns other demographic markers such as ethnicity, which could be further investigated through future primary research.

such as dementia, physical ailments, and difficulty with independent living. They emphasized the importance of recognizing them as an at-risk population that may require targeted interventions.

Collectively, the key informants' observations underline the significance of addressing the distinct mental health needs of seniors, ensuring they receive appropriate support systems and do not slip through the cracks due to competing priorities or assumptions about their well-being.

It is worth noting that the older adult population in Halton is growing and in 2015 Halton Region released the Halton Region Older Adult Plan (HOAP), which includes a list of opportunities for improving the mental health of Halton's older adults, including:

- promoting safe and supportive housing for older adults
- connecting older adults and their caregivers to resources and services
- integrating strategies to respond to dementia, mental illness and addictions in regional program planning and service delivery
- supporting older adults in the workforce
- ensuring that the social determinants of health are addressed in how regional programs are planned and delivered

(Regional Municipality of Halton, 2018, p. 35)

### *Youth*

In 2022, there was one confirmed suicide in the 10-19 age group in Halton, and the average over the previous five-year period (2017-2021) was 2.6. Three deaths in this age group were reported in the first half of 2023 (OCC, 2023), suggesting a **possible increase of risk in this age group**.<sup>3</sup>

The most recent regional data from the Canadian Health Survey on Children and Youth (2019, scheduled for update in Fall 2024) shows 92% of Halton youth aged 12-17 reported being generally happy (happy and interested in life C somewhat happy); and 90% reported being satisfied or very satisfied with life in general (Regional Municipality of Halton, 2023, p.1). In comparison, more recent provincial data shows that 20% of secondary school students in Ontario reported harming themselves on purpose from 2020-21, and 18% reported seriously contemplating suicide in the same period. (CAMH, 2021, p.5).

Key informants noted that youth in high school and in their early twenties are increasingly affected by mental health issues. HPH shared that they typically hear about one-to-two suicides in high schools each year. CMHA highlighted a recent rise in youth referrals, especially among males aged 16 to 25 presenting with concurrent disorders, often associated with cannabis use and psychosis.

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<sup>3</sup> Across Canada, particular attention is also due to Indigenous children under the age of 15. From 2011-2016, “nationally, the suicide rate among First Nations boys was four times higher than among non-Indigenous boys. It was ten times higher among First Nations boys living on reserve” (Government of Canada, 2020, p.23) However, this varies across communities; for examples 60% of First Nations and 11 of 50 Inuit communities have a suicide rate of zero (Ibid).

Support House also noted an increase in youth seeking support, particularly young adults aged 16 to 25, possibly due to struggles with isolation during COVID-19. Members of the MCRRT also noted an increase in younger populations seeking crisis intervention assistance.

Physician B specifically highlighted a notable increase in teens struggling with interpersonal relationships, largely impacted by social media. They shared the belief that social media platforms allow for rapid, often unexplained changes in social dynamics, which can trigger intense emotional responses. Physician B noted that many struggling teens come from unstable home environments, marked by parental separations and acrimonious divorces, which create additional pressures and stressors that can lead to symptoms resembling post-traumatic stress. They further explained that post-traumatic stress in this population is often underdiagnosed and undertreated, attributed partly to treatment challenges and a lack of adequate resources within the system.

The DCH raised concerns about the mental health challenges faced by post-secondary students and international students, noting that these struggles are often exacerbated by academic pressures and financial stress related to the rising cost of living and attending school. Additionally, they've observed that children who have been at home during formative years due to the pandemic may lack maturity or problem-solving skills and are facing challenges adapting to the educational environment. The DCH also reported receiving many calls from teachers who are not necessarily equipped to deal with students who are struggling.

HMH said that while the younger generation is more likely to seek support for mental health issues, they are still unlikely to seek help with addiction. HHMH also emphasized that youth with disabilities face significant barriers to accessing support systems, which exacerbates their mental health challenges. They noted that individuals on the autism spectrum or with certain personality disorders often do not benefit from the support available, because social connection is more challenging for them. This point was vividly illustrated by one participant in the survivors' focus group, who described her son's experience. She explained that,

Prior to entering the school system, my son was a rather happy-go-lucky young little fellow. He was speech delayed, and that presented some behavioral challenges. I always considered my son to be the onion, and in our journey with him, we were sort of uncovering one layer at a time. Through the course of his educational career, he was diagnosed with generalized anxiety disorder. He was diagnosed with ADHD. He was diagnosed with central auditory processing issues. And then in grade eight, he was diagnosed on the autism spectrum. He lacked social skills in the school system and was pretty much bullied from the time he was in grade one to the time he entered grade 10, at which point he had finally had enough in grade 10 and was suspended because he almost tried to jump on one of the kids that was trying to bully him in high school. He had a lifetime of a school system that was telling him he wasn't good enough, he wasn't behaving enough, he wasn't paying attention. He wasn't, he wasn't, he wasn't, he wasn't, he wasn't. And that, in my opinion, eroded any sense of self-esteem he might have had... Once he had the autism diagnosis,



the school board came running to us and said, what can we do for your son? What can we possibly do for your son?

This parent's account illuminates the complex challenges faced by children with disabilities within the education system and emphasizes the need for more proactive and compassionate approaches to better serve youth with diverse needs and prevent the compounding of mental health challenges over time.

## What are the most common means of suicide?

We do not know the most common means of suicide in Halton at the time of writing because the coroner's office has not released this information. We do know that nationally "more than half of all deaths [in 2018] were due to suffocation (including hanging and strangulation)" (Government of Canada, 2020, p.16). For women, suffocation was the most common means of suicide (52%) followed by poisoning (31%) (Government of Canada, 2020, p.19).

In Halton, six service providers specifically mentioned **hanging** as a means of suicide they have encountered in their work. Both CMHA and the MCRRT reported that hanging is common, and MCRRT confirmed it most often occurs in people's homes.

Substance misuse and **overdose** were also identified as prevalent means. CMHA noted that youth and females who die often overdose but it is difficult to determine if overdoses are intentional. We also heard about the ambiguity of overdoses among patients who misuse their prescription medicine. Physician B shared their experience:

That's certainly what I saw in the emerge [emergency room] a lot because it's easily accessible and they're using the same medications they're using to treat them...you often used to hear, and you still do, "I just want to sleep. I'm just tired. And I'm taking extra because I'm just tired. I don't know if I wanted to harm myself."

In addition to hanging and overdose, **jumping** was identified by three service providers as a common means of suicide in Halton. HHMH questioned the rationale behind constructing tall buildings, particularly where support services are housed, given the evidence-based understanding that structures over six stories high have a 90% lethality rate for jumps. They also identified GO stations and train tracks as areas of significant concern for suicide attempts but noted that most completed suicides seem to occur between stations, which makes erecting safety barriers more challenging. Moreover, HHMH emphasized the specific risks posed in downtown Oakville, with its overpasses to lakes and train tracks, underscoring the need for strategic planning to mitigate these hazards and ensure safety measures are in place.

Physicians A and B mentioned **firearm** use in suicide. One noted that males tend to use more lethal means such as guns, while the other shared a specific case of a patient in Halton who appeared stable and supported but died by shooting himself. Finally, one research participant noted that there have been a few recent reports of deaths by **carbon monoxide poisoning**.

## What are the primary risks and protective factors in Halton?

Halton region has identified evidence of the following **mental health risk indicators** in the age bracket most affected by suicide (hereafter referred to “adults” vs. “youth” or “older adults”):

- Adults tend to have higher rates of emergency department visits and hospitalizations for mental health than other age groups (Regional Municipality of Halton, 2022. p. 3).
- These rates tend to be highest in lower income neighbourhoods and peak in early adulthood (Regional Municipality of Halton, 2018, p.13-14).
- Adults (especially those aged 18-24) are least likely to rate mental health as very good or excellent. Self-rated mental health is also lowest in low-income neighbourhoods and among those who are unemployed. (Regional Municipality of Halton, 2019, p.1-3).
- Adults have been the least likely to report having a strong sense of community belonging (60%) compared to other age groups (68-88%) (Ibid).
- Adults report higher stress than youth and older adults. (Regional Municipality of Halton, 2018, p. 12).
- Life satisfaction has also been shown to decrease with age for adults. (Ibid.)
- 13.9% have reported mental health issues during pregnancy (Ibid. p. 5).

These are the main indicators of mental health risk for adults in Halton, based on the available literature.

**Outside of Halton**, these prominent **risks factors related to suicide** (regardless of age) have also been highlighted in the grey literature:

Risks:

- Mental illness, including substance use disorder (Henriksson et al., 1993; Cavanagh et al., 2003 as cited in CAMH, 2020, p.6)
- Exposure to violence, abuse, and other traumas (WHO, 2018; MHCC, 2018, as cited in CAMH, 2020, p.6)
- A family history of suicide. (Zai et al., 2012, as cited in CAMH, 2020, p.7).
- Ready access to lethal means such as firearms or large doses of medications (CAMH, 2020, p.8).
- Bullying (CAMH 2021, p. 4, 6)

This list is provided for general information and consideration since these factors relate to suicide specifically as opposed to mental health generally.

Key informants highlighted risks they have observed in Halton. The likelihood of **comorbid or concurrent mental illness** appears high, based on observations from two Halton-based physicians. Physician B noted the prevalence of substance use, anxiety, depression, and post-traumatic stress disorder, while Physician A pointed out that young adults in their 20s, especially those diagnosed with borderline personality disorder or bipolar disorder, have a heightened risk of suicidal ideation compared to individuals with straightforward depression or anxiety.

**Postpartum mental health issues**, such as anxiety and depression were identified by HRHD as a growing concern throughout the pandemic. They noted a substantial surge in calls to the parenting support line, driven by isolation, and reported that current long waitlists for breastfeeding support are also impacting the mental health of both mothers and their families.

**Social isolation** emerged as another significant risk, particularly amplified by the COVID-19 pandemic. Nine key informants commented on increasing social isolation experienced across age groups. DCA said they have observed a surge in calls from socially isolated community members, who experience significant anxiety about the future and a pervasive sense of social division instead of solidarity. Support House also expressed particular concern for isolated individuals who rely heavily on emergency services such as hospitals and distress lines. They described a "revolving door effect" as these individuals repeatedly encounter the same issues without finding lasting solutions or ongoing support. Research participants said that the COVID-19 pandemic has further reduced social connection and access to support services. Consequently, more people turn to emergency services like 911 for issues better addressed by community support.

The adverse impact of **excessive social media use** on interpersonal relationships and personal resilience was highlighted both by MCCRT and by Physician B. They explained that social media as exacerbated isolation and compromised relationships, especially among youth although not limited to them. For example, members of the MCCRT shared the view that,

Everybody's kept to themselves, and we all have kids, and everybody has phones, and we barely see our kids these days. Everybody wants to be left alone or with just their small circle of friends...The individual resilience is lacking because we have a lot of young people who do not have the problem-solving skills and they don't have the know-how to be resilient. And we can all say that social media is damaging.

While social media may be intended to create more social connection, it is the view of this provider that it is creating more separation between people in real time, and thereby impairing social and cognitive skills.

Research participants also told us that **economic stress**, particularly in the wake of the COVID-19 pandemic, has become increasingly pronounced. The DCH highlighted that farmers seem to be under particular strain. HHMH explained that such strain can lead to impulsive self-harm or suicide:

We've seen a lot of financial loss, a lot of financial loss, a lot of individual family members taking on the financial burden, obviously with housing and mortgages and everything just being more expensive. We're seeing suicide attempts by people who really don't have a significant or already established diagnosis, but who are really in the throes of what is a difficult, challenging time for a lot of people, and they are not the ones who are going to put up their hands and ask for support.



This comment highlights how socioeconomic conditions put people who are disconnected from services and supports into crises. It also draws attention to the need for prompt, effective responses to acute, situation-driven crises.

Building on this perspective, Physician B described the intense stress experienced by the "sandwich generation," which shoulders responsibility for both children and aging parents. Additionally, they emphasized disparities within Halton, noting economic pressures and resource deficiencies in certain areas:

Economic stress has been a big problem in terms of problem solving and it's not even that people aren't working but the mismatch between what they're earning and what they're spending. It's just so much pressure there and the sandwich generation component that has created so much of a challenge because resources to support seniors as they develop their cognitive problems are lacking. And so, it all falls on these one or two individuals, women in particular, but families too and it creates a whole host of problems. Even after someone's passed, dealing with the estate and all, these are huge things. And I think it's just a confluence because you can deal with one crisis, a second, not a third and a fourth that you didn't plan for and didn't expect... [also] while Halton is not very socio-economically diverse, there are areas that struggle significantly. These areas often face the same triggers, like economic pressure and lack of resources.

Such economic strain can lead to a variety of other issues, such as **homelessness** and **substance use**. Support House sees this combination of factors affecting their service users, who they say experience **hopelessness**. The absence of stable shelter and long service waitlists, coupled with challenges encountered upon release from detox, hospital, or prison, further compounds their struggles, leaving them unable to "see past tomorrow".

The MCRRT reported that **alcohol** consumption has been on the rise since the pandemic began, leading to increased domestic violence at home. HHMH further supported this assertion by sharing that, while there has been a slight increase in opioid use over the past couple of years in Halton, "when it comes to self-harm and suicide, there's a high likelihood, at least in this area, that alcohol is involved."

Additionally, key informants noted that they are seeing amongst service users the detrimental impact of **major life transitions related to employment**. Physician A noted a heightened risk among males facing retirement or career changes and recounted a tragic incident involving the spouse of a patient who lost his job and subsequently took his own life. This respondent also referred to the "lost boys' phenomenon," in which young males experience low self-esteem and depression when they struggle to find employment after college or university. Likewise, a focus group participant shared that her son's inability to quickly find employment post-graduation compounded his feelings of inadequacy and hopelessness and ultimately led to his suicide.

Other family members of individuals who have died by suicide shared additional insights into the multifaceted nature of their mental health struggles. Their accounts highlighted a **complex interplay of factors** such as childhood diagnoses of concurrent mental health conditions,

experiences of bullying, family stress, the impact of parental separation, sexual assault trauma, eating disorders, and the exacerbating effects of the COVID-19 pandemic on existing mental health challenges. Their stories also describe the role of familial patterns of mental illness, including instances of suicidal ideation and depression across generations.

In 2018, Halton identified four areas of opportunity to improve the mental health of Halton residents in general, which speak to priority **protective factors for mental health and wellbeing**:

1. Promoting opportunities to foster social connectedness.
2. Creating supportive, healthy, safe and inclusive environments where Halton residents live, learn, work and play;
3. Increasing resiliency of Halton residents (i.e. ability to bounce back after major challenges) by promoting individual protective factors for mental wellness; and
4. Improving awareness and understanding of mental illness and reducing stigma.

(Regional Municipality of Halton, 2018, p.11)

The region has also noted that for new parents, “having a strong social support network is essential to reducing parenting stress” (Regional Municipality of Halton, 2018, p.23). At the time of writing, we do not know about the availability or quality of **parental support networks** in Halton or the degree of belonging experienced by parents.

**Outside of Halton**, these prominent **protective factors related to suicide explicitly** have been highlighted in the grey literature:

Protective factors:

- Responsible reporting in the media. (WHO, 2022, as cited in Centre for Suicide Prevention [CSP], 2022a, p.1)
- Fostering the life skills of young people. (Ibid.)
- Early identification, management, and follow-up of mental health issues. (Ibid.)
- Mobilizing Indigenous knowledge for resilience and suicide prevention. (Adapted from the National Inuit Suicide Prevention Strategy, cited in Government of Canada, 2020, p.26)
- Social equity. (Ibid.)
- Cultural continuity in services. (Ibid.)
- Access to a continuum of mental health services. (Ibid.)
- Nurturing healthy children from birth. (Ibid.)
- Healing unresolved trauma and grief. (Ibid.)

Key informants applauded several protective factors that exist in the form of mental health **programs for youth**, such as those offered at the ROCK, ADAPT, and the Rainbow program for gender dysphoria. They report that these services are increasingly visible in Halton. Informants also recognized the value of Parental Involvement Committees (PIC), through which school boards actively engage parents. We heard that one school board has seen significant participation with over 600 parents signed up for PIC conferences, indicating a robust re-engagement effort post-

pandemic. Efforts to integrate Indigenous teachings and promote social equity in the schools (through the hiring of social workers, child/youth workers and additional staff) were also acknowledged by key informants.

**Teacher training and support systems** are valued by key informants because they can foster developmentally appropriate relationships between teachers and students, and lead to student support interventions such as the designation of inclusion rooms (dedicated spaces within schools where students can go if they feel that they need some connection and want to engage in activities that promote social-emotional learning and inclusion). HPH noted that mental health and means safety training for teachers have been provided in addition to other mental health training modules by School Mental Health Ontario. HHMH reported a significant shift in approach over the past 2-3 years in school policy, which now directs teachers to immediately contact emergency services when there is any indication of self-harm or suicide ideation. Additionally, the MCRRT police officer noted that he regularly conducts presentations in both primary and secondary schools to raise awareness about COAST (Crisis Outreach and Support Team) services and other supports.

**Other community resources and services** were noted by multiple key informants, including Thrive, which provides counselling support to individuals in need. However, concerns were raised about wait times to access these services.

The Heartache2Hope focus group members also praised both the closed and open **support groups** offered through this organization, explaining that they have been highly beneficial in helping them to process their trauma and grief and connect to other resources for surviving family members (such as the Lighthouse for Grieving Children peer group). Many participants also shared that they now actively engage in peer support calls, illustrating the supportive community dynamics fostered by **bereavement programs** such as Heartache2Hope.

Similarly, **peer support** is a cornerstone of Support House's approach. Through their Center for Innovation in Peer Support, they prioritize accessibility by offering low-barrier drop-in options, ensuring individuals can access support without encountering lengthy waitlists.

**Senior support programs** (such as the Friendly Visitor Program and Links to Care) were recognized by key informants for providing protection to this population, because they extend vital assistance and connection to older adults in the community. MCRRT shared the view that senior support systems are among the strongest networks in Halton. However, Support House said many programs are hampered by lengthy waitlists.

The MCRRT noted that many clients interacting with healthcare professionals for the first time often feel stigmatized or in trouble when seeking support. They emphasized that the MCRRT partnership between officers and trained mental health clinicians is intended to promote sensitivity, reduce stigma, and provide a more supportive crisis intervention experience. As one police officer explained:

You're going through something in your life, and you're experiencing that...Our goal is to minimize that and to deescalate and reintroduce and re-inform them about what we

[MCRRT] do. Some people think they're in trouble if police show up by law. We try to reassure them and explain every step of the way as much as we can to make it a somewhat easier experience.

This kind of attitude amongst service providers is a promising indication that **compassionate approaches to crisis intervention** are being implemented in Halton.

The MCRRT also has a role in identifying mental health issues beyond an immediate crisis. Their mental health clinicians “can identify risk factors or major mental illnesses like first episode psychosis or schizophrenia ... [and] share this information with hospital colleagues or make referrals within Halton region.” Consequently, MCRRT helps community members to gain **coordinated access** to services, which reduces suicide risk.

Coordinated access is also facilitated through One Link, which connects community members to a range of addiction and mental health services within Halton through a single referral and intake process. Physician A reported that, “One Link has done a good job. It's much better in terms of speed, and I receive confirmation that they've made contact with the patient. While I may not always know the timeline for their next steps, I appreciate knowing that patients can self-refer.” This suggests that Halton has had some success in coordinating access.

Some key informants also acknowledged improvements in **early identification and intervention**. However, HPH stated that people are “usually in severe crisis by the time they get the supports they need.” To address this issue, some service providers are implementing proactive strategies. Physician A discussed their use of standardized assessments, such as the PHQ-9 and GAD-7, for patients with depression, anxiety, or other mental health concerns. These assessments include questions about suicidal ideation. They also ask patients to save distress line phone numbers and they develop safety plans with patients. We do not know how pervasively this approach is practiced by other healthcare providers in Halton.

Research participants also spoke about the value of **postvention**. In 2018, HHMH implemented a **Brief Contact Intervention (BCI) program**, inspired by a successful European pilot that reduced suicide rates in community settings. This program targets patients from emergency departments or inpatient units who exhibit suicidal intent or have aborted/interrupted suicide plans. Upon discharge, the hospital enrolls these patients in a follow-up schedule consisting of phone calls at one week, two weeks, three weeks, four weeks, three months, nine months, 12 months, and 18 months. During these follow-up calls, staff use standardized questions to assess the patient's well-being, support systems, and appointment adherence. If the staff detect an increased risk at any point, they promptly refer the patient to urgent care clinics. This proactive approach aims to provide timely support and intervention before the situation escalates to another emergency or crisis call.

Various DCH programs have been pivotal in expanding **outreach** efforts. A notable example is Telecheck, an outbound call program offering telephone support and friendly social connections to individuals experiencing isolation, and emotional and mental health concerns. It has seen

significant growth, with monthly call averages increasing from approximately 1,200 in 2019 to 16,465 by the end of the last fiscal year. Furthermore, DCH highlighted ongoing efforts to enhance mental health literacy through outreach programs aimed at informing community members about available resources and facilitating proactive help-seeking. In 2025, they plan to launch outreach programs tailored for men and post-secondary students.

Another protective factor is **responsible reporting in the media**. HRHD noted the persistent use of stigmatizing language such as "commit suicide" in media, but also noted that stigma reduction efforts, particularly for the 2SLGBTQ+ community, seem to be well received on social media and contribute to early identification and connection to support services. The DCH said that media seems to have become more responsible, showing more respect when reporting on suicide deaths and avoiding clickbait. However, MCRRT cited a specific incident wherein an active jumper on a bridge in Oakville was widely reported on social media, which traumatized social media users both reading and posting about this event.

The value of **harm reduction** practices were also observed by key informants in Halton. For instance, Support House discussed training their staff in harm reduction, and facilitating drug testing to reduce self-harm.

## What gaps and limitations exist in community services?

The United Way of Hamilton C Halton and the McMaster Research Shop conducted a capacity needs assessment of community services across Halton in 2023. The project asked:

1. What are the greatest organizational challenges for nonprofit organizations in Canada?
2. What kind of capacity building activities (knowledge sharing/education, resource sharing, skills training, etc.) would help address these challenges (i.e., are most needed) for Hamilton and Halton nonprofits?
3. What form of capacity building activities (e.g., in-depth workshops vs. short webinars) are most preferred by Hamilton and Halton nonprofit staff?  
(Camargo et al., 2023, p. 20-21)

The findings identified various needs within the non-profit sector concerning funding and human resources, and other ways in which organizations are under resourced. But there is no mention in the report of service gaps, demand for programs or services, or access barriers. This is significant because, according to the authors, this is the only assessment of the needs of non-profits in this region since the pandemic (Camargo et al., 2023, p.2). So, **we lack published data on the state of existing community services**.

A wider review of literature revealed the following evidence of system gaps outside of Halton:

- In Ontario, 42% of students (from grades 7-12) experienced an **unmet need for mental health** support in 2021, compared to 35% in the previous year (CAMH, 2021, p.7).

- The Centre for Suicide Prevention released a 2016 report that captures the perspectives of survivors (outside of Canada). It found that **stigma was a major barrier to accessing services**.
- The same report asserts that when people do seek medical attention they report being dismissed or **treated poorly by healthcare providers** and are not given follow-up support (CSP, 2016, p.1).

We investigated these and other gaps through the key informant interviews and learned that there is evidence of these system issues in Halton: lack of access to timely care, lack of continuity of care, limited cultural sensitivity and equity, ongoing stigma, limited awareness of available services, lack of supportive housing, and concerns over treatment approaches.

**Lack of access to timely care** for mental health support was identified as an issue by six key informants. Physician A reported **long wait times** to see psychiatrists and the unavailability of same-day appointments for people in crisis. CMHA Halton stated that the long waitlist for services is the greatest service system problem because, while they can reach help during a crisis, service users often need long-term counseling, case management, and addictions treatment. Support House echoed this frustration, citing long waitlists for programs—sometimes up to two years—and insufficient community support to protect people in the lengthy time periods between appointments.

**Location** is another access issue when it comes to detox programs, which are non-existent in Halton. One key informant described this as “a constant struggle” because vulnerable people must be displaced from their home community to access this critical service.

HMH shared a problem in school policy that they believe creates a delay in accessing appropriate services and a burden on emergency services. Teachers are currently directed to immediately contact emergency services when they have any indication of student self-harm or suicide ideation. HHMH stressed the need for enhanced training and support for teachers to help them better differentiate between acute suicidality and maladaptive coping mechanisms, enabling them to offer appropriate support without automatically resorting to emergency department referrals. They report that an over-reliance on emergency departments, does not provide community members with the comprehensive care and appropriate attention they may need. Emergency departments are not equipped to address the ongoing mental health needs of individuals, leading to dissatisfaction with outcomes.

The **lack of continuity of care** is a related issue that was emphasized by seven key informants. Individuals with complex mental health conditions, and those who are known to be high risk, have difficulty accessing consistent, ongoing support. Several key informants noted that the transition from hospital-based services to community support tends to be piecemeal, with no real navigation system in place. One respondent explained, “that’s where people tend to fall through the cracks, right? They don’t meet criteria for one [service provider]. They can’t really connect with another. That’s where I think challenges exist. That’s what puts people at-risk.” People need to have a long-

term connection to supports, even when they are doing well, so they can quickly find assistance if personal circumstances change and bring on a crisis.

Physician A also emphasized the challenges faced by youth when moving from child to adult mental health services, attributing these difficulties to fragmented resources. They explained that while kids under age 18 can access a variety of good resources through one easy access point at the ROCK, when they age out, they must locate resources that are scattered across multiple agencies and harder to access. Support House stressed the lack of robust transition planning for individuals moving from institutions to community supports. They explained that “when someone's in an institution, whether it's hospital or jail, they're fully supported and that transition planning is, in my opinion, not strong enough, whether it's for substances or mental health... they're going from seeing a nurse every minute to nothing. And I think that's a big gap, that's where we're losing people.” These comments underscore the needs for comprehensive and seamless care transitions, to ensure individuals receive consistent assistance during critical periods of vulnerability.

A few key informants reported that Halton has made some progress in increasing the **cultural sensitivity of service providers**, but it seems challenges persist in ensuring equitable access to support for vulnerable populations. CMHA Halton acknowledges protective factors within religious and cultural communities, such as prohibitions against self-harm and strong support networks. They also highlight a significant lack of cultural supports for Indigenous community members in Halton. This leads CMHA Halton to refer people outside of the region, which means they encounter transportation barriers.

However, HHMH acknowledged recent training initiatives centered on Indigenous cultures and approaches, in response to research data showing a disproportionate number of Indigenous community members are presenting in emergency departments and substance use clinics. HRHD also said they have been doing outreach to Indigenous communities on social media, and Physician B highlighted ongoing efforts to Integrate “Indigenous services” within primary care networks.

The MCRRT also reported that while it is not a persistent issue, there are instances when the limited availability of professional interpreters during a crisis can hinder the delivery of linguistically and culturally appropriate services. This potentially impacts the effectiveness of crisis response for certain individuals or communities. In such situations, they improvise by quickly accessing any available multilingual service provider.

MCRTT commented that the cultural diversity of the region is another reason why greater effort must be made to inform diverse community members about existing mental health supports, and to normalize discussions of suicide and mental health across various cultural contexts. HRHD echoed these sentiments and noted that they are encountering more newcomers and cultural aspects where they sometimes feel inept, but they are actively learning and adapting to better address health and wellbeing challenges in these communities.

HMH reported a significant rise in individuals from Eastern Europe accessing their services, including clinics and the psychiatric emergency department. They acknowledged a shortfall in training to effectively address the needs of these cultural backgrounds.

Additionally, CMHA Halton shared that a review of the COAST program revealed that the presence of police can be a barrier to effective crisis intervention. Many individuals in crisis do not require police presence, and some feel uncomfortable or unsafe when police are involved. This discomfort can deter individuals from seeking help or fully engaging with the available support services.

The MCRRT stressed the need for ongoing **public education to reduce stigma** surrounding mental health services. They highlighted that many populations in Halton resist engaging with mental health services and police services because of the associated stigma. CMHA Halton also noted that in Halton people often struggle silently due to cultural norms that discourage asking for help and fear of social judgment or police involvement. They acknowledged that virtual support has increased willingness to seek help, but feel that stigma remains a barrier, particularly in affluent communities. MCRRT advocated for more public discussions about mental health and suicide, to promote awareness of the existing support options, including 24/7 services, home-based services, and community-based services. CMHA added that targeting older adults through community centers, social networking, and seniors' communities can help reduce stigma and inform people about available support.

One focus group participant said that she has seen a reduction in stigma over the past decade since her husband died. She explained how stigma prevented early intervention in his case. Conversely, another participant relayed her experience advocating for more open conversations about suicide and grief in secondary schools. She has found the majority of school contacts avoid addressing these subjects.

**Increasing awareness about available mental health services** was called for by research participants. Physician A said that general practitioners need updated information about mental health services as well as readily accessible resources, such as guides or checklists for suicide prevention strategies like safety contracting. They also advocated for the establishment of a centralized public hub to enhance the visibility of mental health resources for adults.

DCA said that the distinctions between various crisis hotline number is not well understood by the public. They also said there was not much uptake of the Safe Talk mental health first aid training DCA offered, suggesting the need for further promotion of that resource.

A focus group participant stressed the necessity for more comprehensive support for families affected by suicide as well as those who have survived a loved one's suicide attempt, emphasizing the need for more structured preventative measures and systemic changes to enhance crisis support. However, CMHA expressed a concern about the system's capacity to respond to interest that is raised by public awareness campaigns. As they said, "the more you're out there doing promotion, the more you have to have better supports to back it up." This comment signals that public awareness efforts must be highly intentional and strategic, backed-up by adequate system capacity.

Multiple key informants also stressed the critical need for **supportive housing**. Currently, there are no housing options in Halton that effectively integrate support services and housing, such as self-contained units with centralized support hubs. The lack of stable housing exacerbates the need for supports, increasing the demand for supportive housing solutions. To address this issue in-part, Support House advocates for creating accessible service hubs within senior residences. These hubs would provide essential services and aim to reduce suicide ideation among this vulnerable population.

Focus group members reported that mental health services often **rely heavily on medication** rather than comprehensive therapy. One research participant lamented the lack of guidelines or support provided to families or individuals upon discharge from the hospital after a mental health crisis. She shared her experience with her husband's treatment following a failed suicide attempt:

They are just pushing pills; I'm not saying pills are wrong. In some cases, they help a lot, in some cases; but they shouldn't be only focusing on the medication. Here's the medicine, go home, take this, you'll be fine. But the person is not fine...They have this list of questions. They just tick mark and yes, you're depressed and here's the meds, take it. And then when he brought the medication home, I had to call her to find out if this medicine is going to be okay with his other meds because he was on epilepsy medicines as well. Oh, yeah, we give this to the kids. Can you please check? Oh, sorry, it doesn't go with the medicine. So, this is where my frustration and anger or whatever you want to call it comes from because the medical field wasn't any help.

In this case, service providers' faith in medication not only left the family feeling unsupported in other ways but also created the added risk of contraindication.

The reliance on medication may also explain why focus group participants said their loved ones were subjected to minimal attention in emergency rooms and **hasty discharges**. One participant criticized the overall lack of empathy from first responders and in hospital-based mental health care. Another participant expressed concern that her son was discharged from the hospital without a safety plan:

I will tell you that on his release back home, his dad and I were completely panicked, wondering, is it possible this is going to happen a second time? We were very fortunate that he did not succeed in his attempt at home, but totally dismayed and unsure what to do once we got him home. ... I have no idea why any patient, especially a young person, would be released back home after making an attempt without that safety plan in place.

Other participants similarly expressed frustration over the lack of follow-up support and guidance from emergency responders and hospitals and noted that doctors often follow a checklist approach. Two participants likened the hospital environment to that of a prison, highlighting intense security measures and uncomfortable waiting areas. Such experiences highlight the need for more

comprehensive and compassionate approaches to emergency room mental health services in Halton.

## What gaps and limitations exist in community data?

There is an identified lack of standards in death determination and data collection practices, which the Federal Framework for Suicide Prevention aims to address. Data should include a breakdown by **gender (beyond male and female), sexual orientation, age, Indigeneity, ethnicity, race and occupation** (CSP, 2022b, p.2) to support risk assessment.

At the time of writing, significant data gaps and limitations also persist in Halton related to suicide ideation. Some key informants reported that their organizations do collect demographic data about service users but there are barriers to accessing that data. There does not appear to be a standardized practice for collecting and sharing data across agencies.

Physician A noted that their EMR system does not track wait times and that family medicine practices typically do not conduct formal studies or collect data from EMRs about patients presenting with suicide-related complaints. Meanwhile Physician B highlighted that while relevant risk data exists in the Family Health Teams, it is not easily accessible or formalized in a usable format, which poses a real challenge to comprehensive data analysis and informed decision-making. They explained that:

The whole constant of family health organizations and teams is really to create this medical home where everything can be accessed in one place. And a big part of that is using data to help you to practice more efficiently, more effectively. But you need to have the data. You need to be able to access the data, and then you need to be able to interpret the data. The problem is none of those things have been realized. ... Even though we have it, it's not accessible.

Not only is much of the data that is collected inaccessible to practitioners, but there are also notable gaps in specific data points, particularly regarding gender diversity. While some organizations, like CMHA Halton, track gender diversity through health equity questions and referrals, the overall landscape across various service providers in Halton shows a significant absence of gender diversity data.

Physician B lamented the lack of centralized data management and comprehensive assessments across Halton's mental health services. They emphasized that data should not just be in the hands of the data scientists. Everyone should have access to that information so that it can percolate into the way they think and inform their decisions and practices, from referral processes to recruitment and beyond.

Physician B also proposed using algorithms to more accurately identify and support individuals at highest risk. This approach aims to tailor interventions effectively, focusing on those with complex needs who may benefit from wrap-around care provided in community settings rather than

hospitals. They expressed concerns about the adequacy of current efforts to reach high-risk populations.

Organizations also seem to lack formalized program evaluations and systematic needs assessments to guide decision making and improve health outcomes. Support House is an exception. They actively evaluate how effective their services are in reducing crises, hospitalizations, and emergency department visits. However, they discussed the challenge their organization faces when someone passes away, particularly in cases where the cause of death is suspected to be suicide, based on police interactions and scene assessments, but that is not confirmed by the coroner's office. They highlighted this lack of information as a knowledge gap.

While initiatives aimed at improving data collection and evaluation are underway in Halton, the current data landscape remains opaque. Addressing these gaps through enhanced coordination, standardized data collection, and comprehensive demographic data integration would enhance service delivery, improve risk assessment, and support more equitable access to services across diverse communities.

## Research highlights

HSPC's next steps will be to determine and prioritize responses to the findings summarized below.

### *Priority populations*

1. **Adult men (aged 20-64):** This population group has the highest reported suicide rate. Often these men are not accessing services at the time of death, which may be related to cultural norms emphasizing self-reliance, that hinder help-seeking. We also heard about the stressful impact of major life transitions around employment affecting this group.

Other vulnerable groups were described by key informants as follows:

2. **Women (aged 20-64):** Traditionally, four times as many women as men attempt suicide, often by overdose. Mothers are suffering due to long waitlists for breastfeeding support.
3. **Seniors:** Social isolation and socioeconomic factors such as housing and food insecurity, compound mental health issues that can be overlooked by healthcare providers who are focused on addressing other age-related ailments.
4. **Youth:** The system is seeing increased referrals for youth aged 16 to 25 for concurrent disorders, linking cannabis use and psychosis. Youth are struggling with parental separations and the impact of excessive social media use. Youth with disabilities have alienating experiences with services. Post-secondary and international students are grappling with academic pressure, financial stress, and difficulties adjusting to their displacement.

### *Common means of suicide*

1. **Hanging:** Six key informants reported this as one of the most prevalent means of suicide in Halton, often occurring in homes, across various demographics.

2. **Overdose:** Multiple sources reported overdose to be common, particularly among women and youth, although intentionality is ambiguous.
3. **Jumping:** Three key informants identified jumping as a common means in Halton. Concerns were raised about tall buildings (especially those over six stories), GO stations, and train tracks. While GO stations were noted as areas of concern, most completed suicides reportedly occur when individuals access tracks elsewhere.
4. **Firearms:** Two physicians in the study mentioned the use of firearms by local men.
5. **Carbon monoxide poisoning:** CMHA Halton noted that this means of suicide has been used in a few recent attempts.

### *Risk factors*

1. **Comorbid mental illness:** Key informants said that the co-occurrence of anxiety, depression, and untreated post-traumatic stress are increasing suicide risk in Halton.
2. **Social isolation:** Research participants said that social isolation has increased for many community members, and been exacerbated by the COVID-19 pandemic, especially for seniors.
3. **Postpartum mental health issues,** HRHD reported that long waitlists for breastfeeding support are impacting the mental health of mothers and their families.
4. **Excessive social media use:** Respondents said they are observing increasing numbers of people, especially youth, experiencing more isolation and relationship problems because of social media.
5. **Economic stress:** Financial pressures caused by the rising cost of living are reported to be increasing many community members feelings of stress, hopelessness, and suicidal ideation.
6. **Substance use:** Service providers witness how substance use, usually compounded by other issues such as homelessness, foster increasing hopelessness in some community members, leading to suicide. Increasing alcohol consumption was observed in Haton as a major problem leading to self-harm.
7. **Employment transitions:** Key informants said they are seeing the detrimental impact of retirement, job loss, or difficulty finding work, especially among men in Haton.

### *Protective factors*

1. **Youth mental health programs:** Some youth focused community programs were applauded by key informants for being visible, having impact, and facilitating coordinated access.
2. **Parental Involvement Committees (PIC):** School boards' active engagement of parents through PIC meetings was acknowledged for promoting community engagement and support for youth in school.
3. **Integration of Indigenous teachings and social equity in schools:** Efforts are underway to integrate Indigenous teachings and promote social equity in schools, through the hiring of additional in-school staff focused on these goals.

4. **Teacher training:** Training for teachers to foster relationships with students and supportive interventions, such as the designation of inclusion rooms, are benefiting school communities in Halton.
5. **School policy:** Schools are contacting emergency services when there is an indication of self-harm or suicide ideation among students. (However, this has raised some concern about the misuse of emergency services.)
6. **Community support services:** Organizations such as Thrive are recognized for providing counselling support to individuals in need. (However, some community services are also plagued by long waitlists.)
7. **Bereavement programs:** Heartache2Hope's support groups for families coping with loss is appreciated by its users, who also said the organization has been helpful in connecting them with other resources such as Lighthouse for Grieving Children.
8. **Peer support programs:** Peer support initiatives offered by organizations such as Support House are recognized for providing accessible, low-barrier options.
9. **Senior support programs:** Services such as the Friendly Visitor Program and Links to Care are recognized for providing help and connection to older adults in the community.
10. **Early identification and intervention strategies:** Some healthcare providers in Halton are using standardized assessment tools and safety planning to patients in distress and connecting them with the appropriate hotlines.
11. **Responsible media:** Research participants said that they typically observe responsible media reporting but would like to see this further developed, especially as it pertains to social media.

### *Service gaps*

1. **Lack of access to timely care:** Key informants noted long wait times for services, no same-day appointments, and a lack of specialized programs (such as detox programs, or Indigenous specific programming) in Halton.
2. **Lack of continuity of care:** There is inadequate transition planning from intensive care to community support, and when youth age out of services. There is also an over-reliance on emergency services.
3. **Limited cultural sensitivity and equity:** Research participants call for service provider training to improve understanding of diverse cultural groups within Halton and thereby improve equitable access to support services.
4. **Demand for more outreach:** Greater community outreach is needed to inform diverse populations about available mental health resources and further destigmatize suicide and mental health.
5. **Demand for supportive housing:** The absence of supportive housing is particularly needed for seniors and community members with concurrent disorders.
6. **Concerns over treatment approaches:** Emergency rooms for providing inadequate attention to patients and rushed discharges without safety planning. There is also a tendency in mental health services to prioritize medication over more comprehensive approaches.



### *Data gaps*

1. **Lack of standardized data practices:** There is no standardized practice for collecting and sharing data.
2. **Lack of centralized data management:** There is a lack of centralized data management across Halton's mental health services, impacting data accessibility and usability for practitioners and decision-makers alike.
3. **Limited demographic data:** There are gaps in the demographic identifiers collected by various service providers.
4. **Limited program evaluations and needs assessments:** Most organizations lack formalized program evaluations and needs assessments.
5. **Challenges in death determination:** Limited communication with the coroner's office means that service providers do not receive confirmation of suicide deaths among their service users. This lack of feedback limits organizations' ability to learn from incidents and improve prevention strategies.



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