UNDERSTANDING SUICIDOLOGY: RESEARCH & PRACTICE

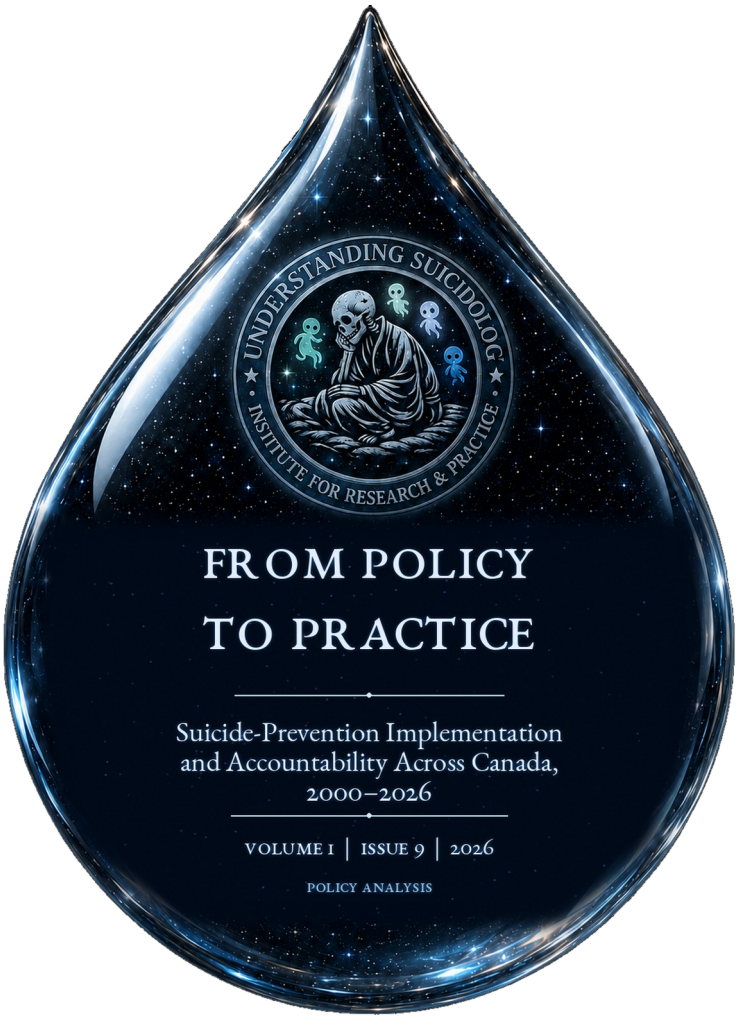
RESEARCH ARTICLE | CANADIAN SUICIDE-PREVENTION POLICY

From Policy to Practice: Suicide-Prevention Implementation and Accountability Across Canada, 2000–2026

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Policy architecture • Implementation • Accountability • Evaluation

Abstract

Background: Suicide-prevention policy is often evaluated as though the presence of a strategy were the intervention. This can misclassify aspirational, weakly implemented, targeted, and distributed systems as equivalent exposures.

Aims: To evaluate suicide-prevention architecture, implementation fidelity, accountability, and outcomes across the Canadian federal system and all 13 provinces and territories.

Method: Public legislation, strategies, action plans, budgets, audits, program reports, and surveillance sources were reviewed through October 7, 2026. Policy commitments were coded by implementation status, current systems were cross-walked against WHO LIVE LIFE interventions and foundations, and accountability was assessed from commitment through population-outcome evaluation. Statistics Canada mortality data from 2000–2019 formed the primary historical series; recent surveillance was analyzed separately. Policy-specific longitudinal analyses were used where timing and scope permitted.

Results: Six of 13 provinces/territories had a current standalone population-wide suicide-specific policy; seven used distributed, targeted, clinical, community, or transitional architectures. Across 14 federal/provincial/territorial systems, multisectoral collaboration and capacity building were documented in 14/14, whereas explicit means-safety policies showed documented system-level operation in 5/9 and responsible-media policies in 3/5. All systems demonstrated commitment, some identifiable funding supporting suicide-prevention implementation, and operational activity; 9/14 demonstrated aggregated reach/output evidence. No current policy cycle met the study's strict criterion for a completed public whole-plan evaluation or population-outcome effectiveness evaluation. Longitudinal findings were heterogeneous and strongly conditioned by pre-existing trends and implementation intensity.

Limitations: Public-document ascertainment may miss unpublished or local activity; observational analyses remain vulnerable to policy endogeneity and recent data limitations.

Conclusion: Canada's main policy gap is not absence of activity but incomplete translation from policy content to verified implementation and from implementation to formal outcome evaluation. Strategy presence alone is an inadequate causal exposure.

Keywords: suicide prevention, health policy, implementation, accountability, Canada

Introduction

Suicide-prevention policy is commonly compared using a simple distinction: whether a jurisdiction has a strategy. That distinction is administratively convenient but analytically weak. A strategy may be aspirational, underfunded, incompletely implemented, or narrowly targeted; conversely, a jurisdiction without a current standalone strategy may operate substantial crisis, training, surveillance, community, and postvention infrastructure. The policy exposure of interest is therefore not a document alone, but the sequence through which commitments acquire authority, resources, implementation, reach, and evaluation.

Canada provides an informative test case because federal, provincial, and territorial policy has developed through markedly different pathways. Federal activity includes the Federal Framework for Suicide Prevention Act, national frameworks, 9-8-8, Indigenous-led strategies, and the 2024–2027 National Suicide Prevention Action Plan (Government of Canada, 2024). Provinces and territories variously use population-wide action plans, youth strategies, clinical frameworks, community models, broader mental-health plans, coroner recommendations, and long-standing program infrastructure. Treating these forms as equivalent "strategy exposure" risks substantial misclassification.

The World Health Organization's LIVE LIFE framework identifies four core interventions: limiting access to means, responsible media interaction, socio-emotional life skills for adolescents, and early identification, assessment, management, and follow-up. These interventions are supported by situation analysis, multisectoral collaboration, awareness and advocacy, capacity building, financing, and surveillance/monitoring/evaluation (World Health Organization, 2021). The distinction between interventions and foundations permits a more specific question than whether a strategy exists: what does the policy contain, what is operational, and how far does public accountability extend?

Recent international evidence reinforces the need to separate strategy adoption from implementation and outcome evaluation. Crisis reviews have documented substantial variation in national strategy components and continuing limitations in evidence of impact (Schlichthorst et al., 2023; Sinyor et al., 2024). A 2026 review of 26 quantitative national-strategy studies likewise found heterogeneous and sometimes discrepant outcomes and argued that national suicide-prevention strategies should be evaluated as complex interventions using multilevel, mixed-method approaches rather than as simple policy on/off exposures (Altavini et al., 2026). The present study extends that problem to a federal system by decomposing policy presence into operationalization, reach, accountability, and outcome evidence across both national and subnational levels.

This study evaluated the federal government and all 13 provinces and territories to determine (a) how suicide prevention is currently organized; (b) how comprehensively current systems cover and operationalize LIVE LIFE domains; (c) how far accountability chains progress from commitment and funding to reach and evaluation; and (d) where timing and data permit, whether population or target-population outcomes depart from prior trajectories or appropriate comparators. A PRISMA-inspired documentary review flow diagram and a pilot computational stress-test workflow are provided in the Supplementary Appendix (Figures S1–S2) to make the audit trail and reproducibility steps visible.

Method

Design and policy coding

We conducted a longitudinal comparative policy implementation and outcome evaluation with a documentary cutoff of October 7, 2026. Core policy analysis covered 2004–2026, with earlier antecedents included when they materially affected exposure history. Public legislation, strategies, action plans, budgets, annual reports, audits, coroner/medical-examiner materials, program reports, and surveillance sources were reviewed.

The unit of policy analysis was the individual commitment or action. Implementation was coded as implemented as specified, implemented with delay, partially implemented, implemented in altered form, underway, deadline not reached, public evidence not located, superseded, or not assessable. “Public evidence not located” was not treated as nonimplementation.

Year-specific architecture codes distinguished: no formal suicide-specific architecture identified; broad/distributed mental-health or public-health architecture with explicit suicide content; targeted/clinical/community/youth suicide-specific policy or program; and standalone population-wide suicide-specific strategy/action plan/framework. Scope compatibility with all-age mortality was coded separately. A stricter historical exposure required evidence that a population strategy progressed beyond publication into plan-level operationalization. Coding was investigator-led using explicit codebook definitions. Ambiguous cases were revisited against the underlying source text and coded conservatively. The current archetypes are descriptive rule-based groupings derived from the coded architecture, intervention-operation, and accountability variables; they are not validated scales or quality rankings.

Document identification and source adjudication

The documentary review was iterative and jurisdiction-specific rather than a conventional bibliographic systematic review. Searches combined each jurisdiction name with terms including suicide prevention, strategy, action plan, framework, program, funding, annual report, evaluation, audit, coroner, mortality, and self-harm, supplemented by known policy titles, site-limited searches of government domains, and source snowballing from identified policy documents. Primary official sources—legislation, government strategies and reports, official statistical products, coroner/medical-examiner materials, and formal government evaluations or audits—were prioritized for coding. Peer-reviewed studies and recognized organizational sources were used for methodological context, triangulation, or document discovery when appropriate. Generic mental-health documents were not coded as suicide-policy instruments unless they contained suicide-specific commitments needed to characterize a distributed system. Superseded documents were retained only when they defined a historically relevant exposure era. When public evidence could not be located, the code 'public evidence not located' was retained rather than recoding the item as nonimplementation. The final audit workbook retained 144 unique public URLs; this is an audit-trail count, not a PRISMA count of records screened. Figure S1 presents the documentary identification and analytic workflow.

WHO LIVE LIFE and accountability

Current federal and provincial/territorial architecture was cross-walked against the four WHO LIVE LIFE interventions and six implementation foundations (World Health Organization, 2021). Policy coverage was classified as explicit, partial/indirect, or not verified; operational evidence was classified as documented, some/local, or not verified. Postvention/suicide-loss support and Indigenous/culturally grounded governance were retained as Canadian extensions but were not included in the 10-domain WHO count. The separation of implementation evidence from service or population outcomes follows the broader implementation-science distinction between implementation outcomes and downstream service or clinical outcomes (Proctor et al., 2011) and the process-evaluation emphasis on implementation, mechanism, and context in complex interventions (Moore et al., 2015).

Accountability was assessed as a sequential chain: formal commitment, identifiable funding, operational implementation, measurable reach/output, formal current-cycle whole-plan evaluation, and population-outcome evaluation. Surveillance dashboards or activity reports were not treated as equivalent to a whole-plan evaluation.

Outcome data and analyses

The primary historical outcome source was Statistics Canada Table 13-10-0932-01, using deaths due to intentional self-harm and age-standardized mortality rates based on the 2021 standard population (Statistics Canada, n.d.). National comparative historical analyses used 2000–2019. Recent Statistics Canada values were retained for sensitivity analyses but were not spliced to current Public Health Agency of Canada coroner/medical-examiner surveillance because the sources differ in ascertainment and provisional status (Public Health Agency of Canada, 2026a). Yukon values with known availability/uncertainty problems were excluded from historical inference after 2016.

Policy-specific analyses were used rather than a single national treatment estimate. For longer historical population policies, segmented log-rate interrupted time-series models took the form $\log(\text{rate}_t) = \beta0 + \beta1(\text{time}_t) + \beta2(\text{post}_t) + \beta3(\text{time-after-policy}_t) + \varepsilon_t$, with heteroskedasticity/autocorrelation-consistent standard errors using a one-period lag. The immediate level term and slope-change term were reported separately, and neighboring placebo breakpoints were examined to test whether apparent discontinuities were specific to the policy year, consistent with recommended interrupted-time-series practice (Bernal et al., 2017). Controlled sensitivities used the treated jurisdiction's log rate relative to the mean log rate of comparator provinces. Québec's current strategy was evaluated against its prespecified mortality targets and the long pre-strategy trend. For Alberta's youth plan, a short pre-COVID Alberta–Ontario matched-month comparison used youth self-harm hospitalization rates. CIHI/PHAC self-harm hospitalization was treated as intentional self-harm rather than as a proxy for suicide attempts (Public Health Agency of Canada, 2026b). Exploratory fixed-effects models included jurisdiction and calendar-year fixed effects with cluster-robust standard errors by jurisdiction and were used only to diagnose selection and exposure problems. Because these analyses were exploratory and heterogeneous in estimand, p values were treated descriptively and no multiplicity-adjusted confirmatory family was defined.

Audit trail and pilot computational stress test

The master workbook preserved source URLs, dates, scope decisions, coding notes, implementation-status decisions, data-quality flags, and derived analytic tables. As a supplementary pilot data-integrity stress test, a separate R script was developed to compare organized tabular data with trusted source exports where direct source tables are available. The script checks schema correspondence, record identifiers, dropped or added rows, cell-level agreement, numeric summaries, category counts, missingness and logic rules, reported numeric claims, and a reproducible random manual-review sample. The hardened script also records file fingerprints, analysis settings, and R session information and prevents silent reuse of nonunique identifiers. This procedure is a computational integrity check rather than a second human coding process: it does not estimate inter-rater reliability, validate interpretive policy classifications, or substitute for source-level adjudication. The workflow is shown in Figure S2, and the verification script is supplied as Supplementary Code S1.

Ethics approval was not applicable because the study used public documents and aggregate population data and contained no individual-level participant data.

Results

Policy architecture

At the study cutoff, six of 13 provinces and territories had a current standalone population-wide suicide-specific strategy, action plan, or framework: Québec, Saskatchewan, Newfoundland and Labrador, Nunavut, Nova Scotia, and Prince Edward Island. The remaining seven had identifiable suicide-prevention activity organized through distributed, targeted, clinical, community, or transitional architectures (Table 1). New Brunswick, for example, operated province-wide Roots of Hope infrastructure despite lacking a current official standalone strategy (Mental Health Commission of Canada, 2026), while British Columbia's principal current suicide-specific instrument was a clinical risk-reduction framework for adults receiving mental-health/substance-use care (Government of British Columbia, 2025).

Four recurring jurisdictional archetypes were identified. Integrated operational strategies combined a population policy, broad operational foundations, at least two documented LIVE LIFE interventions, and public reach/output evidence (Québec, Saskatchewan, Nova Scotia). Comprehensive policies with incomplete translation had broad standalone strategies but less complete or less verifiable operation (Newfoundland and Labrador, Nunavut, Prince Edward Island). Distributed/community operating systems lacked a current standalone strategy but had broad foundations and measurable outputs (New Brunswick, Manitoba, Northwest Territories). Targeted/decentralized or transitional systems organized prevention through youth, clinical,

school-board, community-specific, or evolving architecture (Alberta, Ontario, British Columbia, Yukon). These archetypes describe organization, not effectiveness. The year-by-year evolution of these policy forms is shown in Figure 2.

Table 1. Current suicide-prevention architecture across Canadian provinces and territories

Jurisdiction	Archetype	Current architecture	WHO documented /10	Closure /6	Late ASR
Québec	A	Rallumer l'espoir 2022–26, extended to 2028	9	4	13.24
Saskatchewan	A	Pillars for Life 2020–	10	4	17.26
Nova Scotia	A	Suicide Prevention and Risk Reduction Framework 2020–	8	4	13.04
Newfoundland and Labrador	B	Our Path of Resilience 2022–27	5	4	13.44
Nunavut	B	Inuusivut Annirnaqtut 2024–29	6	3	61.54
Prince Edward Island	B	Building Blocks of Hope 2018–	6	4	8.14
New Brunswick	C	Province-wide Roots of Hope work plan; no official standalone strategy	6	4	13.76
Manitoba	C	Province-wide strategy under development with funded implementation	7	4	15.10
Northwest Territories	C	Mind and Spirit + suicide/crisis network + community fund	7	4	22.28
Alberta	D	Youth-plan successor grant architecture	8	3	15.14
Ontario	D	Distributed mandatory school-board suicide protocols + broader mental-health policy	8	3	10.38
British Columbia	D	Adult clinical framework + youth framework under development	7	3	10.98
Yukon	D	Forward Together + Roots of Hope / distributed life-promotion architecture	6	3	18.96

Note. Archetypes: A = integrated operational strategy; B = comprehensive policy, incomplete translation; C = distributed/community operating system; D = targeted/decentralized or transitional architecture. Archetypes describe current architecture at the October 7, 2026 study cutoff and are not quality rankings. WHO documented /10 = number of the 10 WHO LIVE LIFE domains with documented operation. Closure /6 = highest accountability stage publicly demonstrated. Late ASR = mean age-standardized suicide mortality per 100,000 for 2015–2019, except Yukon (2012–2016 because of Statistics Canada data limitations).

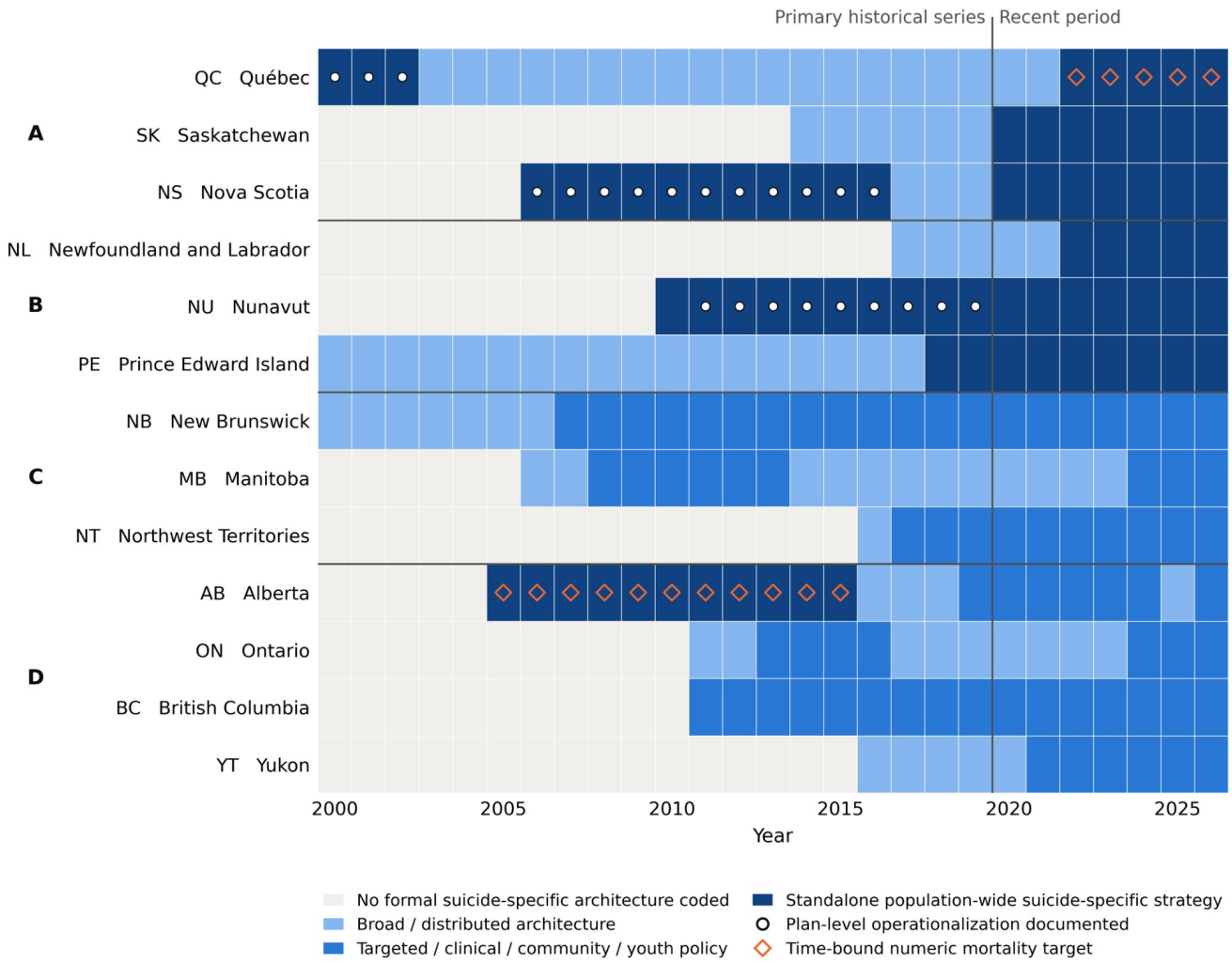


Figure 2. Policy architecture by jurisdiction and year, 2000–2026. Cells show the coded form of suicide-prevention architecture in each province and territory. Circular markers identify years in which plan-level operationalization of a standalone population-wide policy was documented under the study's strict historical exposure rule; diamond markers identify a time-bound numeric mortality target. The vertical rule separates the primary 2000–2019 historical mortality window from the recent period. Policy form is not a quality or effectiveness rating.

WHO LIVE LIFE translation

Implementation foundations were more consistently operationalized than the complete four-intervention package (Table 2). Multisectoral collaboration and capacity building were explicit and documented in all 14 federal/provincial/territorial systems. Situation analysis, awareness/advocacy, financing, and surveillance/monitoring were also common.

Translation was less complete for several core interventions. Means safety was explicit in 9/14 systems, but only 5/9 had documented system-level operation under the strict coding. Responsible-media reporting was explicit in 5/14 and documented as operational in 3/5. Youth socio-emotional life-skills activity was common in indirect forms, but only 3/14 explicitly framed it in a way closely matching LIVE LIFE, with documented operation in 2/3. Early identification, assessment, management, and follow-up was the most consistently translated intervention: 13/14 systems had explicit policy coverage and 12/13 showed documented operation. The explicit-to-operational gap across domains is visualized in Supplementary Figure S3.

Policy breadth did not guarantee implementation completeness. Prince Edward Island's 2018 plan explicitly addressed all four core interventions (Government of Prince Edward Island, 2018), yet only one met the study's strict system-level operational threshold; other components were local, partial, or not publicly verified. Newfoundland and Labrador specified three of four interventions, while public evidence was strongest for selected training, bereavement, and service actions rather than the full intervention package (Government of Newfoundland and Labrador, 2022).

Table 2. WHO LIVE LIFE policy coverage and translation into documented operation

Domain	Explicit /14	Explicit+documented	Conversion
Limit access to means	9	5	55.6%
Responsible media reporting	5	3	60.0%
Youth socio-emotional life skills	3	2	66.7%
Early identification/management/follow-up	13	12	92.3%
Situation analysis	12	11	91.7%
Multisectoral collaboration	14	14	100%
Awareness / advocacy	11	10	90.9%
Capacity building	14	14	100%
Financing	10	10	100%
Surveillance / monitoring / evaluation	13	9	69.2%

Note. Conversion is the percentage of explicitly covered systems with documented operation.

Accountability closure

Every system demonstrated an accountable suicide-prevention commitment, some identifiable funding supporting suicide-prevention implementation, and operational activity (Table 3; Figure 1). Nine of 14 also demonstrated aggregated reach/output evidence through service volumes, communities reached, training counts, grants, or other policy-linked measures. The chain narrowed sharply thereafter.

No current policy cycle met the study's strict criterion for a completed public whole-plan evaluation linking the complete policy to implementation fidelity and outcomes, and no current cycle closed the chain through a formal population-outcome effectiveness evaluation. This does not mean governments do not evaluate suicide-prevention programs. Historical formal strategy-level evaluations were located for Québec and Nunavut, and many current systems monitor mortality or publish implementation updates. The recurrent gap was evaluation at the level of the whole policy.

Saskatchewan illustrates the distinction. Pillars for Life has recurring funding and annual public updates documenting Roots of Hope expansion, training, means safety, postvention, and community grants (Government of Saskatchewan, 2020, 2026). Northwest Territories publicly reports dedicated community suicide-prevention funding and recipient counts (Government of Northwest Territories, 2026). These outputs establish implementation and reach, not population effectiveness.

Table 3. Current accountability closure across 14 Canadian systems

Accountability stage	Systems	Percent
Formal commitment	14	100%
Some identifiable funding supporting implementation	14	100%
Operational implementation	14	100%
Aggregated reach / outputs	9	64.3%
Completed formal current-cycle whole-plan evaluation	0	0%
Completed current-cycle population-outcome evaluation	0	0%

Note. Stages reflect publicly evidenced accountability, not the causal effectiveness of policy.

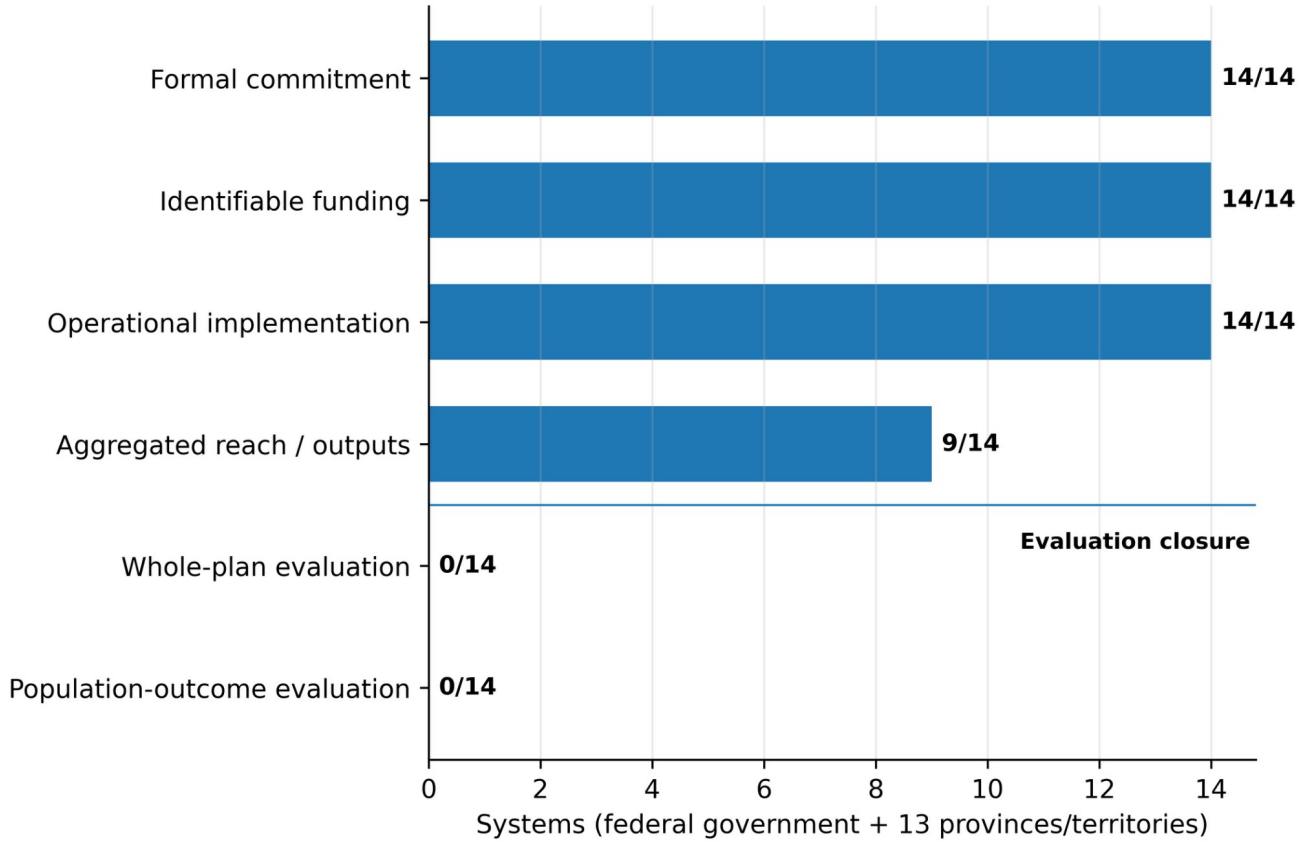


Figure 1. Public accountability closure across the Canadian federal government and 13 provincial/territorial systems. The figure shows the number of systems with publicly demonstrated evidence at each sequential accountability stage; stages are not measures of policy effectiveness.

Reading note. "0/14" means no public evidence met this study's strict current-cycle evaluation criterion; it does not prove that no evaluation activity occurred.

Longitudinal findings

Policy-specific outcome analyses were heterogeneous (Table 4). Alberta's 2005 population strategy produced an apparent immediate 10.6% decline at the strategy breakpoint in a segmented log-rate model ($p < .001$), followed by a +3.5% per year slope change ($p = .002$). Nearby placebo breakpoints also generated substantial changes, and a later Alberta Health Services review concluded that the strategy was never fully translated into a tangible implementation plan and had only minimal resources (Alberta Health Services, 2018). The pattern therefore indicates a mid-2000s trajectory change, not a causal strategy effect. Full actual-versus-placebo breakpoint sensitivity is shown in Supplementary Figure S5A–S5B.

Nova Scotia's 2006 framework showed no robust policy-onset discontinuity: the estimated immediate change was +4.7% ($p = .647$) and the slope change +1.2% per year ($p = .645$). Concrete implementation nevertheless occurred, including a four-year Communities Addressing Suicide Together initiative (Province of Nova Scotia, 2006). The absence of a mortality break cannot therefore be interpreted as absence of implementation.

Nunavut's 2010 strategy was triangulated with a formal 2015 evaluation. The segmented model estimated a +34.6% level change around 2010 ($p = .028$) and a +5.0% per year slope change ($p = .043$), but nearby breakpoints were also unstable. The formal evaluation reported meaningful progress in services, training, youth coping, and collaboration, while finding no evidence that suicide rates were decreasing and identifying major funding, workforce, research, communication, and community-development gaps (Aarluk Consulting, 2015). Together, these findings demonstrate absence of population improvement during the first strategy/action-plan period, not causal harm.

Québec provided the clearest current target-attainment case. The 2017–2019 baseline was 1,094 deaths and 13.0 per 100,000, corresponding to 10% thresholds of 984.6 deaths and 11.7 per 100,000 (Gouvernement du Québec, 2022, 2026). Final 2023 data did not meet either threshold; provisional 2024 data showed 964 deaths and 10.7 per 100,000, provisionally meeting both (Institut

national de santé publique du Québec, 2026). However, the mortality rate had already been declining by approximately 0.225 per 100,000 annually from 2000–2021 (R^2 = .841), so target attainment does not establish an incremental strategy effect. Supplementary Figure S6 places target attainment against the pre-existing mortality trend.

For Alberta's 2019 youth plan, target-population analysis was limited to the early pre-COVID period. Female youth self-harm hospitalization rates declined in Alberta, but the matched-month Alberta–Ontario difference-in-differences estimate was -0.253 per 100,000 (95% CI -0.899 to 0.393; p = .403). The male estimate was -0.0325 (95% CI -0.377 to 0.312; p = .838). Early Alberta declines were not statistically distinguishable from concurrent Ontario declines (Dharma et al., 2024).

Table 4. Selected longitudinal and target-attainment findings

Case	Design	Primary finding	Defensible conclusion
Alberta 2005–15	Segmented log-rate ITS	-10.6% immediate level; +3.5%/yr slope change	Mid-2000s change, not causal strategy effect; implementation was weak.
Nova Scotia 2006	Segmented log-rate ITS	+4.7% level; +1.2%/yr slope change; neither statistically distinguishable from zero	No robust mortality break at framework onset.
Nunavut 2010	ITS + formal evaluation	+34.6% level; +5.0%/yr slope change; evaluation found no decreasing rates	No demonstrable population improvement in first strategy period; no causal harm established.
Québec 2022–	Target attainment + pre-trend	2024 provisional 964 deaths; 10.7/100k; both below 10% thresholds	Target provisionally attained; strong decline predates strategy.
Alberta youth 2019–	Matched AB–ON pre-COVID self-harm comparison	Female DiD -0.253, p = .403; male -0.0325, p = .838	No early Alberta-specific effect detected.

Note. ITS = interrupted time series; DiD = difference-in-differences. Policy-specific estimates are observational diagnostics, not causal effects.

National comparative diagnostics

Current policy form did not map onto a monotonic historical mortality gradient. Median late-historical age-standardized mortality was 13.24 per 100,000 in the integrated-strategy archetype, 13.44 in comprehensive/incomplete-translation systems, 15.10 in distributed/community systems, and 13.06 in targeted/decentralized or transitional systems. Within the integrated group alone, Québec had a long historical decline while Saskatchewan and Nova Scotia had rising pre-policy trajectories. The historical burden and timing of standalone policy are shown in Supplementary Figure S4.

Exploratory fixed-effects diagnostics reinforced why this pattern should not be interpreted causally. Simply having a standalone population policy active was not associated with lower mortality in preferred log-rate models, while an apparently adverse result in a raw level-rate specification disappeared when Nunavut was excluded or the outcome was log transformed. Restricting exposure to demonstrably operationalized policies did not resolve the problem because stronger policies were concentrated in higher-burden settings. These results were treated as evidence of confounding by indication and exposure heterogeneity rather than as national policy-effect estimates.

Discussion

This study indicates that Canada's central suicide-prevention policy problem is not policy absence. Every audited system could demonstrate funded and operational prevention activity. The larger differences concerned how policy was organized, which evidence-based interventions were actually operationalized, and whether accountability advanced beyond activity reporting.

The first implication is methodological: strategy presence is an inadequate exposure. Alberta's 2005–2015 strategy appeared unusually strong on paper, with population scope, a 10-year horizon, an explicit mortality target, and planned evaluation, yet retrospective evidence showed weak plan-level operationalization (Alberta Health Services, 2018). New Brunswick presents the converse case: no current official standalone strategy, but substantial province-wide community implementation (Mental Health Commission of Canada, 2026). Evaluations that code Alberta as full treatment exposure and New Brunswick as policy absence would misclassify both. Enactment, funding, operationalization, fidelity, reach, and evaluation should be modeled separately.

Second, implementation foundations were stronger than intervention comprehensiveness. Collaboration, capacity building, financing, situation analysis, and monitoring were widespread, and crisis/clinical identification and management was especially

well developed. Responsible-media intervention and system-level means safety were less consistently verifiable. Foundations create the conditions for prevention, but they are not substitutes for the interventions themselves.

Third, accountability closure remained weak even where implementation reporting was strong. The finding that all systems demonstrated implementation but no current cycle met the strict whole-plan evaluation criterion should not be read as "governments do not evaluate." Training counts, crisis-line volumes, grants, and communities reached answer whether activity occurred. They do not establish whether the full policy was implemented as intended, reached intended populations equitably, changed hypothesized mechanisms, or altered population outcomes beyond secular trends.

Fourth, population evaluation requires temporal and target-population discipline. Québec shows why explicit targets improve evaluability but do not solve attribution when a strong secular decline predates the policy. Nunavut shows why persistent high mortality cannot be interpreted as simple policy failure in a small population facing major structural determinants and implementation constraints. Youth policies should likewise be evaluated with youth outcomes; all-age mortality is a poor primary endpoint for Alberta's or Ontario's youth-focused initiatives. This distinction also aligns with recent international work showing that only half of identified national strategies contained quantitative targets and that target attainment remained uncommon among strategies whose target dates had passed (Canal-Rivero et al., 2025).

The practical implication is not simply that every jurisdiction should publish another strategy. Different organizational models can support substantial prevention infrastructure. The more useful standard is traceability: commitments should identify accountable actors, resources, timelines, implementation indicators, reach denominators, population targets, and evaluation designs. Federal coordination can strengthen comparability by supporting common accountability standards while respecting provincial/territorial and Indigenous governance.

Limitations

The study relied on publicly accessible evidence and may therefore miss internal evaluations, non-indexed archival materials, and local implementation. Policy instruments were heterogeneous in target population, authority, funding, and mechanism. Recent mortality data are affected by source and ascertainment differences, while small jurisdictions have substantial annual-rate volatility. Observational analyses cannot eliminate policy endogeneity because high or worsening suicide burden may itself generate stronger policy responses. Implementation coding also requires judgment; this was mitigated through explicit categories, source retention, and separation of policy coverage from operational evidence. Long historical youth outcome series remain incomplete for several jurisdictions. Policy coding was investigator-led, and no formal second-human-coder inter-rater reliability statistic was estimated; the pilot R stress test addresses computational and organizational integrity, not interpretive agreement. A future replication would be strengthened by blinded double-coding of a prespecified sample of policy commitments.

Conclusion

Canada has built extensive suicide-prevention infrastructure, but the chain from policy to population impact remains incomplete. Current systems differ substantially in policy form, intervention content, implementation fidelity, and accountability. WHO implementation foundations are more consistently operationalized than the full LIVE LIFE intervention package, and current accountability usually stops before whole-plan and population-outcome evaluation.

A suicide-prevention strategy should therefore not be treated as a binary treatment. Enactment, resources, implementation, reach, and evaluation are distinct exposures. Future Canadian policy should be designed to be auditable as well as actionable: commitments should specify accountable owners, resources, timelines, coverage measures, population targets, and evaluation designs capable of distinguishing policy effects from secular trends.

Publication transparency

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Conflict of interest. The author founded Understanding Suicidology, which operates a non-profit research and practice division and a separate paid education and consultation division. No compensation was received for this manuscript.

Ethics. Ethics review was not applicable: this study used public documents and aggregate population data, without individual-level participant data.

Consent. Not applicable.

Preregistration. This research was not preregistered with an analysis plan in an independent institutional registry.

Research transparency. The author is willing to share the analytic coding workbook, codebook, derived analysis methods, and study materials with other researchers upon reasonable request. Supplementary materials document the documentary identification/coding workflow and the pilot computational stress test. Supplementary Code S1 contains the R data-integrity verifier used for reproducibility stress testing; passing this verifier should not be interpreted as independent validation of policy-coding judgments.

Generative AI disclosure. The supplied author declaration reports the use of Codex-Sol 5.6 for data abstraction and organization. The author reviewed and edited outputs, checked source material and statistical interpretations against the retained audit trail, and takes responsibility for the manuscript. A supplementary R script documents a pilot data-integrity stress-test workflow, not an independent coding or validation study.

Author contributions. Matias Gay: conceptualization, methodology, investigation, data curation, formal analysis, visualization, original draft, review, and editing.

Supplementary material. Supplementary Appendix, documentary methods and reproducibility figures S1–S6; Supplementary Code S1, R data-integrity stress-test script.

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