## Suicide prevention

We agree with Eggertson and Patrick that suicide prevention needs attention.[1] However, we cannot agree that another strategy is the solution. Strategies do exist; now is the time to put them into action.

We aren't lacking in guidance — we have a roadmap, arrived at through extensive consultation. Suicide prevention is an integral component of *Changing directions, changing lives: the mental health strategy for Canada*[2] and its companion piece, *The mental health strategy for Canada: a youth perspective*.[3] Most Canadians who die by suicide are confronting mental health problems or illnesses and share many common risk factors.

We cannot effectively address suicide prevention in isolation from the broader context, which includes a commitment to early identification, timely access to services, treatment and support, and the reduction of the stigma associated with mental health problems and illnesses — all of which figure prominently in the strategy.[2] We cannot in good conscience let a thoughtful document that contains such collective wisdom, gather dust.

That is why the Mental Health Commission of Canada has put forward an evidence-based, action-oriented program to address suicide prevention at the community level. This far-reaching project accounts for fiscal reality and maximizes the use of community resources. It offers a multi-faceted approach to a complex problem — but its actions are simple. It will provide key community members (from coaches and barbers to educators, health care providers and spiritual leaders) with the knowledge and tools to identify those at risk of suicide and connect them to help. It will enhance specialized supports for crises situations and restrict access to methods or places where a high number of suicides occur. The project will improve public awareness and foster bolder research to expand our knowledge about suicide prevention.

Examining this challenging public health issue through a holistic lens is why Inuit Tapiirit Kanatami (ITK), the national Inuit political association, has released the *National Inuit Suicide Prevention Strategy*.[4] ITK and other indigenous communities, like the Thunderbird Partnership Foundation, have taken ownership of the staggering challenge facing its communities.

When it comes to saving the lives of 4000 Canadians every year, we don't have time to reinvent the wheel. The tools and resources, including the 94 calls to action outlined in the final report of the Truth and Reconciliation Commission of Canada, are there.[2–5]

**Louise Bradley**
President and CEO, Mental Health Commission of Canada, Ottawa, Ont.

### References

1. Eggertson L, Patrick K. Canada needs a national suicide prevention strategy. *CMAJ* 2016;188:E309-10.
2. *Changing directions, changing lives: the mental health strategy for Canada*. Calgary, Alta.: Mental Health Commission of Canada; 2012. Available: http://strategy.mentalhealthcommission.ca/pdf/strategy-images-en.pdf (accessed 2016 Sept. 16).
3. *The mental health strategy for Canada: a youth perspective*. Ottawa, Ont.: Mental Health Commission of Canada; 2015. Available: www.mentalhealthcommission.ca/sites/default/files/2016-07/Youth_Strategy_Eng_2016.pdf (accessed 2016 Sept. 16).
4. *National Inuit suicide prevention strategy*. Ottawa: Inuit Tapiriit Kanatami; 2016. Available: www.itk.ca/wp-content/uploads/2016/07/ITK-National-Inuit-Suicide-Prevention-Strategy-2016.pdf (accessed 2016 Sept. 16).
5. *Honouring the truth, reconciling for the future*. Winnipeg, Man.: Truth and Reconciliation Commission of Canada; 2015. Available: www.trc.ca/websites/trcinstitution/File/2015/Honouring_the_Truth_Reconciling_for_the_Future_July_23_2015.pdf (accessed 2016 Sept. 16).

***CMAJ* 2016. DOI:10.1503/cmaj.1150128**

## Doing any test is *not* better than doing no test

Murray's letter repeats a common mistake in thinking about screening, that "doing any test is better than doing nothing at all."[1] In fact, sometimes doing nothing is better than doing something: more is not always better.[2]

There are risks and harms with all medical interventions including screening.[3] It is imperative not only that cancer screening programs find malignancies early but also that they yield more benefit that harm: harm generally arises from false-negative results, false-positive results and overdiagnosis.[4]

Although the risk of a false-negative result may be mitigated by repeat screening, it may also lead to harm.[4] A person falsely reassured may continue an unhealthy lifestyle and be less likely to return for repeat screening.[5] A false-positive result often leads to a cascade of increasingly invasive medical interventions, as well as the psychological distress of becoming a patient and being labeled as "ill."[4,5]

Specific to colonoscopy are a number of risks. Murray correctly states that a 1:1000 risk of perforation is rare,[1] but rare events add up quickly when numerous people are screened. With millions of Canadians eligible for colon cancer screening, rare risks are not negligible.[6]

It is true that people with "symptoms … will need to be investigated."[1] However, these people are not being screened.[6] Screening is meant to catch disease early and is carried out on apparently well asymptomatic people. Though the current evidence does not support the use of colonoscopy for population-based primary screening — hence, colonoscopy is not recommended as a primary population screening test[6] — colonoscopy does have other roles in health care.

**Lisa K. Freeman MD**
Public Health and Preventive Medicine, Alberta Health Services and University of Alberta, Edmonton. Alta.

### References

1. Murray I. Colonoscopy as best screening test not proven [letter]. *CMAJ* 2016;188:973.
2. Choosing Wisely Canada. Why more medicine isn't always better medicine: appropriateness of care and choosing wisely. Available: www.choosingwiselycanada.org/resources/videos/2015/02/19/choosing-wisely-canada-more-medicine-is-not-always-better-medicine/ (accessed 2016 Sept. 25).
3. Wintermute K, McDonald K, Huynh T, et al. Addressing overuse starts with physicians: Choosing Wisely Canada. *Can Fam Physician* 2016;62:199-200.
4. Barrett B, McKenna P. Communicating benefits and risks of screening for prostate, colon, and breast cancer. *Fam Med* 2011;43:248-53.
5. Marteau TM. Psychological costs of screening. *BMJ* 1989;299:527.
6. Canadian Task Force on Preventive Health Care. Recommendations on screening for colorectal cancer in primary care. *CMAJ* 2016;188:340-8.

***CMAJ* 2016. DOI:10.1503/cmaj.1150129**