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HOSTED BY DR. DAVID GRATZER

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Episode 44: Suicide prevention with Dr. Mark Sinyor

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[Musical intro]

David Gratzter: Back in med school, it seemed all we really needed to know about suicide prevention was captured by SAD PERSONS, that an acronym listing chronic and acute risk factors. Of course, there's a bit more to know on the topic of suicide prevention. And gosh, there's also that evolving and rich literature on the topic. How are pesticides linked to suicide? What's the role of suicide barriers? What to think about AI?

My name is Doctor David Gratzter. I'm a psychiatrist here at CAMH. And today on *Quick Takes*, a podcast by physicians for physicians, we consider these questions and more as we consider suicide prevention. Joining me today, Doctor Mark Sinyor. Doctor Sinyor is a professor in the Department of psychiatry at the University of Toronto. He's a staff psychiatrist at Sunnybrook Health Sciences Centre, and the author of more than 150 peer-reviewed papers, including one that recently was published in *World Psychiatry* with a colleague from Oxford. Welcome, doctor.

Mark Sinyor: Thank you so much for having me.

David Gratzter: You're prolific. What got you interested in this topic in the first place?

Mark Sinyor: You know, like most people who work in suicide prevention, it's two sides. Um, people often don't talk about it, but certainly in my personal life, I've had some lived experience of suicide, which typically draws people to the field. And then when I was starting second year medical school, we had a project where we had to study, something in the community for community public health. And the project that I was assigned to was at the coroner's office here in Toronto, looking at the effectiveness of a suicide barrier on a bridge here.

David Gratzter: And that lent itself to further work. And of course, one of your big early papers was talking about the Bloor Viaduct.

Mark Sinyor: Yeah. And that actually has really informed the way that my whole career has progressed because the original research into the barrier showed that it didn't work. At least it looked like it didn't work. You would think that something preventing someone from having access to the methods of suicide should work. And in fact, the spoiler alert is it does. It's the most reliable way of preventing suicide. But what happened is that when the barrier was created, this is now more than two decades ago, there was a media event that happened at the same time in which our national media wrote things like, "this is a waste of money." "People who are intent on suicide will find other means of suicide." And unfortunately, we saw a media event that was parallel to the barrier, and at least for a few years, it seemed to abolish the effect. Now, in fairness to

the media, I think that a lot has been learned between then and now, and certainly there's a lot more sensitivity. I don't think that what was written then would be written these days, in part because of some of our efforts. But as a result of that work, it really got me passionate both about the idea of means restriction in trying to restrict access to suicide methods, but also the issue, maybe underexplored issue of the impact of media and public narratives. And so that if anything has taken on a larger role in my work over the last decade.

David Gratzer: Well, let's stick with the Bloor Viaduct for a moment, because it's a good example of public policy that can, in fact, save lives. I thought the best paper criticising the original paper was the paper you wrote for *The Canadian Journal of Psychiatry* in, what, 2025. Drawing on, what was it, 19 years' worth of data? Do you think that the debate is somewhat settled? So, I mean, the original debate was that maybe there's a suicide magnet, but prevention doesn't really work because people would just choose another bridge or another means or something of the sort. Is this still an active debate, do you think?

Mark Sinyor: No. I would answer the question by saying very definitively the debate is settled. That restricting access to means prevents suicide. I know most of your listeners are physicians and other health care workers. Everybody knows that there's no intervention that's 100%. So, nothing gets you all of the way. But does the intervention make a difference and make a huge difference? The answer is yes. We know that from studies of all sorts of means that have been restricted across the world. The thing that was odd about our particular example in Toronto is that, you know, in defence of the original paper, you wouldn't expect a barrier to take years to kick in. Once it's there, you would expect it to show something. And so we just assume that you would see a positive effect initially. The wonderful thing about the 2025 paper is that we were very, you know, clearly able to show that after those first few years, it worked exactly as was intended. There were about ten deaths per year at that location beforehand, and there have been something like 150 or plus deaths that have been prevented since then. So, you know, it's essentially worked exactly as intended, except during that initial media spike.

David Gratzer: So, let's talk now about suicide prevention at a national level. Something you've written about. One of the things you've talked about is pesticides and low- and middle-income nations.

Mark Sinyor: Yeah. So, pesticides in some ways are a really good news story but a cautionary tale. There have been some studies about locking them up, essentially finding a way to allow people to use very dangerous pesticides, but keeping them under lock and key. And interestingly, those were not particularly effective. What is effective are national laws banning highly lethal pesticides. And we were talking just before we started about Sri Lanka which is a great example of a country that had sort of the two key parts of the means restriction debate. The first one you've talked about, does it work? The answer is yes; it does work. And then often there's some kind of an objection in the case of pesticides, the objection is, well, what about our crops? We farm and what will happen to our economy if we get rid of these? One of the fascinating aspects of the laws that banned highly lethal pesticides in Sri Lanka is that, if anything, the crop yields increased afterwards. So, there was no economic disruption. If anything, the economies grew. And many, many lives were saved in that country and in several others where that kind of broad-based ban was put into effect.

David Gratzer: So, we're talking about prevention. We're talking about good news stories. I mean this is important work. And in fact, you've taken a global role in this work. Why don't you tell us about that?

Mark Sinyor: Yeah. So that's another interesting story of how it happened. During the pandemic I ended up becoming the Canadian representative of a worldwide research collaborative, which was focused on understanding the effect of Covid on suicide, because like everybody else, all the researchers were stuck at home and tried to find something to do. There's actually a good news story with regards to that. We were able to show that the initial months and year and a half of the pandemic were associated worldwide, if anything, with a reduction in suicides or certainly no change. Contrary to what people expected. Um, and then through that work, I had met a number of international colleagues who, one of whom Professor Steve Platt from the Uni-

versity of Edinburgh, asked me to take on a role as part of a large initiative that's undertaken by the International Association for Suicide Prevention (IASP) called Partnerships for Life. The reason for Partnerships for Life, or the rationale for it, is that something like 90% of researchers and research funding happen in high income countries. But in fact, we know that most suicides, actually 75% or so of them, occur in low- and middle-income countries. And so, the IASP decided to put together this initiative in order to try to prevent suicide and create national and regional strategies across the world. They asked me to be in charge of the Americas. And actually, as of this month, I'm now the global lead of the initiative, which is a bit of a daunting situation, trying to think of how can you think strategically about preventing suicide across the entire world? Luckily, I have many, many wonderful colleagues who are engaged and involved in the initiative. And it's a really exciting thing.

David Gratzer: And as somebody from a high-income nation, how's your thinking evolved in terms of strategies relevant in countries that aren't so affluent?

Mark Sinyor: It's an interesting question because, you know, ultimately there are two sides to it. On one hand, my bias is that what works works everywhere. So, the World Health Organisation has something called the *LIVE LIFE Implementation Guide* to create national suicide prevention strategies. And it includes four pillars: that's restricting access to methods; making sure that journalists are reporting responsibly – although I would broaden that to say that narratives across the media need to be carefully constructed; early life skills for youth, fostering life skills; and early detection and intervention for people who are at risk. And the reality is that works as well in Canada and in Panama and Costa Rica and Colombia, all across our world and in other in other regions of the world. The issue is that the implementation differs depending on the country, but the reality is that even amongst high income countries like Canada or the US, our implementation is going to differ broadly as well. So, I think the core principles are the same. It's just a question of the cultural context.

David Gratzer: What's a learning you've had in this role?

Mark Sinyor: Oh, that's such a broad question. I think partly it's that there's, you know, incredible interest and thirst for this work really in every country around the world. And the other thing is that maybe partly embedded in the question is that maybe in low- and middle-income countries, they're so under-resourced that they can't manage. And certainly, that's a concern that they will share with you. However, I will tell you that I've been amazed at how countries that have very limited resources have been able to pull together and really do good work to prevent suicide. And so, I think actually, if I had to pick one, learning, it would just be that you don't actually need billions of dollars to prevent suicide. You just need really good coordination.

David Gratzer: Are you optimistic about the future?

Mark Sinyor: I think so. First of all, for a variety of reasons, I think part of the role of people who are working in suicide prevention is to hold on to hope. There always has to be hope that we can do something. And I don't think that it's a pie in the sky idea. Worldwide, there were more than 800,000 suicides recorded 10-15 years ago, and now we've gotten it down to 700,000 suicides per year – 720,000. But, you know, that's a, that's a large reduction, almost 10%. So, the bottom line is I don't see why we can't continue to do that. There, there are two main schools of thought. One school of thought is that we don't know how to prevent suicide, and we need more research to figure it out. And there's an element of that. But if you want my bias, maybe slightly controversial, I think largely we know how to prevent suicide; it just doesn't get implemented well.

David Gratzer: Well, on that topic, we can speak about good news stories, but there are bad news stories too. In fact, suicide rates, as an example, are rising in the United States. How would you reconcile the US as being a high-income nation with such a daunting statistic?

Mark Sinyor: Yeah, I think that there's a few different ways to think about that. You know what is contributing

to suicide? What causes suicide? One of the things that we know, as discussed at a population level is such a big issue is, is means. And the US is an incredible outlier in the world as being the only country, as far as I know, that has a 50% rate of suicide by firearm. So, the United States has a massive means problem. But in addition to that, there are other factors that are potentially playing a role. For example, there's good access to health care amongst a certain percentage of the population, but amongst another group of the population, it's inadequate. And that may be partly responsible. And I think, you know, social unrest, social difficulties, usually suicide rates tend to be lower where there's a sense of belonging and social cohesion. And I think that that was largely more present decades ago in the US than it is now. Back to the notion of hope. I really do have some hope that all of those things could be addressed in some way, but it's a tough time.

David Gratzer: You've written about media reporting in North America. A recent paper, you looked at South Korea and the *Squid Games*. My son would be excited about this. Um, what's a thread that runs through your research findings, whether you're looking at North American media or shows in South Korea?

Mark Sinyor: So, the most important thread is that when we tell stories of survival, we see more survival across the population. So, this has a name it's called the Papageno effect, and we've repeatedly shown it. There was a hip hop song that was released by an artist named Logic in 2017 [titled] "1-800-273-8255," which was the old number for the national US crisis line. And there was an incredible amount of interest in the song. It was about a young man surviving a suicide crisis. After the song came out in the month of maximum interest, there were 10,000 more calls to the US crisis line and 245 fewer suicides. Another example of this is last year we looked at the top movies, box office movies in the United States. And from 1950 to about the turn of the millennium, we found 60 movies that showed a story of survival. And in the years in which those movies came out, there was a drop in suicides across the US. So, the first point is when we model survival, we see people following it. This follows another key point, which is that when we model death, death follows.

So, I'll say something about *Squid Game*, but just to understand it, you have to understand *13 Reasons Why*. So, there was a Netflix show, *13 Reasons Why*, it showed the death of a character, Hannah Baker, whose suicide seemed inevitable. And in a way, it was violating many, many rules that we, that we've suggested in terms of guidelines for how you talk about suicide. Certainly, a person who was at risk watching that it could potentially increase their risk of thinking that suicide was inevitable. And we saw both in the United States and in Canada that there was an increase in suicides and in Ontario, more visits to emergency rooms with self-harm.

The reason we looked at *Squid Game* is because it has in some ways, more suicide content than the *13 Reasons Why* series. However, um, it's a kind of almost anti-suicide show. Or if anything, the narrative is ambiguous. The main character doesn't want a mass suicide and doesn't want people to die. And so, it has all the same content, but with a different narrative. And we expected that with that narrative, we wouldn't see an increase in suicides, and we didn't.

David Gratzer: I mean, it would seem that there are some clear and obvious themes. Um, you've done work on media reporting guidelines in Canada as an example, how have things changed in terms of media reporting in light of all of this?

Mark Sinyor: Well, there are a list of do's and don'ts. Things like, do include a crisis line, do include a story of survival, do include a message of hope. Don't talk about methods, don't make suicide a monocausal phenomenon where one thing inevitably causes suicide and so on. There's a whole list of them. And in fact, we've seen a large improvement in the reporting on suicide. And that has been associated with a trend of reduction in suicides, at least in the area where we looked at, which is the GTA, which is a large proportion of the population even of the country. The only thing about it is that we still don't see a lot of narratives of survival. Those Papageno narratives, and if we saw more of those, I would expect you to see a statistically significant drop. And that's really the next, I think, horizon.

David Gratzer: On a pivot. You have mentioned school-based initiatives. What are your thoughts on school-based initiatives? I mean, we see this more and more. Not, of course, just in terms of suicide, but in terms of cognitive behavioural therapy and mindfulness and school age children being exposed to that. And in fact, there's a bit of a moment now for school-based initiatives, right? I think in New York City, kids are encouraged to take five minutes of mindfulness a week. On the one hand, one wants to see more young people informed. On the other hand, one finds a certain flakiness. I mean, with mindfulness, will five minutes a week accomplish anything?

Mark Sinyor: Yeah. I agree with both the point that it's a good idea and also that it has to be done very carefully. One of the problems I think is that originally the school-based interventions with respect to suicide were just teaching kids about suicide. Which in a way is a sort of categorical error. Just like if you're trying to prevent diabetes, you don't teach the kids about what's going on with, with the pancreas, you probably just teach them to exercise and eat healthy. A lot of suicide prevention in schools is really just about basic common sense coping strategies. And also telegraphing to kids that we know that they will be in emotional distress at some point in their life and that they have to have a plan.

I'm slightly biased with regards to this because we have our own school-based intervention, which is My Owl, myowl.org, which is free to use to anybody in grade seven and eight. It's an intervention where the kids use the third book in the Harry Potter series, *Harry Potter and the Prisoner of Azkaban*, and they learn basic cognitive behavioural therapy skills along with Harry and how to manage depression. And they graduate as CBT wizards who have a personalised toolbox of stress busters that they can deploy if they have an issue. The thing that I like about our intervention, obviously I'm very biased, is that I think part of the issue is that many interventions come across as patronizing. And I tend to think it's good to try to find something that young people would just naturally gravitate towards. So, I have a real interest in looking at popular media and things that youth actually already consume and thinking about how you can use them in order to, um, to provide that kind of intervention.

David Gratzer: And you've, of course, published on this. And I think you and I have discussed this in the past. What are some of your results?

Mark Sinyor: So, the pandemic actually interrupted our work. Um, so we have the kind of pre-pandemic and now the ongoing work. I will tell you that the older work that we did was very promising. We had hundreds and hundreds of kids in randomised controlled trials and found that there were substantial reductions in depression and anxiety and improvements in coping skills in the kids who got it versus the ones who didn't. Um, and as I said, I mean, one of the critiques that we get is, well, what if you don't like Harry Potter? Or what about other ages and other things? I currently have a grad student, my PhD student, Rachel Lebovic, who's working on an intervention for younger kids using some of the Disney movies. So, I think the principle is good we just have to expand to other kinds of media as well.

David Gratzer: Doctor, we've talked about some things that aren't necessarily tech savvy, but more and more, our field thinks about AI and the potential of AI. How might that affect suicide prevention?

Mark Sinyor: I think that there are many answers to that question. Much of what you see in public about AI is these few unfortunate occasions where a chatbot tells a young person to die by suicide. That gets, rightly so, lots of media coverage. Part of the issue is that these chatbots are learning from what we put up online, and I think a lot of what we put online is problematic. That's what we spend a lot of time trying to work with, with our media. Um, and so part of it is trying to tailor our own message to something that's healthy and scientific so that our chatbots mirror those messages. The other side to it is, is around detection. There's definitely an interest in my area in higher level interventions with AI, trying to find people you know, who might be at risk of suicide. I have really mixed views of that. I think it's an area that deserves study. The thing that worries me is that it's not like a myocardial infarction (MI), suicide. You know, if you have 200 people and you can identify the one person who's at risk of an MI and give them treatment and kind of ignore the other 199, the other 199

might be quite happy with that. In suicide, everybody is in distress. So, you can't really just identify the one person who's actually going to end their life and treat them and ignore the other 199. We need to give a good treatment for everybody. So, I just worry a little bit about that aspect of AI.

David Gratzer: So that might prove more complicated with time. Fair. But in terms of real time deployment of interventions, you know chatbots are available 24-7. Do you think a bit of the problem, though, is the agreeable nature of chatbots? There's a new paper in *NPJ Digital Health* talking about posing silly questions to chatbots that put them in the box, like, which would be safer, Tylenol or acetaminophen? Um, and of course, some chatbots actually struggle with that because they're agreeable. Is a bit of the issue around safety that when you go to a chatbot and talk about suicidal ideation, it wants to agree with you or be supportive of you, but not necessarily direct you to an emergency department?

Mark Sinyor: I think that has been a problem. I'm hopeful that that will get solved. You know, the problem with AI is that it's really the Wild West. And when you go to the Wild West, you might step on a snake. Um, you know, and so there's sort of two sets of problems. One problem is that these bots are in their infancy. And I don't think we've really worked out how to control them or how to refine them in the best way or interventions that they can give that are optimal. People are working on that constantly. The other thing is that it's new to all of us. Even our digital native kids are sort of learning how to use AI. They don't completely understand it yet. And so, we have a kind of a flawed product and a not non-savvy necessarily user base. And that seems a big problem. Obviously, I think those things will evolve over time, although I expect that AI will both create benefits but also new challenges.

David Gratzer: What haven't we talked about that you'd like to talk about?

Mark Sinyor: What I would say, especially to clinicians in the audience, is that sometimes people tend to overestimate how complicated suicide prevention needs to be. Sometimes it is very complicated. You have someone with a very serious bipolar disorder; you have to get exactly the right mood stabilizer. But largely suicide prevention in the office is about communicating that you care about somebody. If you could do one clinical intervention, it would be something along the lines of authentically saying to someone, you matter to me. You're important. I care about you. Let's see what I can do to help. And I think the other thing is safety planning, which we haven't talked about, is that something like the Stanley and Brown crisis algorithm which essentially takes you through a stepwise process of escalating interventions that a person can take, starting with things like distraction exercises all the way down to going to the emergency department that people can do if they're in a suicidal crisis. The reason it's important is that people who are suicidal feel stuck. And one of the most important things is to telegraph that you're not stuck. There are maybe 30 things that you can try and having a list on a person's phone or on their fridge of all the 30 things that can be tried, if they're in a crisis can be lifesaving.

David Gratzer: We've covered a lot of ground today. It is a *Quick Takes* tradition to close with a rapid-fire minute. That is, we put a minute on the clock and ask a series of questions. Are you up to the challenge, doctor?

Mark Sinyor: Yes. Just remember that in suicide prevention, nothing is black and white. But let me. Let me give it a try.

David Gratzer: We'll note your ambivalence and put a minute on the clock. All right.

What's one thing you want all clinicians to think about in terms of suicide prevention?

Mark Sinyor: Care and connection with your patient.

David Gratzer: What's one thing about the research being done now that excites you?

Mark Sinyor: Oh no my minute is going to run out! I will say narrative public narratives and making them healthier.

David Gratzer: What was it like publishing in *World Psychiatry*, the highest impact factor journal?

Mark Sinyor: Exciting. Although I have to say, I published with Keith Hawton, who's widely considered the greatest of all time, the GOAT in suicide prevention. He is like most people, and all people, really in suicide prevention, he's a lovely person. I was so glad to publish with him.

David Gratzer: You were the Messier to his Gretzky?

Mark Sinyor: I will *not* agree with that.

David Gratzer: Well, speaking of sports metaphors, who do you consider, at the buzzer, to be the best Raptor of all time?

Mark Sinyor: Oh, we had this debate. I think I have to say Kyle Lowry, because I think it's the consensus pick. However, I have a very soft spot in my heart for DeMar DeRozan because of his raising awareness of how to manage depression.

David Gratzer: I'm glad you were able to evolve your answer with time and finally see eye to eye with me, perhaps under the slight coercion of being on my podcast. Uh, doctor, it was a treat as always, to have a conversation and particularly glad that you could do it in the form of this podcast. And, and congratulations again on all you've achieved, including that paper in *World Psychiatry*.

Mark Sinyor: Thank you so much for having me.

[Outro:] *Quick Takes* is a production of the Center for Addiction and Mental Health. You can find links to the relevant content mentioned in the show and accessible transcripts of all the episodes we produce online at CAMH.ca/professionals/podcasts.

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