BRITISH COLUMBIA | Coroners Service

NEWS RELEASE

For Immediate Release
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Ministry of Public Safety and Solicitor General
BC Coroners Service

More focus on outreach, treatment key to preventing suicides

Providing young people with the everyday tools and skills to support mental well-being and ensuring that health professionals have clear and accessible mental health practice and treatment guidelines are among the key recommendations of a death review panel into child and youth suicides.

The panel identified three key areas to reduce child and youth suicide deaths and improve public safety:

- Adopt mental well-being strategies as part of social emotional learning for students;
- Identify and distribute provincial best practice youth mental health guidelines; and
- Expand youth mental health services, including psychiatric services, to non-urban areas through outreach models.

The review of 111 child and youth suicide deaths between Jan. 1, 2013, and June 30, 2018, found that:

- Although suicide risk factors are understood, predicting suicides is very difficult;
- Psychiatric medication prescribing guidelines for children and youth were not readily accessible for all health professionals;
- Barriers existed for families to successfully engage with or access services; and
- There is a need for timely access to mental health supports and services, particularly in non-urban areas.

The death review panel, chaired by Michael Egilson, included 19 panel experts with expertise in youth services, child welfare, mental health, addictions, medicine, nursing, public health, Indigenous health, injury prevention, education, income support, law enforcement and health research. The panel's recommendations are aimed at preventing death in similar circumstances and improving public safety overall.

"Suicide is the leading cause of injury-related death among children and youth in B.C.," Egilson said. "Almost 70% of serious mental health issues emerge before the age of 25. Programs directed at children in schools and best practice guidelines for health-care providers providing diagnosis and services are important in preventing these deaths.

"Predicting suicide is difficult, which is why it is so important to ensure that all youth have access to the tools and resources to support their mental well-being, as well as ensuring appropriate services are available for youth who are struggling."

This review builds on the earlier work of the Child Death Review Panel: A Review of Child and Youth Suicides (2008-2012), which included recommendations for improved service co-

ordination, access to mental health services, and changes to B.C. Coroners policy and practice.

Learn More:

Youth Suicide Death Review Panel Report: https://www2.gov.bc.ca/assets/gov/birth-adoption-death-marriage-and-divorce/deaths/coroners-service/child-death-review-unit/reports-publications/youth_suicide_drp_report_2018.pdf

To read the report Child Death Review Panel: A Review of Child and Youth Suicides (2008-2012) report, visit: https://www2.gov.bc.ca/assets/gov/birth-adoption-death-marriage-and-divorce/deaths/coroners-service/child-death-review-unit/reports-publications/child-youth-suicides.pdf

Death review panels: https://www2.gov.bc.ca/gov/content/life-events/death/coroners-service/death-review-panel

BC Crisis Centre: https://crisiscentre.bc.ca/

Canadian Association for Suicide Prevention: https://suicideprevention.ca/

Mindset – Reporting on Mental Health - Resources for journalists in covering suicides: https://sites.google.com/a/journalismforum.ca/mindset-mediaguide-ca/suicide

A backgrouder follows.

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BACKGROUNDER

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Facts about death review panel report

- Suicide is the leading cause of injury-related death among children and youth in British Columbia. Youth suicide accounts for more deaths than motor vehicle incidents or overdose;
- Each year in B.C., approximately 20 children and youth die by suicide;
- Of the 111 deaths studied during the review, three times more males died by suicide than females;
- In this review, of the 39 children and youth with medications prescribed for psychiatric conditions, one in five were prescribed psychiatric medications that did not follow prescribing guidelines and 41% were prescribed medications that were considered "off-label" use.
    - Off-label is when a doctor prescribes a medication even though it is not approved for the specific mental disorder that is being treated or for use by persons under a certain age.
- This review found more suicide deaths occurred among older adolescents with 86% of the suicides occurring among youth ages 15 to 18 years.
- More than half of the children and youth had a history of substance use.
- The panel found that 41% of the children and youth who died by suicide had a history of a prior admission to hospital or were seen in a hospital emergency department for mental health concerns.
- This review found higher rates of youth suicide for residents of rural health authorities (Interior, Island and Northern regional health authorities).
    - The Interior Health Authority had almost two times the rate of child and youth suicides as compared to the B.C. rate.
- In this review, almost all children and youth who died by suicide were reported to have experienced personal stressors with “relationship difficulties” being reported as the most common type of personal challenge in more than two-thirds of the deaths studied.
- Of the youth who died by suicide, hanging was the most common means, followed by firearm use and jumping from a height.
- One of the BC Coroners Service’s most important responsibilities is the advancement of recommendations aimed at preventing deaths in similar circumstances. One of the ways the Coroners Service makes recommendations is through death review panels, which bring together experts across disciplines to review a group of deaths in aggregate to identify opportunities for intervention to prevent death and improve public safety.

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