

CREATING CONNECTION, SUPPORTING
STRENGTHS: A REVIEW OF YOUTH AND
YOUNG ADULT DEATHS BY SUICIDE IN
BRITISH COLUMBIA, 2019-2023

BC Coroners Service Death Review Panel

If you or someone you know is planning to hurt themselves, thinking about ending their own life, or is experiencing suicidal thoughts or ideas, reach out for help immediately.

There are resources available to help you and others stay safe. These supports are confidential. There are many [places to get help](#).

- In an emergency, call 9-1-1, or go to a hospital emergency room.
- In a crisis, call **1-800-SUICIDE** at [1-800-784-2433](tel:1-800-784-2433) or [9-8-8](tel:9-8-8) anytime of the day or night.
- Call **310-Mental Health** at [310-6789](tel:310-6789) (no area code needed) anytime of the day or night for emotional support or information on mental health resources or services.
- Learn about [resources and information for youth](#).
- Find more [life-saving supports](#).

There are also organizations that specialize in offering support to First Nations, Métis and Inuit communities. These include:

- **Kuu-Us Crisis Line Society**
 - Adults: 250-723-4050
 - Youth: 250-723-2040
 - Toll Free: 1-800-588-8717
- **Hope for Wellness**
 - 1-855-242-3310
- **Tsow-Tun Le Lum Society**
 - 1-888-403-3123

We acknowledge with humility and gratitude that this Death Review Panel was convened on the territories of the s̓k̓w̓x̓w̓ú7mesh úxwumixw, xʷməθkʷəy̓əm, səliwətał peoples.

And that the lives who were lost, and without whose journeys the following recommendations could not exist, lived and were loved in unceded territories throughout British Columbia.

This report is dedicated to the families, friends and communities grieving the loss of loved ones, and is a call to action to prevent similar deaths in the future.

MESSAGE FROM THE CHIEF CORONER

On behalf of the BC Coroners Service, I am both pleased and saddened to endorse this Death Review Panel report detailing a review of deaths by suicide of youth and young adults.

The report touches on many of the challenges facing young people in British Columbia today and makes recommendations that are intended to both reduce future deaths and address all aspects of health in a manner that improves life for all young British Columbians.

We know that positive mental, physical and emotional well-being is paramount to a healthy and vibrant society. In order to better respond to the unique needs of young people, we must do a better job of working alongside them and learning from them as we co-create a B.C. that works for residents of all ages and demographics. One area I am committed to addressing immediately is to ensure the voices of youth are directly engaged with in future death review panel efforts, as there is no group better positioned to identify solutions to challenges than those who face them head-on every day.

I want to express my sincere appreciation to the panelists whose insights are reflected in the following pages. Your collective commitment to a better province is evident in the thoughtful recommendations put forth. I also acknowledge with gratitude my colleagues in the BC Coroners Service for the effort and dedication that allowed this important initiative to be realized.



Dr. Jatinder (Taj) Baidwan
Chief Coroner
Province of British Columbia

PREFACE

On March 6, 2025, the British Columbia Coroners Service (BCCS) convened a panel of subject matter experts to review the deaths of 435 youth and young adults who died as a result of suicide between January 1, 2019, and December 31, 2023.

Panel support was provided by BCCS staff, Aubrey Baldock, Carla Springinotic, Vince Stancato, and Andrew Tu.

I am deeply grateful to the Panel for their willingness to share their expertise, wisdom and guidance throughout the process. The insights and recommendations that follow are a direct result of the collective efforts of the following members:

Dr. Shelina Babul, Director, BC Injury Research and Prevention Unit

Susan Barth, Senior Coroner, BC Coroners Service

Dr. Danièle Behn Smith, Deputy Provincial Health Officer, Indigenous Health, Office of the Provincial Health Officer

Dr. Tyler Black, Psychiatrist, BC Children's Hospital

Danielle Carter Sullivan, Executive Director, Early Learning, Mental Health and Student Safety, Ministry of Education and Child Care

Dr. Jae Ford, Resident Physician, First Nations Health Authority

Dr. Mojgan Karbakhsh, Investigator, BC Injury Research and Prevention Unit

Kelly McConnan, Executive Director, Child and Youth Mental Health & Substance Use Policy & Indigenous Partnerships, Ministry of Health

Jonny Morris, Chief Executive Officer, Canadian Mental Health Association BC Division

Tricia Poilievre, Executive Director, Complex Care Housing & Community Initiatives, Ministry of Health

Elija Rain, Chief Superintendent, Investigative Services & Organized Crime, RCMP

Dr. Hasina Samji, Simon Fraser University, BC Centre for Disease Control

Annie Smith, Executive Director, McCreary Centre Society

James Wale, Deputy Director of Child Welfare, Ministry of Children and Family Development

Dr. Jennifer White, Associate Dean of Graduate Studies, University of Victoria

Dr. Nel Wieman, Chief Medical Officer, First Nations Health Authority

I would also like to acknowledge the support of Dr. Jennifer Charlesworth, B.C.'s Representative for Children and Youth (RCY), and the entire RCY investigations team. Due to scheduling conflicts, RCY was unable to participate directly in panel discussions, but I am profoundly appreciative of the complementary work that was produced by RCY to support the Panel's efforts.

On behalf of the Panel, I submit this report and recommendations to the Chief Coroner of B.C.

A handwritten signature in black ink, appearing to read 'Ryan Panton', written in a cursive style.

Ryan Panton

Chair, Death Review Panel

Territories of the Lekwungen-speaking Peoples, the Songhees and Esquimalt First Nations

EXECUTIVE SUMMARY

Suicide is the second most prevalent cause of death among children and youth in British Columbia, and the third most common cause among young adults aged 19-29 years. While the number of young lives lost to suicide in British Columbia has remained relatively unchanged over the last several years, little progress has been made in terms of understanding, recognizing and reducing risk.

Identifying those who are at risk of death by suicide is challenging. The mental, emotional and physical health factors – both positive and negative – that are most correlated with suicidal ideation are dynamic and ever-changing, and not all people respond to these shifts in the same manner. Circumstances that may lead one individual to consider or complete suicide may be internalized entirely differently in another.

Risk and protective factors are similarly unique. Systems that have traditionally been viewed as wholly protective of the mental and physical health of young people, such as the K-12 education system, may actually pose significant risk to many.

In B.C., the rate of death among Status First Nations youth and young adults is four times higher than the provincial rate, a fact inextricably linked to colonialization and the multi-generational trauma, racism and discrimination brought to bear by the residential school system and other such structures.

The lack of appropriate understanding and response also extends to other historically underserved groups, including racialized communities and 2SLGBTQIA+ youth. It is further compounded by a health care system that is strained and unable to provide equitable access to mental and physical health resources. These needs are particularly acute in rural and remote communities.

The reality is that health is unique to the individual and, as a result, successful strategies to support positive outcomes must be tailored appropriately. There is no “one size fits all” approach, and the person must exist at the centre of every step taken to ensure the subsequent treatment and care journey is culturally safe and trauma informed.

In March 2025, a group of subject matter experts gathered to discuss ways to reduce the number of suicide-related deaths of youth and young adults and, in the process, better support all young British Columbians.

Panel Guiding Principles:

- Our collective commitments to Reconciliation, the [*Declaration on the Rights of Indigenous Peoples Act*](#) demand acknowledgement of the countless ways that our current mental health and health care systems create unnecessary risk for Indigenous (First Nations/Métis/Inuit)

communities. We must remain committed to identifying opportunities to uphold the inherent rights of all First Nations, Métis and Inuit peoples in British Columbia.

- We acknowledge that many of the solutions to the identified challenges are best addressed by the impacted communities with appropriate resources. It is imperative that the recommendations accepted and implemented through this panel process be co-created with young people from across B.C. Effort must be made to ensure representation from Indigenous youth and young people representing communities that are marginalized to align with the principle of **“Nothing about us without us.”**
- The number of deaths reviewed through the panel process is not reflective of the total population who may be at risk of self-harm or suicide. Efforts must be made to ensure our work uplifts all young British Columbians.

While Coroners Service staff discussed opportunities to engage with young people in advance of the panel, after consultation with expert partners it was determined that the existing panel structure lacked the necessary safeguards to ensure such an engagement could meet the levels of consistency, cultural safety and support demanded. The BC Coroners Service commits to including the input and opinions of young people (and any other impacted community) in future review efforts.

The Panel has identified five key areas to support young people and reduce deaths by suicide. All recommendations are made within the context of the Government of British Columbia’s commitments to Reconciliation and using a distinctions-based approach that acknowledges the inherent right to self-government of First Nations, Métis and Inuit communities throughout British Columbia.

PANEL RECOMMENDATIONS

RECOMMENDATION 1: Create and implement a provincial suicide risk reduction framework specifically focused on youth and young adults.

Priority actions identified by the Panel are:

- By September 1, 2026, the Ministry of Health, in coordination with the Ministry of Children and Family Development, the Ministry of Education and Child Care, the Ministry of Post-Secondary Education and Future Skills and the province’s six regional health authorities will review existing efforts to reduce the risk of suicide for youth and young adults.
- By January 1, 2027, the above-identified parties will implement a process to engage with and learn from youth and young adults in B.C. to identify new opportunities to support positive mental health outcomes and reduce the risk of suicide.
- By September 1, 2027, the above-identified parties will co-create a framework that addresses the gaps in a manner that:
 - Is culturally safe and inclusive;
 - Prioritizes the needs of marginalized groups and underserved communities;

- Is responsive to the specific and changing needs of the young people it supports;
- Is scalable and adaptable to the needs of both urban and rural and remote communities;
- Can be applied to all emergency departments, psychiatric units, and outpatient mental health services; and
- Includes metrics to evaluate efficacy to allow for adjustment on a Local Health Area level.

RECOMMENDATION 2: Improve data collection, information sharing and reporting processes to better understand and support diverse communities throughout British Columbia.

Priority actions identified by the Panel are:

- By September 1, 2026, the BC Coroners Service, in collaboration with the Ministry of Health, will create and implement information sharing strategies with Métis Nation British Columbia and provincial Inuit Leadership to ensure that patient/decedent data relevant to these Nations are appropriately collected and shared.
- By September 1, 2026, the BC Coroners Service, in collaboration with the Ministry of Health and the Ministry of Attorney General, will finalize plans to document information including but not limited to the race and ethnicity, gender orientation and ability of all patients and decedents. The approach should be designed in a manner that recognizes the uniqueness of communities within B.C. and that allows for communities to embrace data-driven approaches to increasing public health and safety initiatives.

RECOMMENDATION 3: Review existing social and emotional health related resources to ensure they meet the needs of the diversity of school-aged students in B.C.

Priority actions identified by the Panel are:

- By September 1, 2026, the Ministry of Education and Child Care will engage with impacted youth to identify current challenges and co-develop new and/or refreshed resources specifically focused on supporting Indigenous and gender-diverse community members, ensuring that such an approach is trauma-informed and responsive to the unique needs and circumstances of these young people.
- By March 1, 2027, the Ministry of Education and Child Care will review and update all existing social and emotional health-related resources to ensure that the content and delivery remain relevant, evidence-based and consistent with current youth mental health and well-being objectives.

RECOMMENDATION 4: Create an educational model to ensure doctors, nurses, paramedics and other emergency medical professionals are appropriately trained on early identification, assessment, management and follow-up of youth and young adults who are at higher risk of death by suicide.

Priority actions identified by the Panel are:

- By September 1, 2026, the Ministry of Health, in coordination with the province's six health authorities, Doctors of B.C., the College of Physicians and Surgeons of B.C., and the B.C. College of Nurses and Midwives, will review and update all existing emergency mental health care guidelines and practice standards with respect to screening and assessment of youth and young adults who present with mental health-related concerns.
- By March 1, 2027, the Ministry of Health, in coordination with the province's six health authorities, Doctors of B.C., the College of Physicians and Surgeons of B.C., and the B.C. College of Nurses and Midwives, will review existing mental health-focussed educational curricula to make sure that all new graduates are equipped with the knowledge and skills to identify, assess and provide care to youth and young adults who are at higher risk of death by suicide.
- By September 1, 2027, the Ministry of Health, in coordination with the province's six health authorities, Doctors of B.C., the College of Physicians and Surgeons of B.C., and the B.C. College of Nurses and Midwives, will create and begin to implement mandatory continuing learning opportunities for all emergency medical professionals to ensure that mental health-related considerations are made during the patient assessment process whenever appropriate.

RECOMMENDATION 5: Co-develop a "third spaces" strategy to create venues for young people to develop and maintain connections in their own communities.

Priority actions identified by the Panel are:

- By March 1, 2026, the Ministry of Housing and Municipal Affairs, in coordination with the Ministry of Citizens' Services, and in association with the Union of B.C. Municipalities, will create a resolution tasking municipal governments throughout the province with identifying existing facilities that are suitable for re-purposing as a "Third Space." The resolution will be introduced at the 2026 UBCM Convention.
- By January 1, 2027, the Ministry of Housing and Municipal Affairs will develop a framework for implementation and collaboration at a community level with relevant Indigenous (First Nations/Métis /Inuit) and municipal partners that addresses and reflects specific local needs to ensure the framework:
 - Is scalable and adaptable to the changing needs of youth; and
 - Contains metrics to evaluate efficacy.

Previous Panel Recommendations

In August 2019, the BC Coroners Service released a death review panel report entitled [*Supporting Youth and Health Professionals: A Report on Youth Suicides*](#). That report included three actionable recommendations aimed at reducing future deaths:

- **Recommendation 1: Adopt mental well-being strategies as part of social emotional learning for students.**
- **Recommendation 2: Identify and distribute provincial best practice youth mental health guidelines.**
- **Recommendation 3: Expand specialty youth mental health including psychiatric services to non-urban areas through outreach models.**

The Panel agreed that some positive progress has been made in response to these recommendations, but that they should remain a priority for the Province and relevant ministries moving forward. **The Panel requests that the Ministries of Children and Family Development, Education and Child Care, and Health provide an update of progress on previous recommendations, and any relevant future plans, as part of the current review engagement by December 31, 2025.**

Death Review Panel

The [Coroners Act](#) provides the Chief Coroner with the discretion to establish death review panels to review the facts and circumstances of deaths to provide the chief coroner with advice on medical, legal, social welfare and other matters that may impact public health and safety and prevention of deaths. A death review panel may review one or more deaths before, during or after a coroner's investigation or inquest.

Members of the panel were appointed by the Chief Coroner under Section 49 of the *Coroners Act* and included professionals with expertise in medicine, public health, First Nations health, Indigenous health, youth mental health, education, health administration, child and family development, suicidology, police, injury prevention, policy and research.

It is acknowledged that panel discussions did not directly include the voices of the young people. This is a significant omission which is not aligned with the principle of "nothing about us without us," and one that the BCCS is committed to rectifying in future panels.

Regardless of their employment or other affiliations, individual panel members were asked to exercise their mandate under the *Coroners Act* and express their personal knowledge and professional expertise. The findings and recommendations contained in this report need not reflect, or be consistent with, the policies or official position of any organization.

While considering deaths by suicide of youth and young adults, the Panel reviewed and discussed:

- Coroners' aggregated investigative findings;
- Information provided by panel members;
- Environmental, social and medical factors associated with the deaths;
- Possible trends or themes;
- The current state of related public policy and strategies; and,
- Existing challenges.

Data Limitations and Confidentiality

The BC Coroners Service (BCCS) operates in a live database environment. Decedent information, investigative notes, case details and findings are regularly updated during a death investigation. The data presented within the case review is based on open and closed BCCS case files. It includes analysis of BCCS investigative notes, police reports, medical records and other documents collected, or protocols completed during the investigation. Some cases are still under investigation and information may be incomplete.

Linkages were made to other data sources; however, due to incomplete or incorrect information, not all cases were linked successfully and therefore the data cannot be considered exhaustive. Where possible, the best available data was used for analysis; however, discrepancies can still occur.

Additionally, chronic disease information was obtained from the Chronic Disease Registries which do not include clinical diagnosis. Instead, each registry has its own defined inclusion criteria from administrative data.

Provisions under the *Coroners Act* and [*Freedom of Information and Protection of Privacy Act*](#) allow for the BCCS to disclose information to meet its legislative mandate and support the findings and recommendations generated by the review process. For the purposes of this report, information is presented in aggregate. The BCCS is sensitive to the privacy of individuals and families that it serves and proceeds with caution when reporting findings. Details that could identify individuals have been omitted to respect the privacy of the person who died and their family.

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INTRODUCTION

“Canada needs a more comprehensive approach to measuring the impact of its suicide prevention initiatives. As we move towards achieving the vision of a Canada where fewer lives are lost to suicide and life is promoted, we will also need to focus on supporting strengths and building and creating meaningful connections along our journey.”³

Suicide is the second most prevalent cause of death among children and youth aged 10 to 18 years in British Columbia. Deaths by suicide are always tragic. When they occur among young people their losses profoundly impact friends, family and communities as we grieve their lost potential and unrealized futures.

Over the last decade, the number and rate of deaths by suicide among youth under the age of 19 have remained relatively unchanged in B.C.; however, despite ongoing efforts to better understand and respond to suicide, progress remains limited. Further, this relative stability should also not be perceived as a reflection of the current state of mental health among young people in the province. Although deaths involving Indigenous (First Nations/Métis/Inuit) youth have also shown minimal change over this time period, rates of death in these communities remain considerably higher relative to non-Indigenous populations.

This review also includes decedents aged 19 to 25 years at the time of their death. Suicide is the third-leading cause of death in B.C. among those aged 19-39 years, and both the total number and rates of death increase significantly as individuals enter young adulthood. The reasons for this increase are difficult to conclusively determine. Long established social networks provided through school, extra-curricular pursuits, and elsewhere, begin to diminish while many young people are also beginning post-secondary studies, new full-time careers, and/or transitioning from the K-12 education system. In many cases, connection to family and friends changes significantly.

There is opportunity to consider ways in which additional support could improve health outcomes and reduce the risk of deaths by suicide during this period of significant transition.

As part of the investigative process for suicide deaths, coroners complete an investigative protocol, a questionnaire which details the decedent characteristics, circumstance of death, suicidal intent, potential risk factors, and medical and mental health history. Coroners use the information gathered from family and witness interviews, scene findings, medical records, police reports and other information gathered over the course of the investigation to answer the questions. As information cannot be collected directly from the decedent, responses to certain questions (e.g. life stressors, suicidal ideation, sexual orientation, etc.) from the protocol questionnaire can be considered speculative or anecdotal in nature.

The BC Coroners Service (BCCS) is mandated to investigate and review all unnatural and unexpected deaths in the province. This includes attending the location of the death, completing a physical examination of the decedent, conducting interviews with family, friends and persons or service providers involved in the decedent's life, arranging necessary post-mortem examinations, obtaining medical records, and documenting the investigation findings in a coroner's report. These investigative findings provide insight into the circumstances of a decedent's life and may also identify issues or challenges, opportunities for preventing similar deaths, and areas for program or policy improvement.

On March 6, 2025, the Chief Coroner convened a panel of subject matter experts to review the circumstances around 435 deaths by suicide of youth and young adults that were reported to the BCCS between January 1, 2019, and December 31, 2023. The panelists were tasked with identifying implementable actions to improve public safety and prevent future deaths. Panels are prohibited from making findings of legal responsibility or expressing any conclusions of law.

Data for this review were extracted on December 6, 2024, and, at the time of extraction, two-thirds of the death investigations had been completed by the coroner. As the BCCS operates in a live database environment, the data are considered preliminary and subject to change as investigations are concluded. For this review, a file review was completed for all cases that met the requirement, and efforts were made to have as complete a dataset as possible.

While the following report contains aggregated data and statistics, it is important to continually remind ourselves that behind each number is a life that was taken far too soon. The loss of a young person leaves a hole in a community that is significant and traumatic.

It is our collective duty to honour their memories and support those grieving their loss.

POSITIVE CHILDHOOD EXPERIENCES

Better mental health-related outcomes are reported for youth and young adults when they:

- Feel able to talk to family about feelings
- Have family who stand by them during difficult times
- Enjoy participating in community traditions
- Feel a sense of belonging in high school
- Feel supported by friends
- Have at least two non-parent adults who took a genuine interest in them
- Feel safe and protected by an adult in their home

PART 1: BC CORONERS SERVICE REVIEW FINDINGS

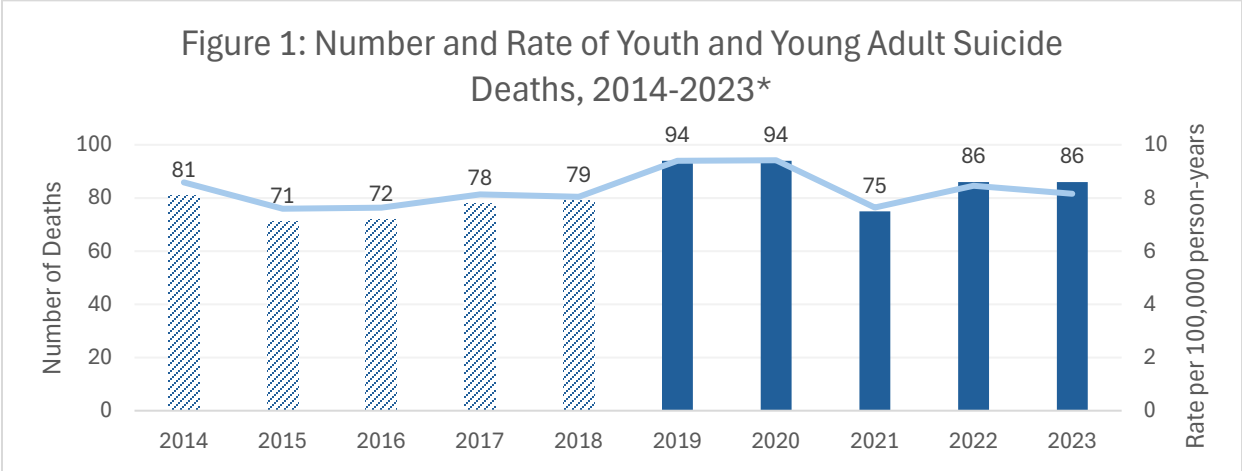
This review summarizes investigative findings regarding deaths by suicide of youth and young adults that were reported to the BC Coroners Service between January 1, 2019, and December 31, 2023.

Major findings of the review included:

- There were 435 deaths by suicide of youth and young adults between 2019 and 2023;
- On average, there were 22 deaths of 9-18-year-olds, and 65 deaths of 19-25-year-olds annually;
- The rate of deaths remained consistent over the 5-year period, with no noted increase during or after the COVID-19 pandemic;
- 66% of decedents were assigned as male at birth;
- 17% of decedents identified as Indigenous (First Nations/Métis/Inuit);
- There were higher rates of death in the Northern and Island Health Authorities;
- Hanging, poisoning, and falls were the most common means of death;
- 60% of fatal incidents occurred at a private residence, and 32% occurred outdoors;
- 44% of decedents had expressed suicidal ideation in the year prior to death;
- 35% of decedents had a history of self-harm;
- 50% of youth (<19 yrs) were involved with the Ministry of Children and Family Development (MCFD) within the year preceding their death;
- The most common life stressors identified were relational or social issues (25%), history of trauma or abuse (14%), and chronic instability in family (12%);
- 58% of decedents had documented anxiety and mood disorders, 22% had substance use disorders, and 8% had schizophrenia and delusional disorders;
- 46% of decedents had a prescription medication for an antidepressant, antipsychotic, antiepileptic, benzodiazepine, or stimulant in the year prior to death;
- 21% of decedents had experienced a mental health or suicide related hospitalization in the year prior to death;
- 52% of decedents had an MSP billing for a mental health issue and/or a suicide attempt in the year prior to death; and
- Decedents who were assigned female at birth were more likely to have a mental health chronic disease, prescription medication, prior hospitalization, and MSP billing for a mental health condition in the year prior to death than those assigned male at birth.

During the period reviewed, there were 435 deaths by suicide of youth and young adults aged 9-25 years (see Figure 1), an average of 87 deaths per year. In comparison, during the previous 5-year period (2014-2018), there were 381 suicide deaths, an average of 76 deaths annually.

While there was an increase in the number of deaths over the previous 5-year period, the rate of deaths in B.C. has remained relatively stable. Between 2014-2018, the rate of suicide death among 9–25-year-olds was 8.0 deaths per 100,000 person-years and in 2019-2023, the rate was 8.6 deaths per 100,000 person-years.



*Solid bars represent period under study.

During the period studied there was an average of 22 deaths by suicide of 9–18-year-olds and 65 deaths of 19–25-year-olds per year (Table 1).

The rate of death among 9–18-year-olds has remained stable over the 5-year period; however, the rate among 19–25-year-olds has decreased from 15 deaths per 100,000 persons in 2019 to 12 deaths per 100,000 persons in 2023.

Table 1: Number and Rate of Youth and Young Adult Suicide Deaths by Age Group						
	2019	2020	2021	2022	2023	Total
9-18 yrs deaths	22	24	19	21	24	110
9-18 Death Rate (per 100,000)	4.3	4.6	3.7	3.9	4.4	4.2
19-25 yrs deaths	72	70	56	65	62	325
19-25 Death Rate (per 100,000)	14.7	14.5	12.1	13.5	12.2	13.4

DEMOGRAPHICS

Age and Biological Sex

This review follows definitions established in the Province of British Columbia’s [Gender and Sex Data Standard](#). The standard confirms sex and gender as distinct concepts, with terminology that cannot be interchanged.

“Sex is a category used to classify people based on physical and physiological features including chromosomes, genetic expression, hormone levels and function, and reproductive/sexual anatomy. Sex is most often assigned at birth based on a visual examination of genitalia by a doctor or other health care provider. Based on this examination, the child is assigned as Female, Intersex, or Male.

“Gender involves a personal, deeply held, internal sense of self as man or woman, a blend of both, or neither. Broadly speaking, gender includes self-identification as well as socially and culturally constructed roles, behaviours, and expressions. The current gender of a person (e.g., Man, Non-binary person, Woman) may or may not align with social or cultural expectations based on their sex assigned at birth (e.g., Female, Intersex, Male). People for whom this is true may identify as transgender.”²⁵

In this review (see Table 2):

- 66% of decedents were assigned male at birth;
- 75% of decedents were between the ages of 19 and 25; and
- The frequency and rate of death increased with age.

From 2019 to 2023, the suicide rate among males was 11.1 per 100,000 person-years, and for females the rate was 6.0 per 100,000 person-years. The sex difference was most pronounced among 19–25-year-olds (18 per 100,000 in males vs. 8 per 100,000 in females).

	Male		Female		Total		Male: Female Rate Ratio
	Freq.	Rate	Freq.	Rate	Freq.	Rate	Ratio
<15 years	11	1.4	11	1.5	22	1.4	0.94: 1
15-16 years	17	6.3	19	7.4	36	6.8	0.84: 1
17-18 years	33	11.7	19	7.1	52	9.5	1.66: 1
19-21 years	67	13.5	33	6.9	100	10.3	1.95: 1
22-23 years	69	19.1	26	7.6	95	13.5	2.53: 1
24-25 years	90	23.4	40	11.0	130	17.4	2.12: 1
Total	287	11.1	148	6.0	435	8.6	1.84: 1

Table 2a: Suicide Death Frequency and Rates (per 100,000) by Age and Sex of Decedent, 2014-2023								
	2014-2018				2019-2023			
	Male		Female		Male		Female	
	Freq.	Rate	Freq.	Rate	Freq.	Rate	Freq.	Rate
9-18 years	84	6.6	24	2.0	61	4.5	49	3.8
19-25 years	187	15.8	86	7.9	226	18.2	99	8.4
Total	271	11.0	110	4.8	287	11.1	148	6.0

Although the male rate has remained relatively the same since the previous 5-year period (2014-2018), the female rate has increased, most notably among the 9-18 age group. There was a 90% increase in the rate of youth female deaths from this period (2019-2023) compared to the previous 5-year period (3.8 per 100,000 vs. 2.0 per 100,000).

In comparison with other provinces, BC rates for both males and females are lower than the Prairie provinces of Alberta, Saskatchewan and Manitoba but slightly higher than Ontario and Quebec (Table 2b).

Table 2b: Suicide Rates (per 100,000) by Age, Sex, and Province, (2019-2022)						
	BC	AB	SK	MB	ON	QC
Males						
10-14	1.1	2.8	-	-	-	0.6
15-19	10.2	18.9	-	-	-	9.0
20-24	18.7	25.7	-	-	-	-
10-19	5.7	-	17.5	15.5	5.5	-
20-29	19.5	-	45.5	28.7	16.1	-
Females						
10-14	1.8	3.2	-	-	-	1.8
15-19	7.1	9.3	-	-	-	4.2
20-24	8.2	11.3	-	-	-	-
10-19	4.6	-	13.4	13.9	4.2	-
20-29	8.0	-	26.7	20.8	6.5	-

Data Source: BC data from BC Coroners Service. All other province data from https://www.suicideinfo.ca/local_resource/suicide-stats-canada-provinces/. BC population estimates from [Population Estimates - Province of British Columbia](#). Alberta population estimates from [Demographic statistics | Alberta.ca](#). Other province population estimates from <https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1710015201>.

Sexual Orientation/Gender Identity

Among youth and young adult deaths by suicide, it was noted by the coroner that thirteen decedents (2.9%) were transgender, eight (1.8%) were homosexual, and nine (2.1%) were bisexual. These numbers are likely underreported as the documented information was voluntarily disclosed during discussions with family or friends.

Data collected through the [BC Adolescent Health Survey](#) found that approximately 50% of school-aged youth identified as male, 45% identified as female, and 5% identified as non-binary. Three quarters of youth identified as heterosexual, which was lower than the previous report in 2018.¹

While suicide deaths of persons who identify as male account for approximately 75% of all suicide deaths in Canada, rates of suicide ideation, plans and attempts are 2, 4 and 5 times higher in persons who identify as female, respectively.^{2,3} Furthermore, while the Public Health Agency of Canada² notes that suicide mortality rates have decreased among youth identifying as male aged 10-14 years since 2008, they have increased among youth and young adults identifying as female aged 10-24 years within the same timeframe.

There is a greater self-reported increase in self-harm and suicidal ideation in populations experiencing marginalization or social exclusion, particularly following the COVID-19 pandemic.⁴ People who identify as 2SLGBTQIA+ are more likely to have thoughts of suicide or make plans or attempts compared with heterosexual and cisgender populations; more than 40% of 2SLGBTQIA+ people between the ages of 15 and 44 years have reported serious thoughts of suicide during their lifetime, and youth 15-17 years from sexually diverse communities had a three times greater risk of suicide thoughts and actions than their heterosexual peers.^{2,3}

It is important to state unequivocally that identifying as 2SLGBTQIA+ does not increase risk of suicidal ideation or death. Rather, it is the sociopolitical discrimination and support (or lack thereof) that existing colonial system structures offer to 2SLGBTQIA+ people that increases risk. Combining increased access to affirming medical care with supportive parental relationships has been shown to reduce risk for suicide and suicidal ideation.⁵

The BCCS recognizes the importance of collecting data that is reflective of the diversity of people in our province and, by extension, more supportive of all British Columbians. Future review work will be demonstrative of this commitment to enhanced gender equity.

Indigeneity (First Nations/Métis/Inuit)

Of the suicide deaths in this review:

- 74 (17%) were among Indigenous youth and young adults (see Table 3);
- 23% of 9–18-year-old suicide deaths were Indigenous; and
- 15% of 19–25-year-old suicide deaths were Indigenous.

Indigenous identity was determined by the coroner from interviews with family/friends, reviewing medical or police records, or from scene findings. The BC Coroners Service is currently unable to distinguish whether Indigenous decedents are First Nations, Métis and/or Inuit.

According to the 2021 Canadian Census, 9.1% of the B.C. population under 25 identified as Indigenous; however, this percentage is likely underestimated due to incomplete enumeration of certain reserves. The information does clearly still reflect the fact that Indigenous (First Nations/Métis/Inuit) youth and young adults are disproportionately overrepresented among those who die by suicide in B.C.

	2019	2020	2021	2022	2023	Total
Indigenous 9-18 yrs	2	6	5	8	4	25
Indigenous 19-25 yrs	8	15	9	9	8	49
Indigenous Total	10	21	14	17	12	74
% Indigenous	10.6%	22.3%	18.7%	19.8%	14.0%	17.0%

The erasure of inherent rights to self-determination, land, family, community and health through systematic colonization and continued racism and discrimination has resulted in lasting and ongoing impacts on the wellbeing of Indigenous communities.³

“However hazardous simply growing up may otherwise be, such risks are necessarily magnified when the cultural backdrop against which development automatically unfolds is unraveled by social-cultural adversities.”¹³

Rates of death by suicide for First Nations, Inuit and Métis communities vary across Canada. In B.C., the rate of death among Status First Nations youth and young adults is four times higher than the provincial rate.⁶ Data collection across Canada is inconsistent, lacking the depth required to fully understand the scope of health outcomes and impacts of initiatives, as “national health data systems lack Indigenous identifiers, do not capture data from some regions, and do not routinely engage Indigenous communities in data governance”.⁷

While the focus of many suicide prevention activities has utilized a deficit-based model of understanding individual and community challenges, Indigenous approaches are shifting the focus towards life promotion and the conditions that support "...strength and capacity in the face of oppressive policies and conditions".³ This approach honours the resilience inherent to, and that is cultivated by, Indigenous communities.

***"Life promotion** is an approach that: "leads with Indigenous ways of knowing and being; emphasizes culture-based interventions; focuses on community level-factors and the Indigenous social determinants of health; (is) strength-based since it works to enhance protective factors; (is) centred on the whole person perspective to promote wholistic wellness and foster a sense of Hope, Belonging, Meaning and Purpose."*

- Thunderbird Partnership Foundation³

Initiatives oriented towards Indigenous mental health in Canada, and which adopt approaches that embrace culture as treatment and land is medicine, have been shown to reduce anxiety, depression, and suicidal ideation.⁸

Health Authority (HA) of Injury¹

Fraser Health (n=133) recorded the highest number of youth and young adult deaths by suicide between 2019 and 2023, followed by Island Health (n=94), and Vancouver Coastal Health (n=89) (Table 4).

There were 8 deaths where the decedent was from out of province.

Table 4: Number of Suicide Deaths by HA of Injury, 2019-2023						
	2019	2020	2021	2022	2023	Total
Interior	14	17	14	16	14	75
Fraser	25	26	19	35	28	133
Vancouver Coastal	19	18	17	17	18	89
Island	22	24	19	12	17	94
Northern	14	9	6	6	9	44
B.C.	94	94	75	86	86	435

The rate of suicide deaths was highest in Northern Health (14 per 100,000) followed by Island Health (13 per 100,000) and Interior Health (10 per 100,000) for the period of 2019 to 2023 (see Table 5). Overall, B.C. had a rate of 8.6 suicide deaths per 100,000 person-years during the same period.

Table 5: Suicide Death Rates (per 100,000 person-years) by HA of Injury, 2019-2023						
	2019	2020	2021	2022	2023	2019-2023 Rate
Interior	9.8	11.8	9.8	10.8	9.3	10.3
Fraser	6.1	6.4	4.7	8.2	6.2	6.3
Vancouver Coastal	8.0	7.6	7.6	7.3	7.5	7.6
Island	14.9	16.3	13.0	8.0	11.3	12.7
Northern	22.3	14.5	9.8	9.8	14.4	14.2
B.C.	9.4	9.4	7.6	8.5	8.2	8.6

Among 9-18-year-olds, Northern Health had the highest rate of deaths by suicide (9 per 100,000 person-years) followed by Island Health (5 per 100,000 person-years) (see Table 6). Island Health had the highest rate of death among 19-25-year olds (22 per 100,000 person-years) followed by Northern Health (21 per 100,000 person-years).

¹ Health authority of death was used in 3 cases of unknown or undetermined health authority of injury.

Table 6: Suicide Death Frequency and Rates (per 100,000 person-years) by HA of Injury and Age Group, 2019-2023				
	9-18 yrs		19-25 yrs	
	Freq.	Rate	Freq.	Rate
Interior	15	3.7	60	18.8
Fraser	35	3.2	98	9.7
Vancouver Coastal	22	4.1	67	10.6
Island	22	5.4	72	21.5
Northern	16	9.0	28	21.2
Total	110	4.2	325	13.4

Population Size of Injury Township

Among those that died by suicide:

- 85% of deaths were in townships with $\geq 10,000$ population (see Table 7); and
- 15% were in townships $< 10,000$ population.

In comparison, 84% of the B.C. population live in townships $\geq 10,000$ population and 16% live in townships with under 10,000 population.

Table 7: Youth Suicide Deaths by Population Size of Injury Township*		
	Number (%)	2021 % for B.C.³
$\geq 10,000$ population	370 (85.1%)	83.8%
$< 10,000$ population	65 (14.9%)	16.2%
Total	435	

Living Arrangement at Time of Death

At the time of death, three youth and young adults were experiencing homelessness. All three were temporarily sheltered either at a homeless shelter or a family or friend's residence. Two youth and young adults were incarcerated at a correctional facility at the time of death.

Student Status

In 2023 there were an estimated 753,059² children and youth between the ages of 5 and 18 years of age residing in the province. Of those, 663,225 (88%) were enrolled in public and/or independent schools as of September 30, 2023³.

Also in 2023, there were an estimated 506,823 young adults aged 19-25 residing in B.C.⁴ Between 2019/20 and 2022/23, an average of 178,014 persons were enrolled full-time in post-secondary institutions in British Columbia giving an estimated 35% of young adults in post-secondary school. This data does not include part-time students or students registered at private degree granting institutions.

Comparatively, of the suicide deaths in this review:

- 74% of 9–18-year-olds were students at time of death; and
- 24% of 19–25-year-olds were students at time of death (see Table 8).

In addition, this review found that 30 of the students were international students. Of these, two decedents were aged between 9-18 years, and 28 were 19-25 years of age.

Table 8: Suicide Deaths by Student Status			
	9-18	19-25	Total
Student	81	79	160
Not a student	20	109	129
Unknown	9	137	146
Total	110	325	435

² SOURCE: BC Stats. Population Estimates. <https://www2.gov.bc.ca/gov/content/data/statistics/people-population-community/population/population-estimates> (Accessed February 14, 2025).

³ SOURCE: BC Ministry of Education and Child Care. Education by the numbers. <https://news.gov.bc.ca/factsheets/education-by-the-numbers> (Accessed February 14, 2025).

⁴ SOURCE: BC Ministry of Post-Secondary Education and Future Skills. Full-time equivalent enrolments at BC public post-secondary institutions. <https://www2.gov.bc.ca/gov/content/education-training/post-secondary-education/data-research/enrolment-data>. (Accessed February 14, 2025).

CIRCUMSTANCES OF DEATH

Means of Death

This review found that the most common means of death (see Table 9) were:

- Hanging (49%);
- Poisoning: Alcohol/Drugs/Other (12%);
- Falls (12%); and
- Firearm (11%).

There were age and sex differences in the means of death. Hanging was more common among youth than young adults (62% vs. 44%). For males, the most common means of deaths were hanging (44%), firearm (15%) and falls (13%). Hanging (57%), poisoning (16%), and falls (8%) were the most common means of death for females (Table 10).

	9-18	19-25	Total
	Number (%)	Number (%)	
Hanging	68 (61.8%)	144 (44.3%)	212 (48.7%)
Fall	11 (10.0%)	39 (12.0%)	50 (11.5%)
Poisoning: Alcohol/Drugs/Other	11 (10.0%)	38 (11.7%)	49 (11.3%)
Firearm	11 (10.0%)	37 (11.4%)	48 (11.0%)
Motor vehicle incident	2 (1.8%)	12 (3.7%)	14 (3.2%)
Gases/Fumes	2 (1.8%)	12 (3.7%)	14 (3.2%)
Suffocation/Smothering	2 (1.8%)	10 (3.1%)	12 (2.8%)
Stabbing/Cutting	2 (1.8%)	8 (2.5%)	10 (2.3%)
Drowning	0 (0%)	10 (3.1%)	10 (2.3%)
CO Poisoning	0 (0%)	7 (2.2%)	7 (1.6%)
Railway	1 (0.9%)	5 (1.5%)	6 (1.4%)
Other	0 (0%)	3 (0.9%)	3 (0.7%)
Total	110	325	435

*Note: For cases still under investigation, means of death are based on preliminary information and may change as investigations are concluded.

Table 10: Suicide Deaths by Means of Death and Sex, 2019-2023*			
	Male	Female	Total
	Number (%)	Number (%)	
Hanging	127 (44.3%)	85 (57.4%)	212 (48.7%)
Fall	38 (13.2%)	12 (8.1%)	50 (11.5%)
Poisoning: Alcohol/Drugs/Other	25 (8.7%)	24 (16.2%)	49 (11.3%)
Firearm	43 (15.0%)	5 (3.4%)	48 (11.0%)
Motor vehicle incident	12 (4.2%)	2 (1.4%)	14 (3.2%)
Gases/Fumes	9 (3.1%)	5 (3.4%)	14 (3.2%)
Suffocation/Smothering	8 (2.8%)	4 (2.7%)	12 (2.8%)
Stabbing/Cutting	7 (2.4%)	3 (2.0%)	10 (2.3%)
Drowning	7 (2.4%)	3 (2.0%)	10 (2.3%)
CO Poisoning	5 (1.7%)	2 (1.4%)	7 (1.6%)
Railway	3 (1.1%)	3 (2.0%)	6 (1.4%)
Other	3 (1.1%)	0	3 (0.7%)
Total	287	148	435

*Note: For cases still under investigation, means of death are based on preliminary information and may change as investigations are concluded.

Of the 49 poisoning deaths, 15 (31%) were due to unregulated drugs, 11 (22%) were due to prescribed drugs, 10 (20%) were due to sodium nitrate/nitrite, and 3 (6%) were due to alcohol and prescribed drugs. 10 deaths (20%) were due to over-the-counter drugs, including four involving acetaminophen and four involving diphenhydramine.

The prevalence of specific means of death by suicide for Canadians over the age of 10 years between 1981 and 2018 has changed over time. The age-standardized rate of suicide death by suffocation has increased significantly for males and females across Canada, particularly among youth and young adult females.⁹

Poisoning is now the second leading means of death for females in BC, and the third for males behind firearms. There has been a relatively small number of suicide deaths by firearm among females; for males in Canada, death by firearms generally decreased over time, except for an increase in the death rate for males aged 20-34 years.⁹

As the overall rate of suicide across Canada has not decreased in recent years, it may be explained by the substitution of less lethal means of suicide (e.g. poisoning) for more lethal means of suicide (e.g. suffocation) by females.⁹

The use of sodium nitrite or sodium nitrate, a food additive, is an uncommon but emerging method used for suicide; 28 cases of sudden death between 1980 and 2020 were identified in Ontario, with most cases occurring during in 2019 and 2020.¹⁰ Of these 28 deaths, 25 showed evidence of

intentional ingestion of sodium nitrite or sodium nitrate salts. A recent study analyzing conversations about suicide methods in an online forum identified increasing discussion of sodium nitrite, and participants from Canada were the third most likely consumers expressing interest in obtaining sodium nitrite.¹¹ Canada has been identified as the third most likely source country for obtaining sodium nitrite.¹¹

Injury Location

Among the reviewed deaths by suicide of youth and young adults:

- 261 (60%) were injured at a private residence (see Table 11);
- 139 (32%) were injured outdoors; and,
- 20 (5%) were injured at other types of residences (e.g. social housing, shelters, SROs, etc.).

Table 11: Suicide Deaths by Injury Location, 2019-2023	
	Number (%)
Private residence (includes driveways, garages, yard)	261 (60.0%)
Outdoors (includes vehicles, bridges, wooded areas)	139 (32.0%)
Other residences (includes hotels, SROs, social or supportive housing)	20 (4.6%)
Public building	9 (2.1%)
Medical facility	3 (0.7%)
Correctional facility/police station	2 (0.5%)
Other	1 (0.2%)
Total	435

RISK FACTORS

A risk factor is a characteristic, condition or behaviour that increases the likelihood that an individual will contemplate or attempt suicide.³

Risk factors are complex, dynamic across time, and impacted by personal, social and environmental influences. As such, individuals are not inherently “vulnerable” or “at-risk,” but rather experience stressors that may increase the likelihood that they require support to navigate their unique needs.

Suicide risk can be framed by a stress-diathesis model, meaning that a combination of personal and environmental stressors can interact to increase distress.

“The diathesis is a combination of heightened perception of emotional distress, a greater propensity for emotion to influence decisions, impaired learning and problem-solving capacity, and distorted social cognition involving a hypersensitivity to negative social signals and diminished sensitivity to positive social signals.”²⁴

Furthermore, interpersonal stressors have been identified as among the most important risk factors for youth suicide behaviour, particularly when stressors (e.g., social isolation, family dysfunction, conflicts with and/or victimization by peers or parents, parental mental health or substance use challenges) occur during childhood.¹²

Due to the complexity of risk and protective factors, it is not possible to construct a singular profile of a suicidal person, nor is it possible to predict suicidal ideation or behaviour^{13,14}.

The following table highlights individual, interpersonal and community risk factors that serve as potential targets for health promotion activities:³

	Risk	Protective
Individual	<ul style="list-style-type: none"> • Previous suicide attempt • Mental illness • Substance use • Physical health problems including chronic pain • Disability • Life stressors such as loss of job or relationships • Homelessness • Bereavement from suicide • Family history of suicide • Low income and low education 	<ul style="list-style-type: none"> • Effective coping and problem-solving skills • Sense of cultural identity • Religious and spiritual beliefs • Optimistic outlook • Self-esteem • Sense of meaning and reason for living
Interpersonal	<ul style="list-style-type: none"> • Adverse childhood experiences • Loneliness • Bullying (in-person and online) 	<ul style="list-style-type: none"> • Strong personal relationships • Social support networks with peers, friends, partners and family
Community	<ul style="list-style-type: none"> • Discrimination • Exposure to violence, including physical, sexual or emotional violence • Living in a socially or economically deprived area • Living in a rural or remote area • Historical and intergenerational losses 	<ul style="list-style-type: none"> • Feeling connected to community • Safe and stable environment • Access to appropriate health care • Restricted access to means

Note: This is not an exhaustive list and the degree to which these factors affect an individual can vary. The Public Health Agency of Canada’s (PHAC) [Suicide Surveillance Indicator Framework](#), monitors a number of risk and protective factors at the population level.

Suicidal Ideation

This review found that among youth and young adults who died by suicide (see Table 12):

- 44% expressed suicidal ideation within the year preceding death;
- 16% expressed suicidal ideation within 24 hours preceding death; and
- A higher percentage of youth expressed suicidal ideation in the year preceding death compared with young adults (60% vs. 38%).
- Where the information was known, 65% of youth expressed suicidal ideation within the previous year and 18% in the preceding 24 hours, whereas 60% of young adults expressed ideation within the previous year and 29% in the preceding 24 hours.

Because information on suicidal ideation is collected from friends and family (and not self-reported), this information is likely under-represented.

Table 12: Suicide Deaths by Suicidal Ideation						
	Suicidal ideation expressed in year preceding death			Suicidal ideation expressed within 24 hours preceding death		
	9-18 yr	19-25 yr	Total	9-18 yr	19-25 yr	Total
Yes	66 (60.0%)	124 (38.2%)	190 (43.7%)	16 (14.6%)	53 (16.3%)	69 (15.9%)
No	35 (31.8%)	81 (24.9%)	116 (26.7%)	72 (65.5%)	128 (39.4%)	200 (46.0%)
Unknown	9 (8.2%)	120 (36.9%)	129 (29.7%)	22 (20.0%)	144 (44.3%)	166 (38.2%)
Total	110	325	435	110	325	435

Past History of Self-Harm

Of the suicide deaths in this review:

- 35% had a history of self-harm; and
- 31% had a history of self-harm associated with suicidal ideation.

Of those that had a previous incident of self-harm:

- 47 (31%) experienced the incident in the month prior to death;
- 40 (26%) experienced the incident in the year prior to death;
- 26 (17%) experienced the incident more than a year prior to death; and
- in 25% of deaths the date of the incident was unknown.

A higher percentage of youth had a previous incident of self-harm reported compared with young adults (53% vs. 29%).

Table 13: Suicide Deaths by Past History of Self-Directed Violence						
	Previous incident of self-directed violence			Previous episodes of self-directed violence associated with suicidal ideation		
	9-18 yr	19-25 yr	Total	9-18 yr	19-25 yr	Total
Yes	58 (52.7%)	93 (28.6%)	151 (34.7%)	49 (44.6%)	87 (26.8%)	136 (31.3%)
No	33 (30.0%)	73 (22.5%)	106 (24.4%)	37 (33.6%)	82 (25.2%)	119 (27.4%)
Unknown	19 (17.3%)	159 (48.9%)	178 (40.9%)	24 (21.8%)	156 (48.0%)	180 (41.4%)
Total	110	325	435	110	325	435

Family/Friend Concerns

In discussions with family and/or friends of the decedent, about a third (32%) of them expressed concern of a risk of suicide (Table 14). More concern was expressed among the family/friends of youth compared with young adults (39% vs. 30%).

Table 14: Suicide Deaths by Family/Friends Concerns			
	Family/friends concerned of risk of suicide		
	9-18 yr	19-25 yr	Total
Yes	43 (39.1%)	97 (29.9%)	140 (32.2%)
No	58 (52.7%)	123 (37.9%)	181 (41.6%)
Unknown	9 (8.2%)	105 (32.3%)	114 (26.2%)
Total	110	325	435

Life Stressors

From discussions with families or friends of the decedent, review of medical records, or from evidence at the scene, coroners were able to indicate if any life stressors affected the youth or young adults. The data shown below is based on information voluntarily shared by the family or friends or what was uncovered by the coroner and may not show the full extent of these issues among youth and young people that died by suicide.

Among biopsychosocial factors (Table 15):

- 14% of had a history of trauma or abuse;
- 8% had feelings of hopelessness or lack of purpose; and
- 7% had impulsive or aggressive tendencies.

Table 15: Suicide Deaths by Biopsychosocial Factors			
	9-18 yr	19-25 yr	Total
History of trauma or abuse	29 (26.4%)	33 (10.2%)	62 (14.3%)
Hopelessness or lack of purpose	15 (13.6%)	19 (5.8%)	34 (7.8%)
Impulsive and/or aggressive tendencies	17 (15.5%)	13 (4.0%)	30 (6.9%)
Family history of suicide	3 (2.7%)	10 (3.1%)	13 (3.0%)
Major physical illness, injury or pain	2 (1.8%)	11 (3.4%)	13 (3.0%)
Recent arrest and/or charges laid	2 (1.8%)	6 (1.8%)	8 (1.8%)

Among environmental factors (Table 16):

- 25% experienced relational or social issues;
- 12% experienced chronic family instability; and
- 10% had academic difficulties.

Table 16 Suicide Deaths by Environmental Factors			
	9-18 yr	19-25 yr	Total
Relational or social issues	34 (30.9%)	74 (22.8%)	108 (24.8%)
Chronic instability in family	26 (23.6%)	28 (8.6%)	54 (12.4%)
Academic difficulties	25 (22.7%)	20 (6.2%)	45 (10.3%)
Poverty/debt	4 (3.6%)	17 (5.2%)	21 (4.8%)
Legal problems	3 (2.7%)	17 (5.2%)	20 (4.6%)
Job or financial loss	0	18 (5.5%)	18 (4.1%)
Recent immigration/relocation	4 (3.6%)	13 (4.0%)	17 (3.9%)

Among sociocultural factors (Table 17):

- 9% had a lack of social support and a sense of isolation; and
- 6% experienced bullying.

Table 17: Suicide Deaths by Sociocultural Factors			
	9-18 yr	19-25 yr	Total
Lack of social support and sense of isolation	14 (12.7%)	25 (7.7%)	39 (9.0%)
Bullying	20 (18.2%)	5 (1.5%)	25 (5.7%)
Exposure to and influence of others who died by suicide	5 (4.5%)	6 (1.8%)	11 (2.5%)
Barriers to accessing health care	5 (4.5%)	3 (0.9%)	8 (1.8%)

Importantly, none of the above-listed factors were present in a majority of youth or young adults who died by suicide.

Social Media

Where possible, investigating coroners will access and review a decedent's social media presence, in order to understand whether behaviour in this space is reflective of any stressors or other influences.

There are methodological challenges associated with studying social media use and suicide risk among youth and young adults, including changes in technology, patterns of use, algorithms, and ethics. The literature is also inconclusive with respect to potential harm, as some studies have shown a correlation between social media or internet use and suicide attempts, whereas others have shown a decrease in suicide risk. Screen time is one measure of social media or internet use but does not account for all factors influencing or protecting against suicide risk.

...This crude measure of social media behaviour does not capture individual differences in content exposures, youth motivations, youth social experiences, or the algorithmic and interactive features of different platforms that may contribute to risk or resilience for suicidal thoughts and behaviours. Social ties cultivated via social media include a variety of types (close ties, loose ties, strangers); social networks can confer suicide risk and are seen as a potential prevention target.”¹⁵

While social media and the internet amplify some known risks for suicide in youth, including “...insomnia, distress, depression, hopelessness, withdrawal or social isolation, social stressors, bullying, and exposure to suicidal behaviour in inspiring role models,” as well as new stress exposures like the rapid dissemination of information, it also offers “...opportunities for social connection and inclusion, factors known to promote resilience in youth”.¹⁵

Global Health Pandemic

In March 2020, the World Health Organization declared a global pandemic regarding SARS-CoV-2 (COVID-19), an infectious disease that was first detected in China in December 2019.

While acknowledging that the effects of large-scale traumatic events such as this cannot be measured in the short term as mental health outcomes may not begin to manifest until years after the event, it is known that quarantines or lockdowns resulting in isolation are known to have adverse psychological impacts.^{4,16}

A review of international studies identified a significant increase in anxiety and depression post-lockdown compared to pre-lockdown, and mental health, violence and suicide crisis lines across B.C. and Canada reported significantly higher call volumes since the pandemic's onset.^{4,16} B.C.'s Provincial

Health Officer acknowledged that response measures exacerbated many factors that increase an individual's risk of self-harm, suicidal ideation, and death by suicide, including: "living alone and feeling lonely; poor health, disability, and chronic pain; mental distress and mental illness; having self-harmed or attempted suicide in the past; financial stress; risk of domestic/intimate partner violence; and substance use".⁴

Children or youth with previous mental health or developmental needs were more vulnerable to the experience of the pandemic due to their need for structure and routine, and young people in general experienced a disruption to the typical developmental trajectory that occurs during this phase of life.^{16,17} Children and youth were also identified to have been particularly impacted by the pandemic due to the decrease in protective health behaviours that build resilience (e.g., physical activity), at the same time that behavioural risk factors linked to mental distress (e.g., excess internet and social media use) increased.⁴

One B.C. population estimate identified that 53.1% of people aged 15 and above self-reported "somewhat worse" or "much worse" mental health since the pandemic began; another noted that 61% of B.C. youth and young adults agreed that COVID-19 "worsened their mental health".^{4,17}

Females in B.C. reported worse mental health compared to males following the COVID-19 pandemic.⁴ Youth who completed the BC Adolescent Health Survey in 2023 were less likely to rate their mental health positively and to report they managed stress well, or very well compared to youth in 2018.¹ "A larger percentage of young adults had suicidal thoughts than other age groups (19% of those age 18-24 and 21% of those age 25-34)".⁴

Despite these concerns, it is important to note that there was no change in rates of suicide among youth and young adults during the COVID-19 pandemic.

MINISTRY OF CHILDREN AND FAMILY DEVELOPMENT (MCFD) INVOLVEMENT

The Ministry of Children and Family Development (MCFD) is mandated to provide critical services and supports to British Columbia's vulnerable children and youth, and to their families, that contribute to their safety, well-being and sense of belonging. In doing so, the Ministry also upholds the inherent right to Indigenous self-determination.

Half (50%) of the youth under the age of 19 that died by suicide were involved with MCFD in the year preceding their death.

Of those receiving services in the 12 months prior to death:

- 58% were in receipt of Child Youth Mental Health (CYMH) services;
- 15% received Child Youth Special Needs (CYSN) services;
- 7% received Child in Care (CIC) services;
- 2% received Youth Justice (YJ) services; and
- 56% received other child services.

Of the 19–25-year-olds:

- 206 (63%) had some contact with MCFD in their lifetime; and
- 19 (6%) had received services in the 12 months prior to their death.

Of those that received services in the 12 months prior to their death:

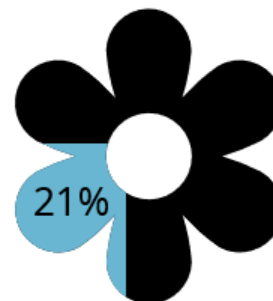
- 9 were related to an Incident;
- 5 were related to a Family Service case;
- 3 were related to a Service Request; and
- 2 received both Agreements with Young Adults and other Strengthening Abilities Journeys of Empowerment supports.

REPRESENTATIVE FOR CHILDREN AND YOUTH (RCY) FINDINGS

The Representative for Children and Youth (RCY) has a legislated responsibility to monitor, review, audit and report on reviewable services provided to children, youth and young adults in B.C., which includes services provided by MCFD.

The RCY Reviews and Investigations team completed a cohort analysis, looking at two groups of children and youth who were in receipt of services between 2020 and 2024: children and youth who experienced suicide attempts and suicidal ideation injuries, and children and youth who died by suicide. While the years of analysis and ages of children and youth differ from BCCS data used by the Panel, the RCY's data provides additional context for the experiences of children and youth who receive services from MCFD.

- Suicide Attempt, Suicidal Ideation (SASI) injuries make up 20% of all critical injuries reported to RCY from 2020 to 2024, making it the second highest injury experienced by children and youth.
- The number of in-mandate SASI injuries experienced by children and youth that were reported to the RCY increased every year from 2020 to 2024 (65% increase from 2020 to 2024).⁵
- Over half of the in mandate SASI injuries were for children and youth who were in care at the time of the injury (54%).
- The highest number of SASI injuries were experienced by youth aged 15 and 16 – making up almost 40% of those reported.
- 15% of the children/youth who died by suicide were missing from their placement at time of their death incident.
- 15% of children/youth who died by suicide had an issue with waitlist or lack of service connected to their death incident.
- 7% of children/youth who died by suicide had substance use connected to their death incident.
- 75% of children/youth who died by suicide were identified as experiencing suicidality⁶ at some point in their life based on the records received.
- Of the children/youth who died by suicide, 69% identified as having a mental health issue⁷ and 29% had complex developmental behavioural conditions at some point in their life based on the records received.



⁵ The changes in reporting, shifts in understanding of what is in-mandate or out-of-mandate based on coding practice over time should be considered when contextualizing this and the following statements.

⁶ Suicidality definition: Child/youth has experienced a spectrum of suicidality, ranging from suicidal ideation to suicide attempts (completed or incomplete).

⁷ The child or youth has been diagnosed with a mental health disorder or there is a suspicion of a mental health disorder.

- 45% of children/youth who died by suicide were identified as experiencing family violence⁸ at some point in their life based on the records received.
- 15% of children/youth who died by suicide were identified as having experienced sexualized violence⁹ at some point in their life based on the records received.
- 13% of children/youth who died by suicide were identified as having one or more parents with mental health issues or complex developmental behavioural conditions¹⁰ at some point in their life based on the records received.
- 5% of children/youth who died by suicide were identified as having intergenerational child welfare involvement¹¹ at some point in their life based on the records received.
- 11% of children/youth who died by suicide were identified as having disconnections from schooling¹² at some point in their life based on the records received.

⁸ Family violence definition: Domestic violence is noted as part of the child, youth or family's history.

⁹ An all-encompassing, non-legal term that refers to sexual acts like sexual assault, rape, sexual exploitation, and sexual abuse. This can include non-contact unwanted sexual experiences.

¹⁰ Parental mental health or CDBC definition: Parent/s or guardian/s have (diagnosed, suspected, etc.) mental health disorders or experience significant difficulties in multiple areas of functioning, such as learning and development, mental health, and behaviour, adaptive and social functioning. This can include a formal diagnosis or suspicion of Neurodevelopmental Disorders or Behavioral Conditions.

¹¹ Complex developmental behavioral conditions (CDBC): The child/youth has significant difficulties in multiple areas of functioning, such as learning and development, mental health, and behaviour, adaptive and social functioning. This can include a formal diagnosis or suspicion of Neurodevelopmental Disorders (ADHD, ASD, NVLD, LD, GDD, ID etc.) and/or ODD, Conduct Disorder, and/or the child/youth has a Behaviour Consultant or Behaviour Interventionist.

¹² Child/youth is not enrolled in an educational program, not attending school reliably, or is otherwise experiencing significant school disruption.

MEDICAL/MENTAL HEALTH HISTORY

The full BCCS investigation list was matched to the chronic disease registry, PharmaNet, hospital records (Discharge Abstract Database [DAD]), and physician billings (Medical Services Plan [MSP]), to determine the medical/mental health history of the decedent and their health service utilization over the year preceding death. Linkage with the datasets was successful for 427 of the decedents (98%).

For this analysis, we considered only diagnoses in the primary diagnostic field of each dataset. Health service visits related to the death event were excluded for the DAD.

Chronic Disease Registry

The BCCS case list was linked to the chronic disease registry to determine the percentage of deaths that had met the case definition for a mental health condition. Data matched with the Chronic Disease Registry found that:

- 60% of youth and young adults met the criteria for at least one mental health condition;
- 58% of had anxiety and mood disorders (including depressive disorders); and
- 51% had depressive disorders;
- 22% had substance use disorders; and
- 8% had schizophrenia and delusional disorders (Table 18).

There were differences in the proportion with chronic disease by age group and sex. A higher proportion of young adults (19-25 yrs) had schizophrenia & delusional disorders (10% vs. 1%) and substance use disorders (25% vs 14%) compared with youth (<19 yrs). Similarly, a higher proportion of females had anxiety and mood disorders (73% vs 50%), depressive disorders (66% vs 44%) and substance use disorders (29% vs 19%) compared to males (Table 19).

For both age groups and sexes, the proportion with each of the mental health conditions was much higher compared with the general B.C. population. B.C. population prevalence data was obtained from the [BC Chronic Disease Dashboard](#)⁴.

Due to differences in age groupings, exact age comparisons were not possible. The age groupings that were available from the dashboard were 1-19 years and 20-34 years OF AGE. The 1-19 yr B.C. prevalence is likely to underestimate the true 9-18 yr B.C. prevalence, and the 20-34 yr B.C. prevalence is likely to overestimate the true 19-25 yr B.C. prevalence. Despite the difference in the age groupings, the prevalence difference between our cohort and the B.C. population is substantial and likely to hold even when compared with the same age groupings.

Table 18: Suicide Deaths by Chronic Disease and Age Group					
	9-18 yr		19-25 yr		Total
	# (%)	B.C. Prevalence 1-19 yr*	# (%)	B.C. Prevalence 20-34 yr*	# (%)
Depressive disorders	54 (49.1%)	4.3	164 (51.7%)	21.4	218 (51.1%)
Anxiety and mood disorders (incl. depressive disorders)	63 (57.3%)	7.5	185 (58.4%)	27.7	248 (58.1%)
Schizophrenia and delusional disorders	1 (0.9%)	0.1	33 (10.4%)	1.1	34 (8.0%)
Substance use disorders	15 (13.6%)	0.4	79 (24.9%)	4.8	94 (22.0%)
Total	110		317		427

*B.C. Prevalence taken from the Chronic Disease Dashboard for the year 2020/21.⁴

Table 19: Suicide Deaths by Chronic Disease and Assigned Sex					
	Male		Female		Total
	# (%)	B.C. Prevalence 20-34 yr*	# (%)	B.C. Prevalence 20-34 yr*	# (%)
Depressive disorders	124 (43.7%)	16.8	94 (65.7%)	26.0	218 (51.1%)
Anxiety and mood disorders (incl. depressive disorders)	143 (50.4%)	22.2	105 (73.4%)	33.2	248 (58.1%)
Schizophrenia and delusional disorders	25 (8.8%)	1.5	9 (6.3%)	0.7	34 (8.0%)
Substance use disorders	53 (18.7%)	5.6	41 (28.7%)	3.9	94 (22.0%)
Total	284		143		427

*B.C. Prevalence taken from the Chronic Disease Dashboard for the year 2020/21.⁴

PharmaNet

The deaths were linked with PharmaNet data to determine the number of people that had a prescription in the 12 months prior to death. Five categories of prescription medications were examined: antidepressants, antipsychotics, antiepileptic, benzodiazepines, and stimulants (see Appendix for list of medications for each category). The categories were made mutually exclusive, so a drug was only included in one category (e.g. clonazepam was included as a benzodiazepine but not as an antiepileptic). There is a possibility that some decedents could have used medications “off label”; as the data does not contemplate the clinical diagnoses used for prescriptions diagnosis cannot be inferred.

In this review:

- 46% of youth and young adults that died by suicide had a prescription medication in one of the five categories in the 12 months prior to death;
- 38% had a prescription for at least one antidepressant;
- 21% had a prescription for at least one antipsychotic;
- 9% had a prescription for at least one antiepileptic;
- 11% had a prescription for at least one benzodiazepine; and
- 10% had a prescription for at least one stimulant; and
- 54% had no prescription from any of the 5 drug categories (Table 20).

Differences observed between age groups included:

- A higher percentage of youth (<19 yrs) having had a prescription for antidepressant (43% vs 37%) and stimulants (14% vs 8%) compared to young adults (19-25 yrs); and
- A higher percentage of young adults having had a prescription for antiepileptic (10% vs 6%) and benzodiazepine (12% vs 8%) compared to youth.

Similarly, differences were observed by sex as a higher percentage of females had prescriptions for all 5 categories of drugs compared to males (Table 21).

	9-18	19-25	Total
	Number (%)	Number (%)	Number (%)
Antidepressant	47 (42.7%)	117 (36.9%)	164 (38.4%)
Antipsychotic	23 (20.9%)	68 (21.5%)	91 (21.3%)
Antiepileptic	6 (5.5%)	31 (9.8%)	37 (8.7%)
Benzodiazepine	9 (8.2%)	37 (11.7%)	46 (10.8%)
Stimulant	15 (13.6%)	26 (8.2%)	41 (9.6%)
None of the above prescribed medications	56 (50.9%)	173 (54.6%)	229 (53.6%)
Total	110	317	427

Table 21: Suicide Deaths by Medication Prescribed in 12 Months Prior to Death and Sex			
	Male	Female	Total
	Number (%)	Number (%)	
Antidepressant	87 (30.6%)	77 (53.9%)	164 (38.4%)
Antipsychotic	53 (18.7%)	38 (26.6%)	91 (21.3%)
Antiepileptic	15 (5.3%)	22 (15.4%)	37 (8.7%)
Benzodiazepine	19 (6.7%)	27 (18.9%)	46 (10.8%)
Stimulant	27 (9.5%)	14 (9.8%)	41 (9.6%)
None of the above prescribed medications	175 (61.6%)	54 (37.8%)	229 (53.6%)
Total	284	143	427

Hospitalizations

The Discharge Abstract Database (DAD) captures all discharges, transfers and deaths occurring in acute care hospitals in B.C. Any hospitalization associated with the death was excluded in the linkage. Of the 427 youth and young adults linked to the DAD:

- 23% had a hospitalization in the year prior to death;
- 35% had a prior hospitalization related to mental health or suicide in their lifetime;
- 21% had a hospitalization related to mental health or suicide in the year prior to death; and
- 18% had an involuntary admission in the year prior to death (Table 22).

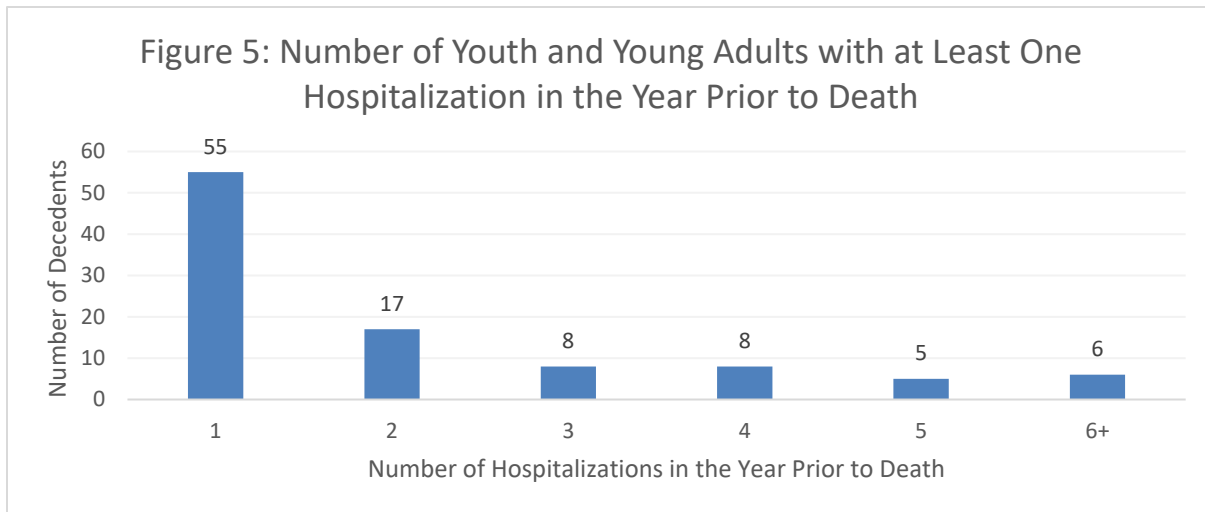
There were no differences in the rate of hospitalizations between youth and young adults. In contrast, females had higher rates of hospitalizations, hospitalizations within 12 months of death, mental health and suicide related hospitalizations, and involuntary admissions compared with males (Table 23).

Table 22: Suicide Deaths by Hospitalizations and Age Group			
	9-18 yrs	19-25 yrs	Total Number (%)
	Number (%)	Number (%)	
Any hospitalization within 12 months of death	27 (24.6%)	72 (22.7%)	99 (23.2%)
Prior hospitalization related to mental health or suicide (lifetime)	35 (31.8%)	116 (36.6%)	151 (35.4%)
Prior hospitalization related to mental health or suicide within 12 months of death	26 (23.6%)	62 (19.6%)	88 (20.6%)
Involuntary admission within 12 months of death	20 (18.2%)	57 (18.0%)	77 (18.0%)
Total	110	317	427

Table 23: Suicide Deaths by Hospitalizations and Sex			
	Male	Female	Total Number (%)
	Number (%)	Number (%)	
Hospitalization within 12 months of death	55 (19.4%)	44 (30.8%)	99 (23.2%)
Prior hospitalization related to mental health or suicide	82 (28.9%)	69 (48.3%)	151 (35.4%)
Prior hospitalization related to mental health or suicide within 12 months of death	50 (17.6%)	38 (26.6%)	88 (20.6%)
Involuntary admission within 12 months of death	43 (15.1%)	34 (23.8%)	77 (18.0%)
Total	284	143	427

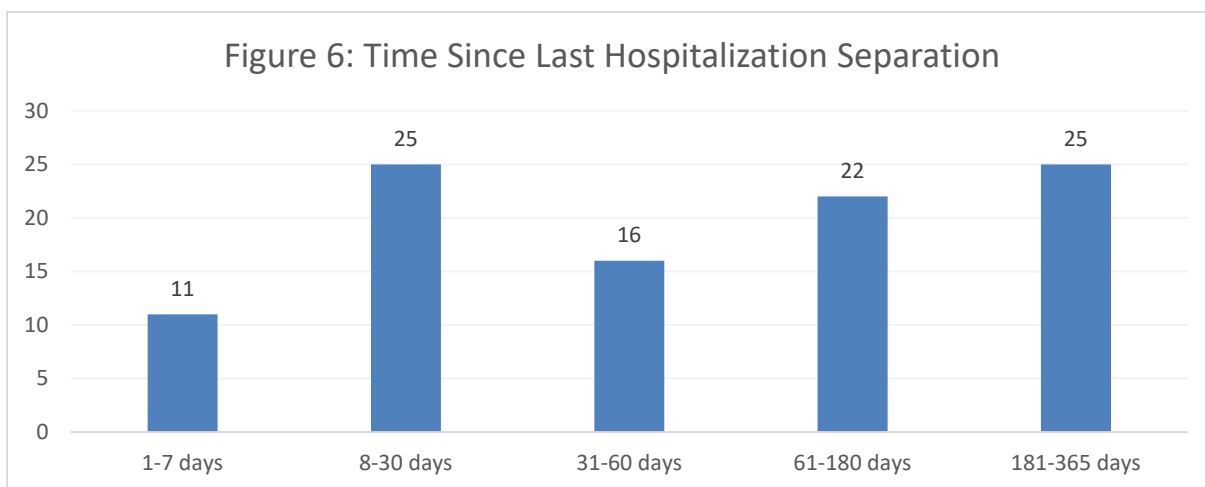
In total, the 99 cases with at least one hospitalization in the year prior to death, had 234 visits. Among the decedents who had a hospitalization in the year prior to death (n=99):

- 56% had one visit;
- 17% had two visits; and
- 27% had three or more visits (Figure 5).



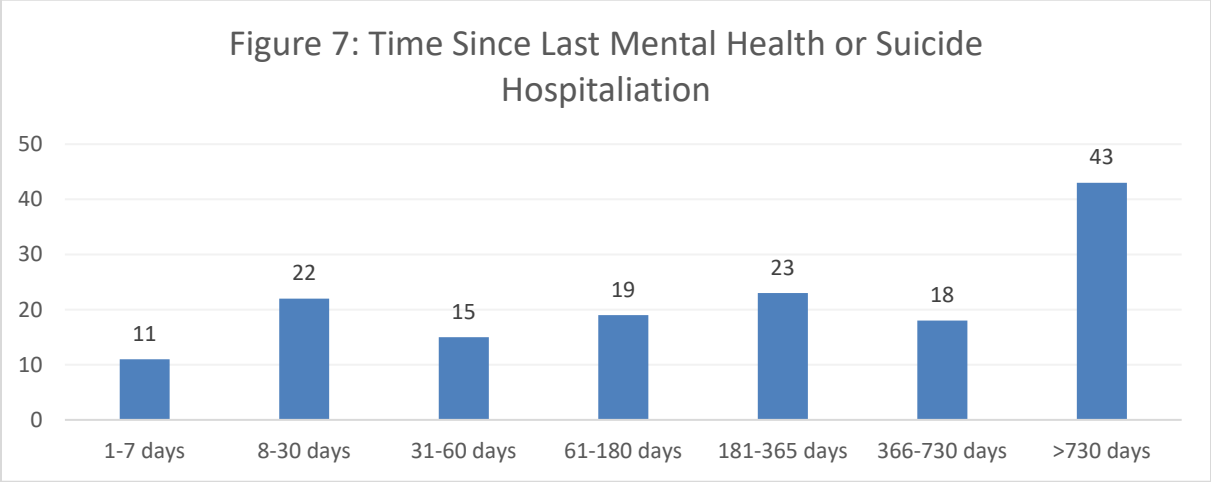
Of the youth and young adults that had a hospitalization in the year prior to death (n=99):

- 11% left the hospital within a week of death; and
- 36% left the hospital within a month of death (Figure 6).



Of the 427 youth and young adults linked to the DAD, 151 (35%) had at least one hospitalization that was mental health or suicide related (ICD 10 – F0-F99; X60-X84). Of those hospitalizations (n=151):

- 7% left the hospital within a week of death; and
- 22% left the hospital within a month of death; and
- 60% left the hospital within a year of death (Figure 7).



Of those with at least one hospitalization that was mental health or suicide related (n=151):

- 29% had an intentional self-harm related hospitalization;
- 27% had a hospitalization related to mood disorders; and
- 17% had a hospitalization related to neurotic, stress-related and somatoform disorders (Table 24).

Of the 11 that had a hospitalization in the week prior to death:

- 5 (45%) had a hospitalization related to intentional self-harm;
- 4 (36%) had a hospitalization related to mood disorders;
- 1 had a hospitalization for mental and behavioural disorders due to psychoactive substance use; and
- 1 had hospitalization related to disorders of adult personality and behaviour.

Table 24: Most Recent Hospitalization Related to Mental Health or Suicide			
ICD 10	Description	Count*	% (n=151)
X60-X84	Intentional self-harm	43	28.5%
F30-F39	Mood (affective) disorders	41	27.2%
F40-F48	Neurotic, stress-related and somatoform disorders	25	16.6%
F10-F19	Mental and behavioural disorders due to psychoactive substance use	24	15.9%
F20-F29	Schizophrenia, schizotypal and delusional disorders	22	14.6%
F60-F69	Disorders of adult personality and behaviour	14	9.3%
F80-F89	Disorders of psychological development	3	2.0%
F50-F59	Behavioural syndromes associated with physiological disturbances and physical factors	2	1.3%

*Counts are not mutually exclusive; individuals can have a diagnosis code (F00-F99) and an E-code (X60-X84).

Medical Services Plan (MSP) Billings

Data on medical services provided by fee-for-service practitioners to individuals covered by the Medical Services Plan (MSP) was linked to our study cohort. The linkage found that:

- 79% of decedents had an MSP billing within 12 months of death;
- 52% of decedents had an MSP billing related to mental health or suicide (ICD 9 – 290-319; E950-E959) within 12 months of death; and
- 30% of decedents had a psychiatrist visit within 12 months of death (Table 25).

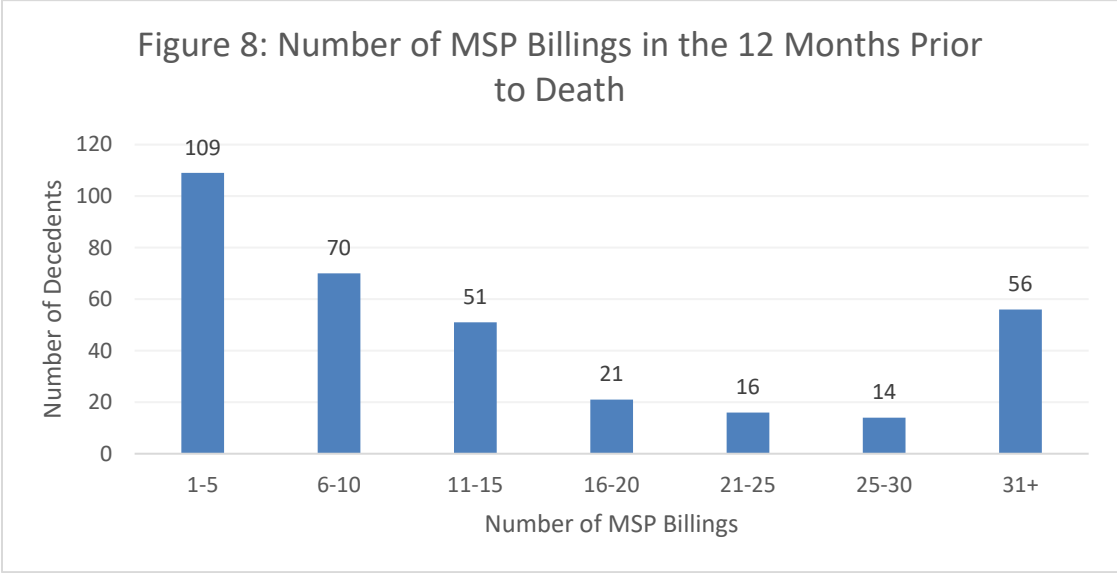
Youth were more likely to have an MSP billing within 12 months of death compared to young adults and females were more likely to have an MSP billing, an MSP billing related to mental health or suicide, and a psychiatrist visit within 12 months of death compared with males (Table 26).

Table 25: Suicide Deaths by MSP Billing and Age Group			
	9-18 yrs	19-25 yrs	Total
	Number (%)	Number (%)	
MSP billing within 12 months of death	98 (89.1%)	239 (75.4%)	337 (78.9%)
MSP billing related to mental health or suicide within 12 months of death	63 (57.3%)	158 (49.8%)	221 (51.8%)
Psychiatrist visit within 12 months of death	35 (31.8%)	92 (29.0%)	127 (29.7%)
Total	110	317	427

Table 26: Suicide Deaths by MSP Billing and Assigned Sex			
	Male	Female	Total
	Number (%)	Number (%)	
MSP billing within 12 months of death	208 (73.2%)	129 (90.2%)	337 (78.9%)
MSP billing related to mental health or suicide within 12 months of death	130 (45.8%)	91 (63.6%)	221 (51.8%)
Psychiatrist visit within 12 months of death	75 (26.4%)	52 (36.4%)	127 (29.7%)
Total	284	143	427

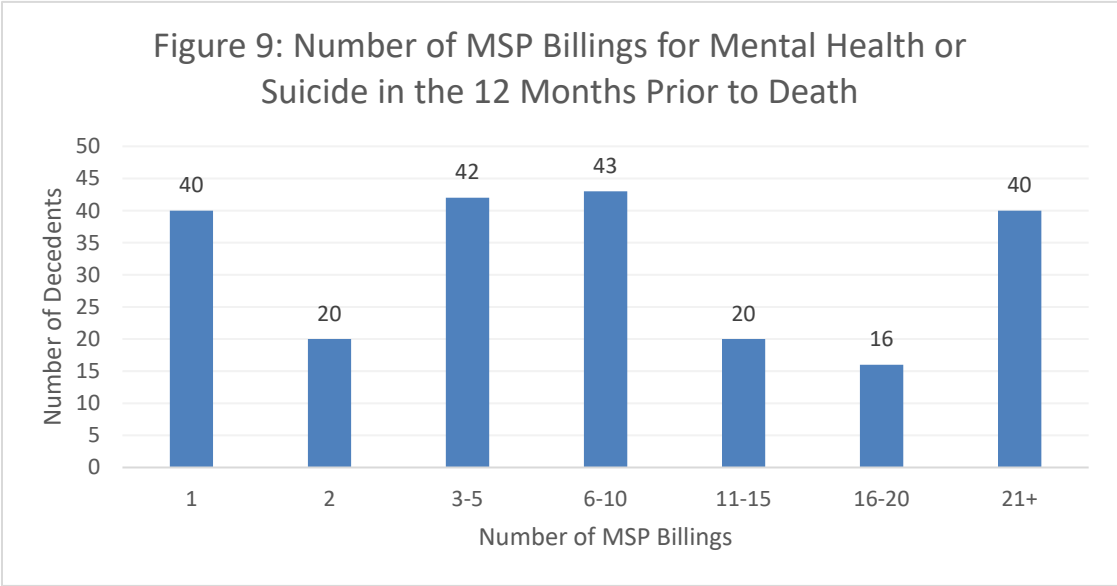
The 337 youth and young adults that had an MSP billing within 12 months of death had, in total, 6208 billings which averages to 18 billings per person. Among the decedents that had an MSP billing within 12 months of death:

- 32% had 1-5 MSP billings;
- 21% had 6-10 MSP billings; and
- 17% had over 30 MSP billings (Figure 8).



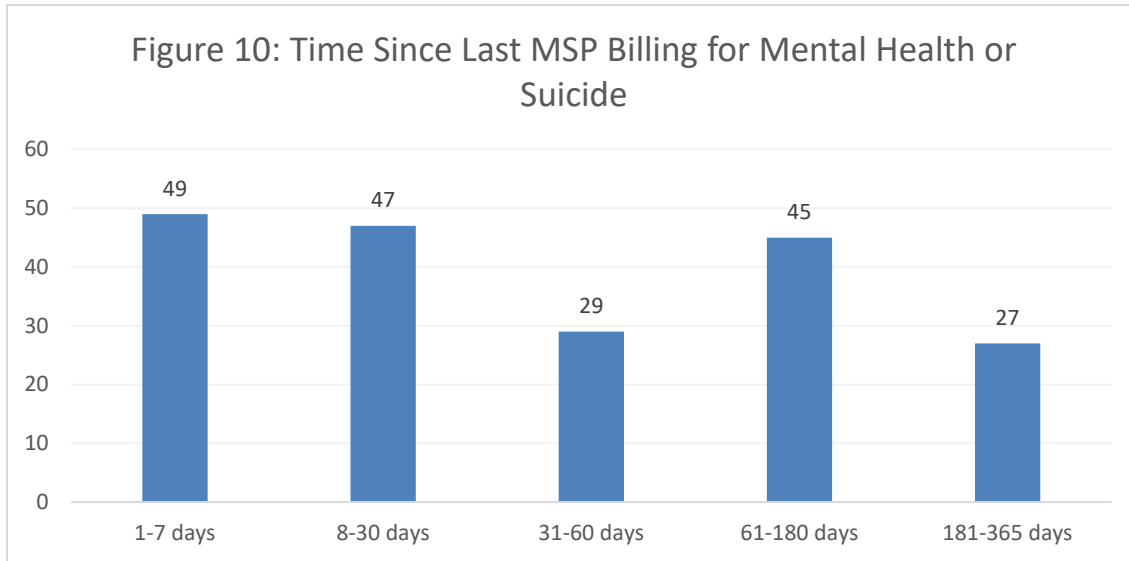
Of the 221 youth and young adults that had an MSP billing for mental health or suicide (ICD 9 – 290-319; E950-E959) in the 12 months prior to death:

- 27% had 1-2 mental health or suicide billings;
- 19% had 3-5 mental health or suicide billings; and
- 18% had more than 20 mental health or suicide billings (Figure 9).



Of those that had an MSP billing for mental health or suicide in the 12 months prior to death and where date of billing was available (n=197):

- 25% had the billing between 1 and 7 days prior to death;
- 24% had the billing between 8 and 30 days prior to death; and
- 13% had the billing between 31 and 60 days prior to death (Figure 10).



*Note: Billings on or after date of death were excluded.

PART 2: DISCUSSION

The Panel considered BCCS investigative findings, a review of relevant literature, presentations made by the McCreary Centre Society and the Capturing Health and Resilience Trajectories (CHART) Lab, and the insights and experiences of fellow panel members to guide its discussions. Panelists recognized that while deaths by suicide of youths and young adults in B.C. had not significantly increased during the period studied, the population at risk and rates of suicide remain unacceptably high. Proactive actions could have a significant positive impact on addressing emotional distress and suicidal ideation, attempts and completions among all young people in the province.

The Panel identified the urgent need for all Ministries and organizations that design and implement youth-oriented programming to directly engage young people and co-create solutions that are relevant to their experiences and perspectives. The principle of “nothing about us without us” holds that no policy should be determined without the direct involvement of the persons or groups for whom the policy is directed. The BCCS is committed to creating a process moving forward that will allow such engagements to take place in a manner that is inclusive and supportive and challenges all Ministries and organizations to make similar commitments.

The Panel discussed ongoing erasure of inherent Indigenous rights, Indigenous-specific racism and settlers colonial violence perpetrated through present day policies and practices as root causes that must be urgently addressed to arrest disproportionate harms to Indigenous children and youth.

It is fundamentally important to situate understanding of the apparent overrepresentation of some communities. Specific recognition was paid to communities that live at the intersections of systems of oppression including but not limited to homophobia, transphobia, racism and ableism, recognizing that these systems perpetuate harm and must be eradicated.

Current State of Youth Mental Health

The Panel discussed the current state of mental health of youth in B.C. While the number and rates of death by suicide of youth and young adults in this province have remained relatively stable over the last decade, panelists observed a decline in the number of youth and young adults reporting positive mental health, particularly in the period following the COVID-19 pandemic. The BC Adolescent Health Survey (AHS) further identifies an increase in self-harm and suicidal ideation, particularly among non-binary youth and girls. More work must be done in all areas to increase the number of young people who rate their mental health as positive.

When youth struggle with their mental health, one coping mechanism they turn to are illicit substances. While the AHS suggests that substance use among youth has decreased in recent years, those who do use substances are doing so at an earlier age. This finding is particularly relevant as B.C. is now in the tenth year of the public health emergency resulting from an ever-increasing toxic, illicit drug supply.

The Panel further noted that not all deaths by suicide can be conclusively linked to mental health challenges; in some instances, in fact, suicide was preceded by physical injuries such as concussions. More work is required in these areas to better understand the role physical trauma plays in suicidal ideation. There is also risk with generalizing suicide entirely to mental health distress given continued stigma about mental health issues and its impact on help-seeking for youth and young adults.¹⁸

There was general consensus among the Panel that service delivery in B.C. is inconsistent, and that challenges with access continue to exist, particularly for youth in rural and remote areas of the province. For Indigenous (First Nations/Métis/Inuit) communities, systemic and ongoing racism and discrimination, combined with a general lack of understanding of the principles of cultural safety create significant additional barriers to services.

Many young people express an interest in seeking support in an in-person environment, but those opportunities may not exist for those living outside of urban centres. There are unique barriers to services faced by people who do not live in urban communities, such as a lack of mental health professionals, infrastructure, distance and isolation.¹⁹

In an effort to make health and wellness services more accessible to young people, integrated models of care are growing in popularity in Canada. Integrated Youth Services (IYSs) are described as “an early intervention model[s] for youth and emerging adults, focusing on accessible and rapid access to coordinated, collaborative, evidence-informed services in youth-friendly settings”.²⁰

It was noted that some young people have greatly benefited from services offered by Foundry BC, a province-wide network of integrated health and wellness services for young people ages 12-24. Foundry’s website highlights its “integrated services (which) make it possible for young people to access five core services in one convenient location: mental health care, substance use services, physical and sexual health care, youth and family peer supports, and social services.”²¹

Seventeen Foundry centres currently exist in communities throughout B.C., with 18 more currently in development, for a total of 35 province-side upon implementation. In addition to its in-person services, Foundry offers online tools and resources and an opportunity for young people to connect with its services virtually.

The Panel expressed a desire to better understand the stated outcomes of the Foundry approach and the performance measurements used to evaluate efficacy. This is particularly relevant given the intention to expand Foundry locations throughout B.C.

“Third Spaces”

Many young people spend much of their time in one of two places: at home, or at school. While these two locations are often considered safe and protective, for some they are neither. This is particularly true for marginalized young people who may feel unsafe in home and/or school settings. At the same

time, these young people demonstrate aptitudes in “*adaptive responding*—the ability to maintain well-being through and despite such contextual constraints”.²² The Panel discussed the need for young people to have additional places at which they can gather, build and sustain connection away from institutionalized settings. Such an approach can also cater to young people who are not attached to a school.

Third spaces are intended to create and foster a sense of belonging for young people that they may not find in more traditional settings. They can exist in existing public facilities, including libraries and community centres, and they provide a peer-supported environment for organic socialization. In essence, they allow young people to develop relationships on their own terms. The Panel agreed that such environments can offer opportunities to enhance resilience and independence. However, the Panel also acknowledged that creating and funding these spaces would require significant allocation of funding and resources.

It is critical that such an initiative directly engage youth in every step of the process, as failure to do so could lead to a reluctance and/or inability to access.

Suicide Prevention and Intervention

Given the complexity of personal, social and environmental factors that make suicidal ideation and action accessible, the approaches to preventing death and promoting life are equally diverse.

The Public Health Agency of Canada released the [National Suicide Prevention Action Plan 2024-2027](#) to address the ongoing need for a thoughtful, holistic, and coordinated response to preventing suicide in Canada. It highlights the complexity of suicide as a public health issue, and an awareness of disproportionate representation by persons experiencing marginalization and discrimination.

While gaps in knowledge exist with respect to understanding the full range of potential benefits or harms of suicide prevention initiatives, particularly given the uneven quality and quantity of data for various demographics and initiatives,^{3,23,24} a systematic review of evidence-based studies suggests the following options for scalable intervention efforts to prevent suicide attempts:

1. Educating primary care physicians in depression management and evaluating the expansion of such programs to other nonpsychiatric medical specialists, such as internists and obstetrician-gynecologists;
2. Educating high school students about mental health and evaluating extension of this approach to college students;
3. Means restriction; and
4. Predischarge education and follow-up contact and outreach for psychiatric patients discharged from the emergency department or hospital and for patients after a suicide crisis.²⁴

In addition to the four focus areas, effective but less scalable options (based on training, delivery, cost and personnel) include specific psychotherapies, like cognitive behavioural therapy and dialectical behavioural therapy.²⁴

School-based interventions have not demonstrated a reduction in the rate of death, however interventions to increase contact between youth and trained professionals have shown promise as a reduction in ideation and attempts have been found following education that incorporates awareness, screening and skills training.²³ A review of suicide prevention interventions has not identified differences with respect to sex or gender identity, though one study identified an increase in ideation for Indigenous youth who received Applied Suicide Intervention Skills Training gatekeeper training.²³ This speaks to the need to ensure that interventions are tailored with and for the communities they intend to serve, a principle repeated throughout Panel discussions.

The Panel noted that recent larger-scale studies of mental health school interventions have reported mixed results, with some showing null or negative results, further highlighting that universal approaches without individualistic considerations may not be helpful.

Youth Perspective

Panel discussions regularly revisited the belief that the autonomy and input of young people must be respected and included in decision-making processes.

Specifically including Indigenous youth voices in governmental processes is crucial because it upholds a rights-based approach to health promotion, ensures cultural relevance and appropriateness, addresses systemic issues, fosters empowerment and belonging, tailors solutions to their unique needs, builds trust, and promotes holistic approaches to health and well-being.

Youth involvement is crucial for creating culturally safe and trauma-informed approaches, improving access to mental health services, and fostering a sense of belonging and empowerment. Integrating youth voices will allow for development of more effective and relevant solutions to the challenges faced by young people, particularly in areas such as mental health, suicide prevention, and systemic issues affecting populations who are harmed by systems of oppression.

Health Care Service Access and Design

Not all deaths by suicide can be linked to associated mental health challenges. Indeed, while some coroner investigations did identify instances in which the decedent had a pre-existing mental health condition, in others no such determination had been made.

For Indigenous (First Nations/Métis/Inuit) youth, this could be a reflection of a mental health system that is discriminatory and/or not culturally safe. It could also stem from a lack of engagement with

health care because of the current shortage of primary care providers in the province, but it could also be the case that the decedent simply never chose to pursue mental health support. Panel consensus was that any preventative interventions acknowledge the reality that some young people who die by suicide do so without ever disclosing their intent.

The Panel discussed the need to support health care providers – and particularly front-line workers such as emergency room physicians and nurses and social workers – to ensure they are aware of and following best practices, including cultural safety, when observing patients and/or clients who may present with evidence of mental health challenges. It was noted that screening for mental health is often only part of a larger assessment process and that there is a risk that taking a patient “at their word” risks creating an environment where simply providing the “right” answer to a question will lead to the dismissal of such concerns. A more robust process for evaluation is required in order to be certain that issues are recognized efficiently and effectively.

PART 3: RECOMMENDATIONS

Following its discussions, the death review panel has developed a set of recommendations it feels will increase public health and safety and positively impact the lives of all British Columbians. In considering the scope of its work, the Panel sought to develop recommendations that were:

- Collaborative;
- Supported by the death investigation-related data and/or supporting literature that was reviewed;
- Focused on increasing the public health and safety of all affected communities;
- Targeted to specific parties; and
- Measurable.

The Panel has identified five key areas to support young people and reduce deaths by suicide. All recommendations are made within the context of the Government of British Columbia's commitments to Reconciliation and using a distinctions-based approach that acknowledges the inherent right to self-government of First Nations, Métis and Inuit communities throughout British Columbia.

PANEL RECOMMENDATIONS

RECOMMENDATION 1: Create and implement a provincial suicide risk reduction framework specifically focused on youth and young adults.

Rationale:

In May 2025 the Province introduced a province-wide suicide prevention framework that “will offer best practices for recognizing and supporting people at risk for suicide, helping more people get the right care and saving more lives.” A similarly coordinated, consistent, province-wide approach will help ensure positive outcomes that meet the unique needs of youth and young adults across the mental health spectrum. Such an approach will increase the ability of mental health care providers to identify individuals at risk quickly, and to establish a person-centered system of treatment. This initiative can be co-created with young people to ensure that the framework is culturally safe, trauma-informed, and responsive to the specific needs of this community.

Priority actions identified by the Panel are:

- By September 1, 2026, the Ministry of Health, in coordination with the Ministry of Children and Family Development, the Ministry of Education and Child Care, the Ministry of Post-Secondary Education and Future Skills and the province's six regional health authorities will review existing efforts to reduce the risk of suicide for youth and young adults.
- By January 1, 2027, the above-identified parties will implement a process to engage with and learn from youth and young adults in B.C. to identify new opportunities to support positive mental health outcomes and reduce the risk of suicide.

- By September 1, 2027, the above-identified parties will co-create a framework that addresses the gaps in a manner that:
 - Is culturally safe and inclusive;
 - Prioritizes the needs of marginalized groups and underserved communities;
 - Is responsive to the specific and changing needs of the young people it supports;
 - Is scalable and adaptable to the needs of both urban and rural and remote communities;
 - Can be applied to all emergency departments, psychiatric units, and outpatient mental health services; and
 - Includes metrics to evaluate efficacy to allow for adjustment on a Local Health Area level.

RECOMMENDATION 2: Improve data collection, information sharing and reporting processes to better understand and support diverse communities throughout British Columbia.

Rationale

There is a need to better understand the reasons why certain populations are overrepresented in coronial data. Currently the only ethnicity-related data reported by the Coroners Service is specific to Indigeneity, and even this is a category too broad to identify trends specific to First Nations, Métis and Inuit communities. The Province has committed to a distinctions-based approach to advancing Reconciliation, which means it is critical that we acknowledge the unique rights, priorities and concerns of First Nations, Métis and Inuit communities. In recent years the province has been working to develop a framework to standardize race-based data collection, but this process has yet to be fully realized. Accordingly, the Panel has identified an opportunity for the Coroners Service to take a lead role in this area. Information gathered can be used by specific communities to tailor local and grassroots mental health and wellbeing initiatives.

Priority actions identified by the Panel are:

- By September 1, 2026, the BC Coroners Service, in collaboration with the Ministry of Health, will create and implement information sharing strategies with Métis Nation British Columbia and provincial Inuit Leadership to ensure that patient/decedent data relevant to these Nations are appropriately collected and shared.
- By September 1, 2026, the BC Coroners Service, in collaboration with the Ministry of Health and the Ministry of Attorney General, will finalize plans to document information including but not limited to the race and ethnicity, gender orientation and ability of all patients and decedents. The approach should be designed in a manner that recognizes the uniqueness of communities within B.C. and that allows for communities to embrace data-driven approaches to increasing public health and safety initiatives.

RECOMMENDATION 3: Review existing social and emotional health related resources to ensure they meet the needs of the diversity of school-aged students in B.C.

Rationale

Unlike the population writ large, where decedents who are biologically male account for a significant majority of deaths by suicide, among youth and young adults the biological sex breakdown is much more even. Additionally, the case review documentation identifies that females are much more likely than males to seek help for and be diagnosed with a mental health condition, and also to be prescribed medication for that condition.

These data suggest a difference in the ways that mental health issues are perceived based on biological sex. As much of the social and emotional learning provided to young people occurs in a school setting, there is a need to review current approaches through this lens, and to consider ways in which approaches can be adjusted to ensure the curricula resonates with specific audiences.

Part of this review should include the way(s) that learning is directed toward communities over-represented in coronial data, including Indigenous youth and gender-diverse young people.

Priority actions identified by the Panel are:

- By September 1, 2026, the Ministry of Education and Child Care will engage with impacted youth to identify current challenges and co-develop new and/or refreshed resources specifically focused on supporting Indigenous and gender-diverse community members, ensuring that such an approach is trauma-informed and responsive to the unique needs and circumstances of these young people.
- By March 1, 2027, the Ministry of Education and Child Care will review and update all existing social and emotional health-related resources to ensure that the content and delivery remain relevant, evidence-based and consistent with current youth mental health and well-being objectives.

RECOMMENDATION 4: Create an educational model to ensure doctors, nurses, paramedics and other emergency medical professionals are appropriately trained on early identification, assessment, management and follow-up of youth and young adults who are at higher risk of death by suicide.

Rationale

A significant number of decedents had been engaged with a medical health professional in the twelve months preceding their deaths. The Panel acknowledged that these engagements often occurred in emergency room settings where time for assessment can be extremely limited, but there remains an opportunity to leverage this connection as an inflection point to determine the acuity of the mental health status of a person.

The Panel also discussed challenges faced by new social workers under the employ of the Ministry of Children and Family Development. MCFD experiences high turnover and burnout rates for new staff, many of whom are not considerably older than the youth they encounter. As social workers also represent first points of contact and connection with at-risk youth, it is imperative that they are appropriately equipped to offer the support young people need while also being professionally supported themselves.

Priority actions identified by the Panel are:

- By September 1, 2026, the Ministry of Health, in coordination with the province's six health authorities, Doctors of B.C., the College of Physicians and Surgeons of B.C., and the B.C. College of Nurses and Midwives, will review and update all existing emergency mental health care guidelines and practice standards with respect to screening and assessment of youth and young adults who present with mental health-related concerns.
- By March 1, 2027, the Ministry of Health, in coordination with the province's six health authorities, Doctors of B.C., the College of Physicians and Surgeons of B.C., and the B.C. College of Nurses and Midwives, will review existing mental health-focussed educational curricula to make sure that all new graduates are equipped with the knowledge and skills to identify, assess and provide care to youth and young adults who are at higher risk of death by suicide.
- By September 1, 2027, the Ministry of Health, in coordination with the province's six health authorities, Doctors of B.C., the College of Physicians and Surgeons of B.C., and the B.C. College of Nurses and Midwives, will create and begin to implement mandatory continuing learning opportunities for all emergency medical professionals to ensure that mental health-related considerations are made during the patient assessment process whenever appropriate.

RECOMMENDATION 5: Co-develop a “third spaces” strategy to create venues for young people to develop and maintain connections in their own communities.

Rationale

The Panel identified that, for many young people at risk of death by suicide, there is a concurrent lack of stability in their home lives. Additionally, schools – which are traditionally thought of as supportive and protective spaces – may actually be risk inducing for some. This may be due to intergenerational trauma caused by the residential school system or due to interpersonal conflicts with other students. The Panel further noted that communal spaces are limited for many young people, particularly (but not exclusively) those in rural and remote communities of B.C.

There is an opportunity to leverage existing facilities that are currently owned and/or leased by the Province and/or municipal governments and to reimagine them as safe, secure spaces for young

people to gather or connect. Such spaces could contain support services for youth, but this is not a necessity. Rather than presuppose a vision for a “Third Space,” the Panel proposed that the vision be individually co-created with the relevant young people for whom the space is meant to service and/or support.

Priority actions identified by the Panel are:

- By March 1, 2026, the Ministry of Housing and Municipal Affairs, in coordination with the Ministry of Citizens’ Services, and in association with the Union of B.C. Municipalities, will create a resolution tasking municipal governments throughout the province with identifying existing facilities that are suitable for re-purposing as a “Third Space.” The resolution will be introduced at the 2026 UBCM Convention.
- By January 1, 2027, the Ministry of Housing and Municipal Affairs will develop a framework for implementation and collaboration at a community level with relevant Indigenous (First Nations/Métis /Inuit) and municipal partners that addresses and reflects specific local needs to ensure the framework:
 - Is scalable and adaptable to the changing needs of youth; and
 - Contains metrics to evaluate efficacy.

Previous Panel Recommendations

In August 2019, the BC Coroners Service released a death review panel report entitled [*Supporting Youth and Health Professionals: A Report on Youth Suicides*](#). That report included three actionable recommendations aimed at reducing future deaths:

- **Recommendation 1: Adopt mental well-being strategies as part of social emotional learning for students.**
- **Recommendation 2: Identify and distribute provincial best practice youth mental health guidelines.**
- **Recommendation 3: Expand specialty youth mental health including psychiatric services to non-urban areas through outreach models.**

The Panel agreed that some positive progress has been made in response to these recommendations, but that they should remain a priority for the Province and relevant ministries moving forward. **The Panel requests that the Ministries of Children and Family Development, Education and Child Care, and Health provide an update of progress on previous recommendations, and any relevant future plans, as part of the current review engagement by December 31, 2025.**

APPENDIX 1: GLOSSARY

The following terms are used within this report to mean:

2SLGBTQIA+: An acronym representing Two-Spirit, Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex, Asexual, and other sexual orientations and gender identities.

Anxiety and Mood Disorders: Mental health conditions characterized by significant feelings of anxiety and depression.

Biopsychosocial Factors: Factors that include biological, psychological, and social aspects influencing an individual's health.

Chronic Disease Registry: A database that tracks individuals with chronic health conditions.

Cultural Safety: An approach that recognizes and respects the cultural identities of individuals and communities.

Decedent: A person who has died.

Distinctions-Based Approach: A method that acknowledges the unique rights, priorities, and concerns of First Nations, Métis, and Inuit communities.

Emergency Medical Professionals: Healthcare providers such as doctors, nurses, and paramedics who work in emergency settings.

First Nations, Métis, and Inuit: Indigenous peoples in Canada with distinct cultures, languages, and histories.

Integrated Youth Services (IYS): A model of care that provides coordinated, collaborative, and evidence-informed services for youth in accessible settings.

Mental Health and Substance Use Disorders: Conditions involving significant disturbances in thinking, emotion, or behavior, often including the misuse of substances.

PharmaNet: A network that tracks prescription medications dispensed in British Columbia.

Public Health Agency of Canada: A federal agency responsible for public health, emergency preparedness, and response.

Self-Harm: The act of deliberately inflicting pain or injury on oneself.

Social and Emotional Learning (SEL): The process through which individuals acquire and apply the knowledge, attitudes, and skills necessary to understand and manage emotions, set and achieve positive goals, and establish and maintain positive relationships.

Suicidal Ideation: Thoughts about, consideration of, or planning for suicide.

Trauma-Informed: An approach that recognizes the presence of trauma symptoms and acknowledges the role trauma may play in an individual's life.

Youth and Young Adults: Individuals typically aged between 9 and 25 years.

APPENDIX 2: DRUGS AND SUBSTANCES INCLUDED IN PHARMANET DATA LINKAGE

Category	Brand Name	Category	Brand Name
Antidepressant	Amitriptyline Hcl	Antipsychotic	Fluphenazine Decanoate
Antidepressant	Amitriptyline Pamoate	Antipsychotic	Fluphenazine Enanthate
Antidepressant	Amoxapine	Antipsychotic	Fluphenazine Hcl
Antidepressant	Bupropion Hcl	Antipsychotic	Fluspirilene
Antidepressant	Citalopram Hydrobromide	Antipsychotic	Haloperidol
Antidepressant	Clomipramine Hcl	Antipsychotic	Haloperidol Decanoate
Antidepressant	Desipramine Hcl	Antipsychotic	Haloperidol Lactate
Antidepressant	Desvenlafaxine	Antipsychotic	Isopropamide/Prochlorperazine
Antidepressant	Desvenlafaxine Succinate	Antipsychotic	Loxapine Hcl
Antidepressant	Doxepin Hcl	Antipsychotic	Loxapine Succinate
Antidepressant	Duloxetine Hcl	Antipsychotic	Lurasidone Hcl
Antidepressant	Escitalopram	Antipsychotic	Mesoridazine Besylate
Antidepressant	Escitalopram Oxalate	Antipsychotic	Methotrimeprazine Hcl
Antidepressant	Fluoxetine Hcl	Antipsychotic	Methotrimeprazine Maleate
Antidepressant	Fluvoxamine Maleate	Antipsychotic	Olanzapine
Antidepressant	Imipramine Hcl	Antipsychotic	Paliperidone
Antidepressant	Isocarboxazid	Antipsychotic	Paliperidone Palmitate
Antidepressant	Levomilnacipran Hcl	Antipsychotic	Periciazine
Antidepressant	Maprotiline Hcl	Antipsychotic	Perphenazine
Antidepressant	Mirtazapine	Antipsychotic	Pimozide
Antidepressant	Moclobemide	Antipsychotic	Piperacetazine
Antidepressant	Naltrexone Hcl/Bupropion Hcl	Antipsychotic	Pipotiazine Palmitate
Antidepressant	Nefazodone Hcl	Antipsychotic	Prochlorperazine
Antidepressant	Nortriptyline Hcl	Antipsychotic	Prochlorperazine Maleate
Antidepressant	Paroxetine Hcl	Antipsychotic	Prochlorperazine Mesylate
Antidepressant	Phenelzine Sulfate	Antipsychotic	Promazine Hcl
Antidepressant	Protriptyline Hcl	Antipsychotic	Quetiapine Fumarate
Antidepressant	Sertraline Hcl	Antipsychotic	Remoxipride Hcl
Antidepressant	Tranlycypromine Sulfate	Antipsychotic	Risperidone
Antidepressant	Trazodone Hcl	Antipsychotic	Risperidone Microspheres
Antidepressant	Trimipramine Maleate	Antipsychotic	Thiethylperazine Maleate
Antidepressant	Unknown Generic Drug*	Antipsychotic	Thiopropazate Hcl
Antidepressant	Venlafaxine Hcl	Antipsychotic	Thiopropazine Mesylate

Antidepressant	Vilazodone Hcl	Antipsychotic	Thioridazine Hcl
Antidepressant	Vortioxetine Hydrobromide	Antipsychotic	Thiothixene
Antiepileptic	Acetazolamide	Antipsychotic	Trifluoperazine Hcl
Antiepileptic	Acetazolamide Sodium	Antipsychotic	Unknown Generic Drug*
Antiepileptic	Brivaracetam	Antipsychotic	Ziprasidone Hcl
Antiepileptic	Cannabidiol (Cbd)	Antipsychotic	Zuclopenthixol Acetate
Antiepileptic	Carbamazepine	Antipsychotic	Zuclopenthixol Decanoate
Antiepileptic	Cenobamate	Antipsychotic	Zuclopenthixol Hcl
Antiepileptic	Diazepam	Benzodiazepine	Alprazolam
Antiepileptic	Divalproex Sodium	Benzodiazepine	Bromazepam
Antiepileptic	Eslicarbazepine Acetate	Benzodiazepine	Chlordiazepoxide Hcl
Antiepileptic	Ethosuximide	Benzodiazepine	Chlordiazepoxide/Clidinium Br
Antiepileptic	Fosphenytoin Sodium	Benzodiazepine	Clobazam
Antiepileptic	Gabapentin	Benzodiazepine	Clonazepam
Antiepileptic	Lacosamide	Benzodiazepine	Clorazepate Dipotassium
Antiepileptic	Lamotrigine	Benzodiazepine	Diazepam
Antiepileptic	Levetiracetam	Benzodiazepine	Diazepam (In Soybean Oil)
Antiepileptic	Mephenytoin	Benzodiazepine	Estazolam
Antiepileptic	Oxcarbazepine	Benzodiazepine	Eszopiclone
Antiepileptic	Paraldehyde	Benzodiazepine	Flurazepam Hcl
Antiepileptic	Perampanel	Benzodiazepine	Ketazolam
Antiepileptic	Phenobarbital	Benzodiazepine	Lorazepam
Antiepileptic	Phenobarbital Sodium	Benzodiazepine	Midazolam Hcl
Antiepileptic	Phenytoin	Benzodiazepine	Midazolam Hcl In 0.9 % Nacl/Pf
Antiepileptic	Phenytoin Sodium	Benzodiazepine	Midazolam Hcl/Pf
Antiepileptic	Phenytoin Sodium Extended	Benzodiazepine	Nitrazepam
Antiepileptic	Phenytoin Sodium/Phenobarbital	Benzodiazepine	Oxazepam
Antiepileptic	Phenytoin/Mephobarbital	Benzodiazepine	Temazepam
Antiepileptic	Phenytoin/Phenobarb/Methamphet	Benzodiazepine	Triazolam
Antiepileptic	Pregabalin	Benzodiazepine	Unknown Generic Drug*
Antiepileptic	Primidone	Benzodiazepine	Zaleplon
Antiepileptic	Stiripentol	Benzodiazepine	Zolpidem Tartrate
Antiepileptic	Topiramate	Benzodiazepine	Zopiclone
Antiepileptic	Unknown Generic Drug*	Stimulant	Amphetamine Sulfate
Antiepileptic	Valproic Acid	Stimulant	Cocaine Hcl
Antiepileptic	Valproic Acid (As Sodium Salt)	Stimulant	Dexmethylphenidate Hcl

Antiepileptic	Vigabatrin	Stimulant	Dextroamphetamine Sulfate
Antipsychotic	Aripiprazole	Stimulant	Dextroamphetamine/Amphetamine
Antipsychotic	Asenapine Maleate	Stimulant	Diethylpropion Hcl
Antipsychotic	Brexiprazole	Stimulant	Lisdexamfetamine Dimesylate
Antipsychotic	Cariprazine Hcl	Stimulant	Mephentermine Sulfate
Antipsychotic	Chlorpromazine Hcl	Stimulant	Methylphenidate Hcl
Antipsychotic	Chlorprothixene	Stimulant	Modafinil
Antipsychotic	Clozapine	Stimulant	Phentermine Hcl
Antipsychotic	Droperidol	Stimulant	Phentermine Resin
Antipsychotic	Fentanyl Citrate/Droperidol	Stimulant	Pitolisant Hcl
Antipsychotic	Flupentixol Decanoate	Stimulant	Solriamfetol Hcl
Antipsychotic	Flupentixol Di-Hcl	Stimulant	Unknown Generic Drug*

*Full list of DIN/PIN available on request

APPENDIX 3: DATA SOURCES

Multiple data sources were used for this review. A full description of each data source can be found below.

BCCS Data – Includes all suspected and confirmed deaths by suicide in B.C. where the decedent was either a youth (under 19 years of age) or aged between 19-25 at the time of their death. Data includes dates of injury and death, age, biological sex, and Indigeneity of the decedent, and the place of injury and death.

BCCS Protocol Data – A set of questions completed by the investigating coroner to provide more insight into the decedent and the circumstances surrounding the death.

Chronic Disease Registry – Chronic disease registries are derived from administrative data sources maintained by the B.C. Ministry of Health. There are 26 conditions with registries and registries include data up to 2020/21 fiscal year. People on the registries are not identified by clinical diagnoses but through their healthcare service utilization matching specific case definitions for each condition. Case definitions for each registry can be found at: <http://www.bccdc.ca/health-professionals/data-reports/chronic-disease-dashboard>. Heat-related deaths were linked to the chronic disease registry by the BC Ministry of Health.

Medical Services Plan (MSP) – MSP data includes all medically necessary services provided by fee-for-service practitioners, including laboratory and diagnostic procedures, to individuals covered by the MSP, B.C.'s universal insurance program. Practitioners include physicians, supplementary benefit practitioners, and out-of-province practitioners. Heat-related deaths were linked to MSP data by the B.C. Ministry of Health.

Discharge Abstract Database (DAD) – All Canadian hospitals (except those in Quebec) submit their separations records directly to the Canadian Institute of Health Information (CIHI) for inclusion in the Discharge Abstract Database (DAD). The database contains demographic, administrative and clinical data for hospital discharges (inpatient acute, chronic, rehabilitation) and day surgeries. A provincial data set, including various CIHI value-added elements (such as case mix groups, and resource intensity weights) is released on a monthly basis to the respective Ministries of Health.

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