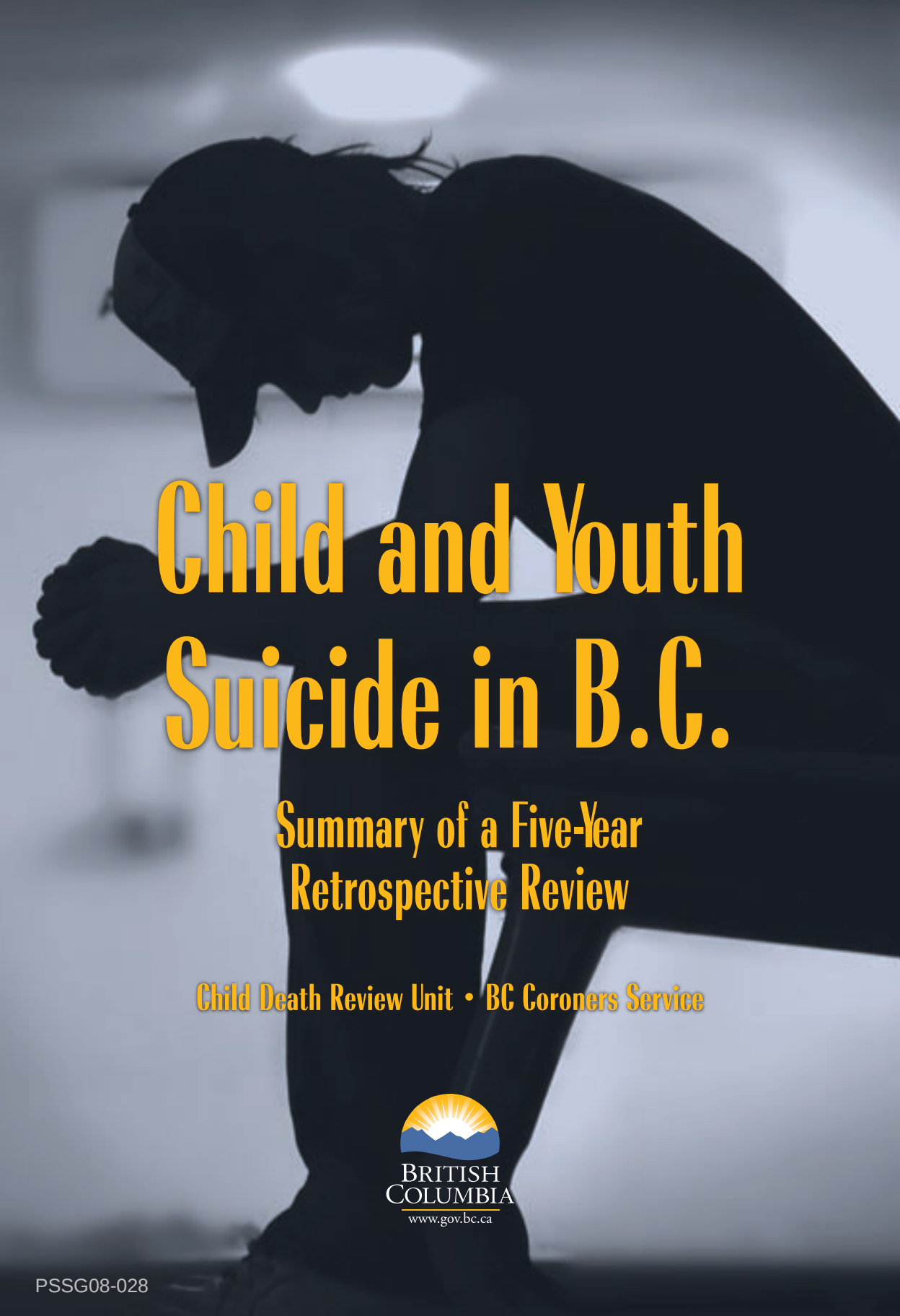

Child and Youth Suicide in B.C.

Summary of a Five-Year Retrospective Review

Child Death Review Unit • BC Coroners Service

BRITISH COLUMBIA
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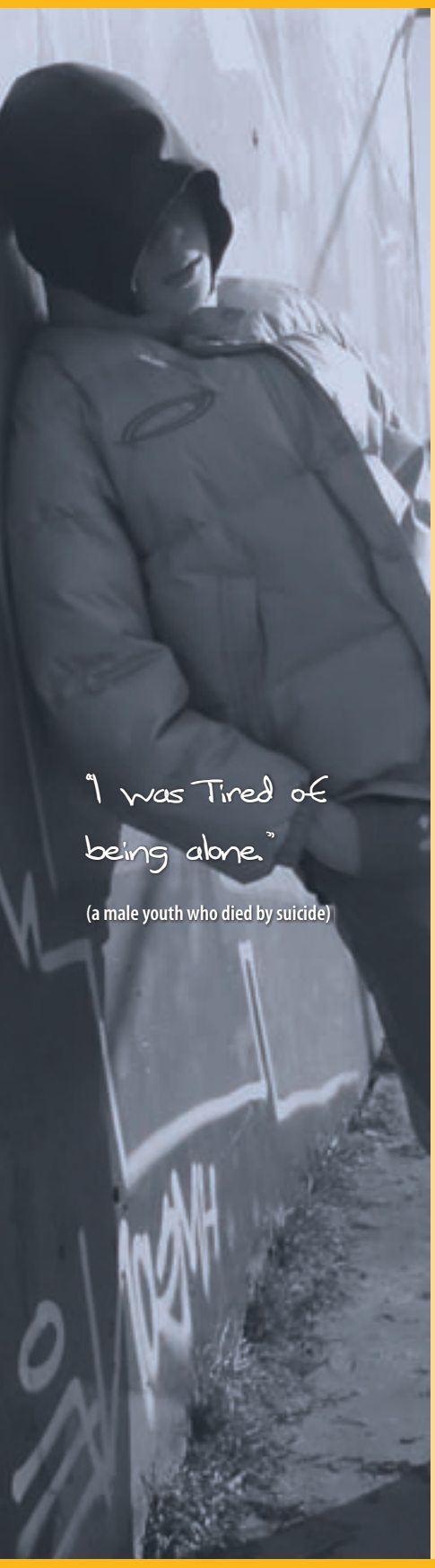


The Child Death Review Unit of the Coroners Service of British Columbia reviews all child deaths in the province. This includes children and youth under the age of 19 who die unexpectedly or through natural disease processes.

A five-year retrospective review

Suicide is the second most common cause of death for B.C. children and youth aged 12 to 18, after motor vehicle incidents. The majority of these deaths are preventable.

Because of both the high number of child and youth suicides and the high degree of preventability, the Child Death Review Unit has produced a special report on child and youth suicide, *"Looking for Something to Look Forward To. . .": A Five-Year Retrospective Review of Child and Youth Suicide in B.C.*

To produce the report, we studied the 81 cases of children and youth who died by suicide in B.C. between January 1, 2003, and December 31, 2007. Of the 81 files, we focused on the 66 closed files – those in which the coroner had completed the investigation – getting more information where possible, and inviting families to tell us about their children. (Our review of the 15 remaining files, which were open – still under investigation – was limited to taking basic information from the coroner's preliminary report.)

Our goal was to find out:

- who the children and youth were and how they died
- what risk factors were present in their lives
- what types of services they received

- which risk profiles identified in the research literature fit the children and youth, and whether any others emerged
- what these children and youth teach us about preventing future suicide deaths.

The findings were presented to a child death review panel composed of survivors and experts, who were asked to provide recommendations aimed at preventing future deaths of children and youth by suicide.

This is a brief summary of what we learned and the panel's recommendations.

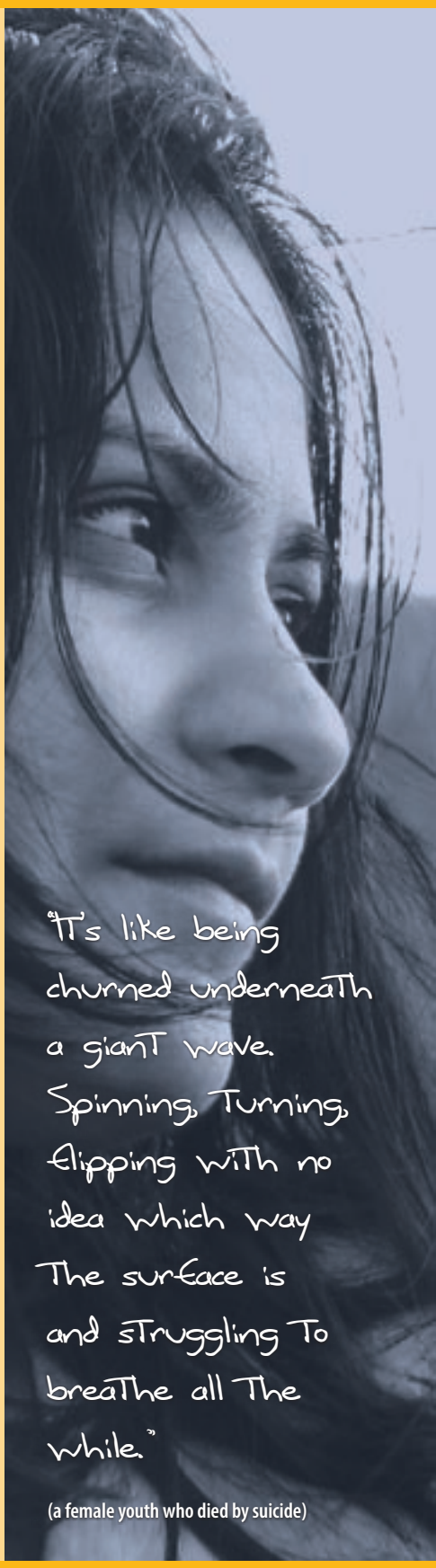
What we learned from the children and youth

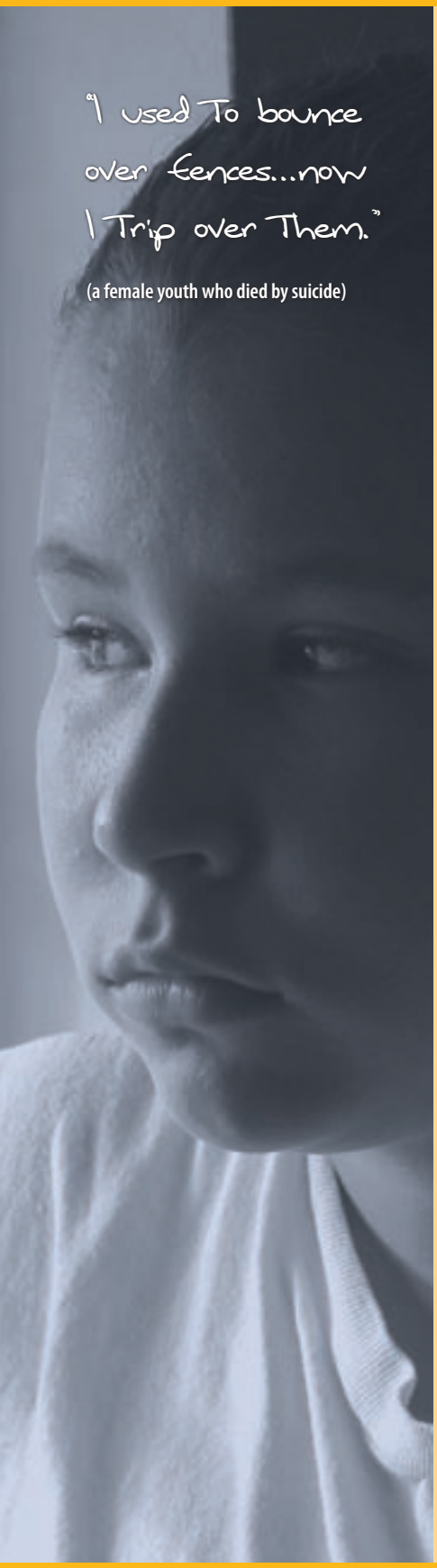
Which children and youth were most at risk for suicide?

- Older youth (17–18-year-olds)
- Males
- Aboriginal children and youth
- Gay, lesbian and bisexual children and youth, and those who were questioning their sexuality

What factors increased the risk of suicide?

- **A history of suicidal behaviour** – More than two-thirds (70%) of the children and youth had exhibited suicidal behaviour (including non-fatal attempts, ideation and threats) before they died. More than a third (38%) had previously attempted suicide, and almost a fifth (18%) had attempted suicide multiple times.





- **A history of illicit drug and/or alcohol use** – Almost two-thirds (61%) of the children and youth had used substances such as alcohol and illicit drugs, and almost a quarter (22%) had been chronic and/or heavy substance users.
- **School challenges** – Half of the children and youth had experienced school challenges, such as learning difficulties and disabilities, chronic absenteeism, dropping out, recent changes in school behaviour, recent disciplinary action, and bullying.
- **Mental health problems** – Almost half (45%) of the children and youth had been diagnosed with a mental or behavioural disorder or noted by a medical or mental health professional as having the signs and symptoms of a disorder. Depressive symptoms were experienced most frequently.
- **Exposure to suicidal behaviour** – Close to half (42%) of the children and youth had been exposed to suicidal behaviour through a family member or peer during their lifetime.
- **Family dysfunction** – Close to half (41%) of the children and youth experienced abuse, neglect, familial substance use and mental health problems and/or were exposed to domestic violence.
- **Poverty** – A fifth (20%) of the children and youth had experienced poverty in their lives, including lack of food or other basic necessities, reliance on government agencies for financial support, homelessness, overcrowding, and recent loss of employment or other source of income.

- **Violent behaviour** – Nearly a quarter (24%) of the children and youth were known to have been violent towards others.

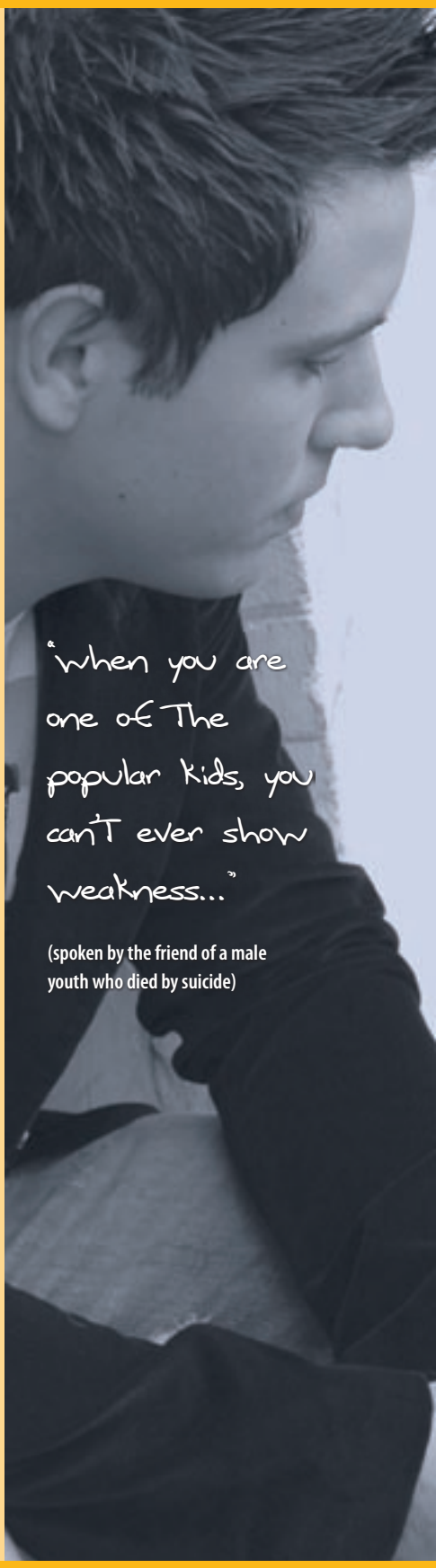
What factors created a crisis that may have brought about the suicide?

- **An acute stressful event** – Two-thirds of the children and youth experienced an acute stressful event before they died, in most cases an argument with a family member or romantic partner or the breakup of a relationship. In the majority of cases the event occurred within 24 hours of death.
- **The use of substances around the time of death** – Almost a fifth (17%) of the children and youth had used substances around the time of their death, in most cases alcohol. (The actual number may be higher, however, as substance use around the time of death could not be confirmed in almost half [44%] of cases where toxicology tests were not performed.)

Who had the children and youth reached out to?

Two-thirds (67%) of the children and youth had spoken with someone about their thoughts of suicide. They had reached out to:

- parents
- siblings and cousins
- friends
- family doctors
- teachers
- school counsellors
- social workers



(spoken by the friend of a male youth who died by suicide)

- child and youth mental health workers
- alcohol and drug counsellors.

What services did the children and youth receive in the year before they died?

- **Medical services** – Nearly half (48%) of the children and youth had been in contact with a medical professional, the majority as a result of a mental health problem or suicidal behaviour.
- **Child and Youth Mental Health services** – A fifth (20%) of the children and youth had received services from Child and Youth Mental Health.
- **School services** – Almost a fifth (17%) of the children and youth had come to the attention of school staff as a result of a mental health problem or suicidal behaviour.
- **Child and family services** – Three of the 66 children and youth (4%) were in the care of the Ministry of Children and Family Development at the time of their death. Almost a fifth (17%) of the children and youth had received services through the ministry's child and family services.
- **Youth Justice services** – Seven children and youth (11%) had received services from Youth Justice as part of a probation order. In most cases the child or youth was under a probation order as a result of physical assault charges.
- **Delegated Aboriginal agency services** – One youth had received family support services through a delegated Aboriginal agency.
- **Other community services** – Eight children and youth (12%) had received other types of services, including alcohol and drug counselling and private counselling.

How did the children and youth die?

- Hanging was the most common method of suicide, followed by gunshot and jumping from a height.
- Most suicide deaths occurred in the child or youth's home.

The panel's recommendations and advice

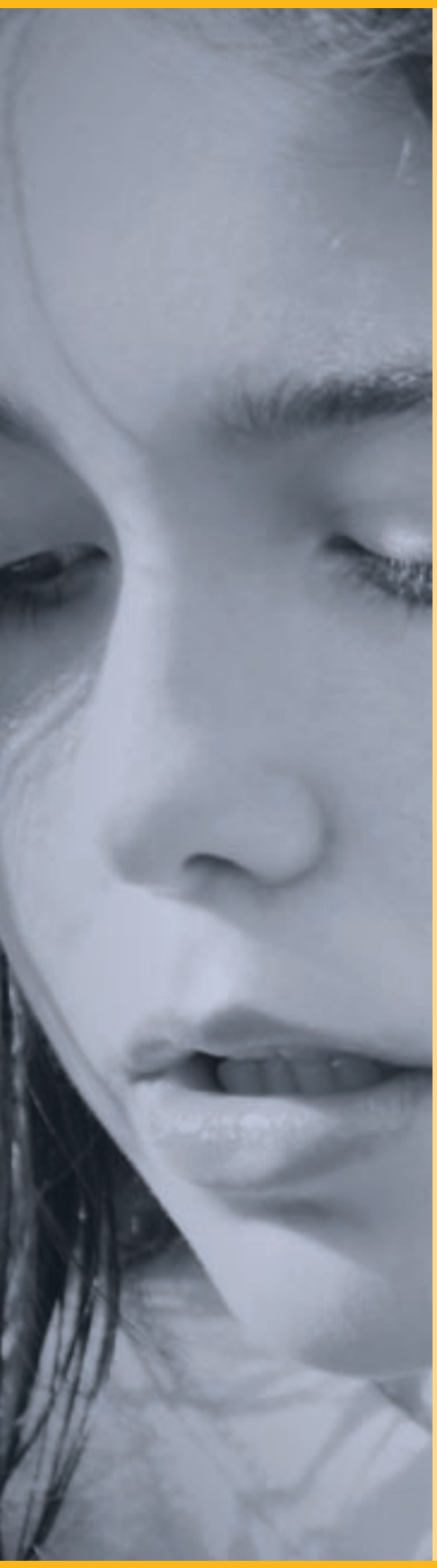
The child death review panel established by the Chief Coroner met in October 2008 to look at the findings of the review and to make recommendations and provide advice aimed at preventing future child and youth suicide deaths.

The panel's recommendations reflect a continuum of prevention that includes mental health promotion, early intervention and detection, clinical intervention and "postvention" (interventions that take place after a suicide occurs in a community).

The panel also provided overarching advice about general practice that should be considered when implementing the recommendations. The panel advised that successful initiatives would need to be:

- collaborative
- youth- and family-centred
- culturally safe
- multi-level, and
- informed by current knowledge.

The complete recommendations and more detailed information about the advice can be found in the full report.



Want more information?

The full report, *"Looking for Something to Look Forward To...": A Five-Year Retrospective Review of Child and Youth Suicide in B.C.*, is available at **http://www.pssg.gov.bc.ca/coroners/child-death-review/index.htm#two.**

For a paper copy of the full report, please contact the BC Coroners Service:

Phone: 604-660-7745

Fax: 604-660-2640

Email: BC.CorSer@gov.bc.ca

Mail: 800–4720 Kingsway
Burnaby, BC V5H 4N2

If you are feeling depressed, distressed or suicidal…

If you or someone you care about is feeling distressed, depressed or suicidal, don't wait – **get help now.**

To talk to someone about your feelings any day, any time, call the **BC Crisis Centre's 24/7 Distress Line**. This is a confidential, non-judgmental and free service.

Distress Line Numbers

Greater Vancouver: 604-872-3311

Toll Free (Howe Sound and Sunshine Coast): 1-866-661-3311

Toll Free (B.C.-wide): 1-800-SUICIDE (784-2433)

TTY: 1-866-872-0113

To email, chat with someone online, or get more information on suicide and mental health issues, please go to the **Youth in BC** website: **http://youthinbc.com.**