BC Coroners Service Child Death Review Panel: A Review of Child and Youth Suicides 2008-2012

REPORT TO THE CHIEF CORONER OF BRITISH COLUMBIA

September 2013

PREFACE

On April 22, 2013, the British Columbia Coroners Service (BCCS) held a child death review panel focused on child and youth suicide.

It is important to firstly acknowledge the 91 children and youth whose lives were lost to suicide. These young people were sons and daughters; brothers and sisters; nephews and nieces; grandchildren; friends; and members of our communities. The review of their unique lives and tragic loss served to help the panel members consider what could be done to prevent future deaths by suicide.

Support for the panel was provided by the staff of the BCCS Child Death Review Unit (CDRU). Adele Lambert and Holli Ward compiled the aggregate case reviews and a review of the research and statistics which formed the basis of the panel discussions.

I would like to thank the following people who participated on the panel for their dedication and commitment to the health and well-being of B.C.'s children and youth. In addition to their individual expertise they also brought the support of their respective organizations. Their thoughtful contributions generated meaningful and action oriented recommendations.

• Dr. Evan Adams	*Office of the Provincial Health Officer*
• Julie Adams	*Ministry of Health*
• Dr. Kelly Barnard	BC Coroners Service
• Michelle DeGroot (On behalf of Marilyn Ota)	*First Nations Health Authority*
• Brendan Fitzpatrick	*Royal Canadian Mounted Police (R.C.M.P.)*
• Shelley Green	*Principals and Vice Principals Association*
• John Greschner	*BC Representative for Children and Youth*
• Dr. Jean Hlady	*BC Children's Hospital*
• Jennifer McCrea (On behalf of Sherri Mohoruk)	*Ministry of Education*
• Dr. Shannon McDonald	*Ministry of Health*
• Dr. Ian Pike	*BC Injury Research and Prevention Unit*
• Dr. Elizabeth Saewyc	*School of Nursing, University of British Columbia*
• Alex Scheiber	*Ministry of Children and Family Development*
• Dr. Jim Thorsteinson	*BC College of Family Physicians*
• Dr. Jennifer White	*School of Child and Youth Care University of Victoria*

On behalf of the panel, I submit this report and recommendations around child and youth suicide intervention to the Chief Coroner of B.C. for consideration.

Michael Egilson
Chair, Child Death Review Panel

EXECUTIVE SUMMARY

The death of a child or youth by suicide is tragic and devastating to family, friends and the community. In any given year between 2008 and 2012, there were approximately 450,000 young people in B.C. between the ages of 10 and 18[1] years. Within this population there were approximately 120[2] deaths per year; on average 18[3] of these were the result of suicide.

A child death review panel was appointed under the *Coroners Act* to review and analyse the facts and circumstances of child and youth deaths by suicide and to provide the Chief Coroner with advice supporting the prevention of future child and youth suicides.

The panel reviewed in aggregate, 91 B.C. Coroners Service (BCCS) cases of child and youth suicide that occurred between 2008 and 2012. A review of the research literature and both national and international statistics about child and youth suicide were also part of the panel process. The panel was comprised of professionals with expertise in First Nations child and youth welfare, injury prevention, health care, mental health, law enforcement, education, advocacy and child welfare. Child and youth suicide remains a complex phenomenon which makes predicting individual deaths by suicide very difficult.

It is apparent that effectiveness, timeliness and appropriate matching of services to the unique needs of individual children and youth are imperative to addressing suicide risk in young people. The panel identified the following key areas as requiring immediate action for children and youth identified as being at risk for suicide: coordination of service providers, access to services, and child and youth engagement. Additionally, the panel identified areas where the BCCS could further support prevention efforts. These areas form the basis for three recommendations put forth to the Chief Coroner for consideration:

Recommendation 1: Service coordination

School districts continue to bring together key community partners involved in serving youth and families to develop community level risk assessment protocols in support of early intervention and prevention of harmful behaviours, including appropriate information sharing among agencies and proactive follow-up with young people and their families.

B.C. provincial government and school districts continue to ensure local front line staff are provided with education on supporting the mental health and well being of children and youth.

Recommendation 2: Access to child and youth mental health services

As part of its child and youth mental health services review and partnership with Ministry of Health (MoH) and Health Authorities, the Ministry of Children and Family Development (MCFD):

[1] BC Stats
[2] BC Coroners Service
[3] BC Coroners Service

- Map MCFD and contracted agency mental health services and service levels across the province and make the information easily accessible and publicly available;
- Identify and address barriers to accessing mental health services, including the perspective of what young people identify as barriers to services;
- Identify and address barriers to transitioning between community mental health and acute hospital services; and
- Identify and address barriers to transitioning from child and youth to adult mental health services.

Recommendation 3: BC Coroners service practice

The BCCS further contributes to the knowledge base of children and youth suicide by:

- Proactively providing child death coroners reports, when deemed appropriate, to stakeholders for educational purposes;
- On a trial basis, requesting toxicological analysis and Pharmanet records for all child and youth suicides;
- Reviewing investigative questions with respect to a young person's sexual orientation to ensure the information is being gathered consistently;
- Reviewing investigative questions with respect to bullying to see if additional light can be shed on this issue;
- Ensuring a young person's use of social media is investigated as an information source for all child and youth suicides.

These recommendations are intended to contribute to the prevention of child and youth suicide in B.C. and this report is intended to be part of a continuing dialogue on child and youth suicide. The BCCS will be holding a series of focus groups with young people across B.C. starting in Fall 2013 to explore the topic of suicide from their perspective, including ideas to make access and engagement with intervention activities easier.

The BCCS acknowledges that child and youth suicide is an ongoing and important concern for young people, their families and all British Columbians. Understanding what can be done to prevent it and supporting interventions remains an ongoing commitment.

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PART 1: INTRODUCTION[4]

Although tragic and devastating to families, friends and communities, children's deaths in B.C. are a relatively rare event. In any given year between 2008 and 2012 there were approximately 450,000 young people in B.C. between the ages of 10 and 18[5] and an average of 120 deaths per year[6]. Most of those deaths were the result of accidental injuries and on average, 18 were the result of suicide[7].

To better understand **child** and **youth suicide** and explore prevention opportunities, the B.C. Coroners Service (BCCS) convened a death review panel to examine this issue. The death review panel reviewed in aggregate, 91 BCCS cases of children and youth who died by suicide between 2008 and 2012 and the research literature and statistics in relation to child and youth suicide. Following this review, panel members shared their perspective based on their field of expertise and collectively identified tangible actions focused on preventing similar deaths from occurring in the future.

THE DEATH REVIEW PANEL

A death review panel is mandated[8] to review and analyse the facts and circumstances of deaths to provide the Chief Coroner with advice on medical, legal, social welfare and other matters concerning public health and safety, and the prevention of deaths. A death review panel can review one or more cases before, during or after a coroner's investigation, an inquest or a review by the BCCS Child Death Review Unit (CDRU) and regardless of any decision made by a coroner or member of the CDRU.

The Chief Coroner established a child death review panel to meet on specific occasions throughout the year to provide recommendations on the prevention of child and youth deaths. The Chair of the CDRU was appointed chair of the child death review panel whose membership includes: a child death coroner, a CDRU coroner and professionals with expertise relating to children and youth including: First Nations child and youth welfare, injury prevention, health care, mental health, law enforcement, education, advocacy and child welfare. In the course of reviewing child and youth suicides that occurred between 2008 and 2012, the panel reviewed:

- BCCS investigative findings;
- Academic and research literature;
- Information provided by panel members;
- Environmental, social and medical factors associated with the deaths;
- Possible patterns, trends or themes;
- The current state of related public policy, programs and available services; and
- Existing challenges.

[4] Key terms appearing in **bold face** are defined in the glossary located at the end of the report
[5] BC Stats
[6] BCCS
[7] BCCS
[8] Under the *Coroners Act*

LIMITATIONS AND CONFIDENTIALITY

The number of children and youth who died by suicide between 2008 and 2012 is relatively small and this presents challenges in accurately analyzing and reporting information while protecting privacy and data accuracy. 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 about the children and youth who died by suicide between 2008 and 2012 are presented in **aggregate** form. The BCCS is sensitive to the privacy of the children, youth and families that we serve and proceeds with caution when reporting case review findings. In general, statistical results are based on a small number of cases and should be interpreted with caution given the potential for random variation.

PART 2: REVIEW OF THE 2008 BC CORONERS CHILD DEATH REVIEW UNIT REPORT ON CHILD AND YOUTH SUICIDE

In 2008, the CDRU completed an aggregate review of 81 child and youth suicides occurring between 2003 and 2007. A child death review panel was convened and recommendations aimed at prevention of child and youth suicide were put forward to the Chief Coroner. The CDRU publicly released the findings of the review and the recommendations in the 2008 report "*Looking for Something to Look Forward To...": A Five Year Retrospective Review of Child and Youth Suicide in B.C.*

Since the release of this 2008 report, other reports, initiatives, plans and strategies contributing to the prevention and intervention of child and youth suicide have followed. Examples[9] include:

- 2009: *Strengthening the Safety Net: A Report on the Suicide Prevention, Intervention and Postvention Initiative for B.C.* (PIP Initiative) (Joshi, Damstrom-Albach, Ross and Hummel, 2009). The PIP Initiative was co-funded by Ministry of Children and Family Development (MCFD), B.C. Mental Health and Addictions Services and the Fraser Health Authority. This initiative offers a conceptual framework and planning template using a community development approach to address suicide across the lifespan. It does not currently receive funding; however, some communities and regional health authorities have implemented activities using the PIP Initiative as a foundation.

- 2010: the B.C. Provincial Government released the 10 year plan *Healthy Minds, Healthy People: A 10 Year Plan to Address Mental Health and Substance Use in British Columbia.* The plan establishes a vision for collaborative and integrated actions focused on opportunities to promote positive mental health, and to prevent mental health and substance use problems before they occur. The plan includes an action statement specific to training programs for suicide prevention and intervention across the lifespan (including children and youth), and several action statements intended to enhance the capacity and quality of the health system's response to mental health and substance use problems in B.C..

- 2011: The B.C. First Nations and Aboriginal Mental Wellness and Substance Use Strategy Council was established to oversee the development of an approach to support community-driven, nation-based solutions to address mental health wellness and substance use. The council is comprised of the tripartite partners including the First Nations Health Authority, the Province of B.C. and the Government of Canada. In 2013, the council released *A Path Forward, B.C. First Nations and Aboriginal People's Mental Wellness and Substance Use-A Ten Year Plan.*

- 2012: the B.C. Representative for Children and Youth (RCY) released *Trauma, Turmoil and Tragedy: Understanding the Needs of Children and Youth at Risk of Suicide and Self-Harm.* This report presented an aggregate review and analysis of suicide and self-

[9] Links to these reports, initiatives, plans and strategies are provided at the end of the report.

harm incidents reported to the RCY between June 2007 and May 2010. Recommendations were forwarded to the provincial government to address trauma informed services for children in care. Following this report, the RCY released its 2013 report *Still Waiting: First Hand Experiences with Youth Mental Health Services in B.C.* Based on the findings in this report, a number of recommendations were forwarded to the provincial government around mental health services for children and youth.

- 2012: the Ministry of Education (MoE) launched the Expect, Respect and Safe Education (ERASE) Strategy which is a comprehensive prevention and intervention strategy designed to address bullying and harmful behaviours. A key component of the strategy is a province-wide training initiative for educators and community partners to address how to foster a safe, caring and inclusive school culture and complete a violence threat risk assessment. A key goal of the violence threat risk assessment training is that school communities and their partner agencies develop community protocols. These community protocols are critical to improving multi-agency collaboration and information sharing to enable early intervention in cases where students pose harm to themselves or others.

Evaluating the impact of these reports, initiatives, plans and strategies on reducing child and youth suicide presents a number of challenges including:

- The issue of child and youth suicide may be included as part of a broader focus on mental health;
- Implementation of plans or strategies may occur over a long period of time;
- The benefits from health promotion/illness prevention efforts are cumulative and may take time to be recognized;
- Evaluation of plans or strategies may focus on the implementation process as opposed to effects on suicide reduction; and
- Implementation of initiatives or recommendations may be dependent on the ability to secure resources and funding.

Despite these challenges, these reports, initiatives, plans and strategies represent the progress and contributions made from a number of different perspectives towards addressing child and youth suicide and child and youth safety and well-being more generally.

PART 3: CHILD AND YOUTH SUICIDE AND THE B.C. CONTEXT

The information presented in this section demonstrates that child and youth suicide is a complex phenomenon and because of that complexity it is very difficult to predict individual deaths by suicide. Specifically, the information in this section represents what arose from the panel's review of the demographics and circumstances of the 91 children and youth who died by suicide between 2008 and 2012[10] in conjunction with what is known about child and youth suicide from national and international statistical information and research literature findings over the last 10 years. Information about child and youth suicide rates and information about the means used by the children and youth who died by suicide in B.C. is initially presented and followed by information about the demographics of these children and youth and the variables that were identified as possibly influencing their suicide risk[11].

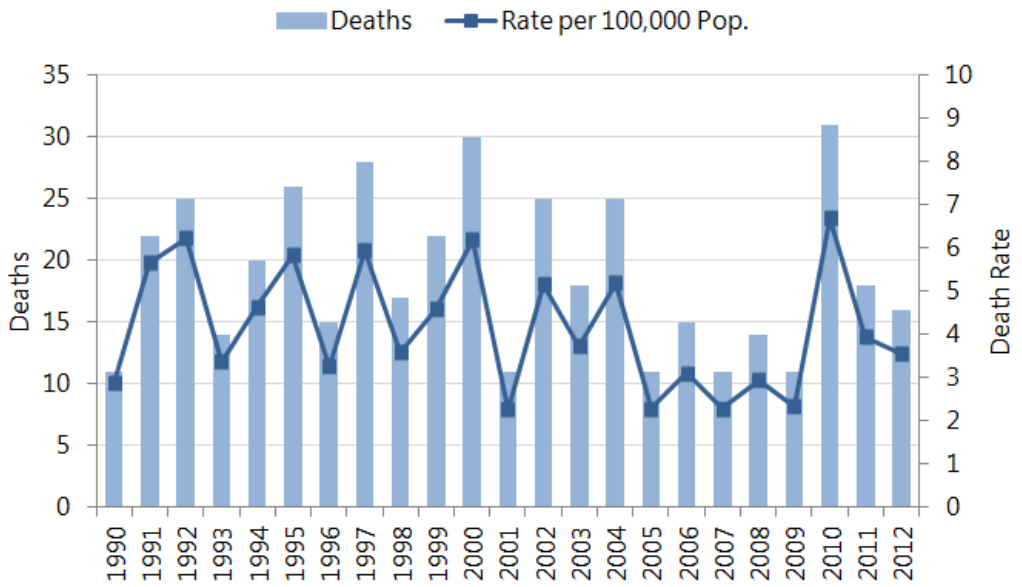
Related to the complexity of understanding why these children and youth died by suicide, it was noted that 35 (39%) of the children and youth left a suicide note. The content of these notes varied as some of the children and youth expressed either their intent to die or provided a rationale for their suicide; or in some cases, expressed both. Regardless of whether a note was left behind, 25 (27%) of the 91 suicides were completely unexpected by family, friends or those who knew the young person.

SUICIDE RATES

Suicide[12] is the second leading cause of death in B.C. youth between ages 15 to 18, preceded only by accidental motor vehicle incidents[13] and followed by homicides[14]. Expanding the age grouping to include all child and youth suicides between 10 to 18 year olds between 2008 and 2012, the suicide rate was 3.43 per 100,000. Looking over a 22 year period between 1990 and 2012, the chart below (see Figure 1) shows considerable historic variance with an average of 19 deaths by suicide each year in children and youth ages 10 to 18 years.

[10] Unless otherwise stated, all statistical information presented in this section refers to the aggregate review of the 91 children and youth who died by suicide between 2008 and 2012.
[11] The information in this section of the report is based on the panel review findings and is not intended to be an exhaustive list of possible variables related to elevating the risk of suicide.
[12] The rate of death is 7.1 per 100,000, 15 to 18 years of age, between 2008 and 2012.
[13] The rate of death is 9.6 per 100,000, 15 to18 years of age, between 2008 and 2012.
[14] The rate of death is 2.1 per 100,000, 15 to 18 years of age, between 2008 and 2012.

Figure 1



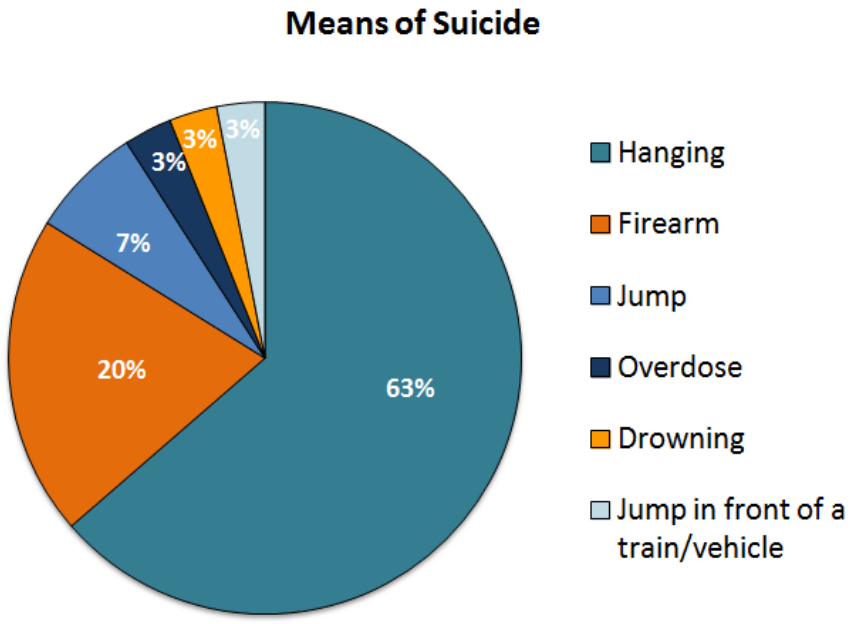
A direct comparison of the B.C. child and youth suicide rates to national or global suicide rates is difficult because of differences in the manner that statistics are presented, the source of the statistics and the years that information is released. Based on information provided by the provinces/territories between the years of 2008-2012, BC appears to have the second lowest rate among 10-18 year olds, preceded only marginally by Ontario.

On a national level, Canada has experienced a slight reduction in suicide rates among children and youth ages 10 to 19 over the past 30 years (Kirmayer, 2012) yet even with this reduction, suicide remains the second leading cause of death in children and youth ages 10-19 and the 9th leading cause of death in Canadians across all ages (Navaneelan, 2012). From a global perspective, suicide is the second leading cause of death in youth ages 15 to 19 years old (World Health Organization, 2012).

MEANS OF SUICIDE

Of the children and youth who died by suicide, hanging was the most common means followed by firearm use and jumping from a height (see Figure 2). In Canada, hanging is the most common means of suicide across all age groups (Navaneelan, 2012). When combined with other factors influencing suicidal behaviour, access to a means of suicide can increase risk of death by suicide.

Figure 2



AGE

The number of suicides increased with age. In B.C., 88 of the 91 deaths by suicide occurred between the ages of 14 and 18, with almost half of all youth suicides occurring between the ages of 17 and 18.

This increase of suicide with age is consistent with 2009 Canadian suicide mortality rates for children and youth that indicate 1.3 per 100,000 children and youth ages 10 to 14 years died by suicide compared to 9.0 per 100,000 youth between the ages of 15 to 19 (Navaneelan, 2012).

GENDER

Of the children and youth who died by suicide in B.C., 59 (65%) were male and 32 (35%) were female. This gender ratio difference has not significantly changed in B.C. over the past 10 years but appears to be closer than national and international ratios where approximately three-quarters of male children and youth to one quarter of female children and youth die by suicide (Organization for Economic and Cooperation Development, 2009).

SOCIAL MEDIA

In the last 5 years, the association between social media and suicide has emerged as a topic of interest. In B.C., 13 (14%) children and youth were known to have expressed either an intention to die by suicide or **suicidal ideation** through a social media forum prior to their suicide. In some cases, the children and youth had accessed material related to means of suicide. It is unknown if any of the children or youth accessed intervention material or online intervention support.

Social media is continuously expanding to include communication platforms such as: websites, chat rooms, video sites, social networking sites, electronic bulletin boards, e-mail and text messaging (Luxton, June and Fairall, 2012). Social media access and use by children and youth exposes them to material and behaviours they may not otherwise experience and it influences who they come into contact with and the way they socially engage with their peers and others. Social media can be an important source of information in helping to understand a young person's suicide.

POPULATION LEVEL ATTRIBUTES

The following groups of children and youth show an elevated risk for **suicidality**. The groups are not mutually exclusive and young people may identify with one or more of these groups.

ABORIGINAL CHILDREN AND YOUTH

Between 2008 and 2012, 18 **Aboriginal** children and youth died as the result of suicide; this is an average of approximately 4 Aboriginal child and youth suicide deaths per year. Compared to the non-Aboriginal child and youth population in B.C., the suicide rate for Aboriginal children and youth appears to be approximately two times higher based on the fact that 20% of the children and youth who died by suicide were Aboriginal and that Aboriginal students comprise only 10% of students between grades 7 to 12[15]. Of the Aboriginal children and youth who died by suicide between 2008 and 2012:

- 3 children and youth had involvement with the MCFD earlier in their lives;
- 11 children and youth were receiving services from MCFD at the time of their death;
- 5 children and youth were **children or youth in care** of an Aboriginal child welfare agency at the time of their death; and
- 4 children and youth were receiving services from an Aboriginal child welfare agency.

The Canadian suicide mortality rate among Aboriginal youths (ages 10 to 29) is estimated to be 5-6 times higher than youth in the general population (White, 2012). The difference in this Canadian rate compared to the approximate B.C. rate may be due partly to differences in the age range used. Additionally, there is remarkable variance in suicide rates across Aboriginal communities (White, 2012). Some Aboriginal communities experience higher rates of suicide whereas other communities may experience low rates or no suicides at all. These findings are similar to the experiences of other Indigenous populations located in the United States, Australia and New Zealand (Harder, Rash, Holyk, Jovel and Harder, 2012).

LESBIAN, GAY, BISEXUAL, TRANSGENDER, TWO SPIRIT AND QUEER (LGBTTQ) CHILDREN AND YOUTH

Youth who identify with a sexual orientation other than heterosexual appear to be at greater risk for attempting suicide compared to their heterosexual peers (Cash and Bridge, 2009; Spirito and Esposito-Smythers, 2006). Specific to B.C., a study exploring the prevalence, disparity and cohort trends in suicidality among bisexual youth compared to heterosexual and gay/lesbian peers[16] found that sexual minority youth experience higher rates of suicidal ideation and attempts (Saewyc, Skay, Hynds, Pettingell, Bearinger, Resnick and Reis, 2007).

[15] 2008 McCreary Centre Society Adolescent Health Survey

[16] This study was based on population based high school surveys.

Children and youth who complete suicide may have not expressed their sexual orientation making it difficult to determine an accurate suicide rate among the LGBTTQ population (White, 2012). Of the children and youth who died by suicide between 2008 and 2012, two (2%) were reported to be questioning their sexual orientation at the time of their death.

To accurately and systematically capture the sexual orientation of children or youth who die by suicide, coroners need to consistently inquire about it during the course of their investigation. This should include thoughtful and sensitive consideration on the types of questions asked, how they are asked and who the questions are directed towards.

CHILDREN AND YOUTH IN CARE

Seven (8%) of the children and youth who completed suicide were in care of either MCFD or an Aboriginal child welfare agency. Population based studies suggest that children and youth in care are at greater risk of suicide compared to their peers who are not in care (Katz, Singal, Brownell, Roos, Martens, Chateau, Enns, Kozyrskyj and Sareen, 2011).

HOMELESS OR RUNAWAY CHILDREN AND YOUTH

At the time of their death, 10 (11%) of the children and youth who died by suicide were living in a shelter or temporarily staying somewhere other than their primary residence. It is difficult to accurately identify children and youth within this population because the terms 'homeless' and 'runaway' are not clearly defined and the circumstances of the children and youth can change. Population based studies indicate that homeless or runaway children and youth experience a higher rate of suicide attempts compared to their peers who are not in these circumstances (Spirito and Esposito-Smythers, 2006).

YOUTH JUSTICE AND LAW ENFORCEMENT CONTACT

The B.C. youth justice system does not generally deal with children under the age of 12. Youth who have committed a criminal offence may receive youth justice services (ages 12 to 17) or adult services (age 18 into adulthood). Nine (10%) of the youth had come into contact with law enforcement[17] or were involved in either the youth or adult justice system within the year prior to their death.

In some cases, law enforcement contact or involvement in the justice system could be a factor associated with elevating the risk of suicide. Research literature generally focuses on youth who have been in custody setting and indicates this subset is approximately four times at greater risk to experience suicidal behaviour than the general child and youth population (Spirito and Esposito-Smythers, 2006). None of the youth who died by suicide had a history of being in either a youth or adult custody setting.

FACTORS ASSOCIATED IN ELEVATING INDIVIDUAL RISK FOR SUICIDE

It is difficult for us to understand why suicide occurs in young people and what would help us accurately predict or identify the risk of suicide. We do know that at a population level, we should focus on supporting the health and well-being of all young people with particular attention paid to the accessibility, timeliness and coordination of suicide intervention activities for young people who experience suicidal thoughts and behaviours.

[17] Law enforcement contact ranged from minor (i.e. a conversation) or infrequent contact to serious (i.e. pending charges) or frequent contact.

The factors presented here are associated with an elevated risk for suicide. These same factors are experienced by large numbers of children and youth and of that larger number it is only a very small percentage of children and youth who die as a result of suicide. These factors can fluctuate across time and may be experienced in various compounding combinations resulting in different levels of influence depending on the child or youth (White, 2012). Most of the 91 children and youth who died by suicide experienced more than one factor associated with elevated risk of suicide.

SUICIDAL BEHAVIOUR

Suicidal behaviour such as: prior suicide attempts, planning or rehearsal is identified as a significant factor related to elevating the risk of suicide (White, 2012; Gould, et.al, 2006). Fifty-one (57%) of the children and youth exhibited previous suicidal ideation and 37 (41%) of children and youth had attempted suicide on one or more previous occasions.

SUBSTANCE USE

Of the children and youth who died by suicide, 34 (38%) had either a history of problematic **psychoactive substance use** or were under the influence of a psychoactive substance at their time of death, with the most common substances used being alcohol and marijuana. Toxicological analysis can determine if ingestion of a psychoactive substance occurred shortly before the time of death and the decision to request the analysis is based on the investigation conducted by the coroner. A toxicological analysis was completed on 28 (31%) of the children and youth. Seventeen of these children and youth tested positive for psychoactive substances with four of the children and youth having lethal levels of a psychoactive substance(s) in their body.

Findings of the research literature review indicate that in the case of psychoactive substance use, when combined with other stressors such as a psychiatric disorder or legal or disciplinary crises, there is an association with death by suicide (Gould, Greenberg, Velting and Shaffer, 2006).

Prescribed medications called selective serotonin reuptake inhibitors (SSRIs) used to treat mental disorders related to depression and anxiety in children and youth carry warnings indicating a possible increased risk of suicidality. Research literature indicates there is no evidence that SSRI use *causes* suicide and concludes that these medications are effective in treating mental disorders that may place children and youth at greater risk for suicide (Gibbons, Brown, Hur, Marcus, Bhaumik, Erkens, Herings and Mann, 2007; Gibbons, Hendricks Brown, Hur, Davis, Mann, 2012; Soutullo and Figueroa-Quintana, 2013).

MENTAL DISORDERS

Suicide is strongly associated with mental disorders among children and youth. In particular, the prevalence of either one or more disorders associated with mood, substance use, anxiety, eating and conduct may elevate the risk for suicide (White, 2012; Gould, et.al, 2006). In our case reviews, 35 (39%) of the children and youth presented with one or more mental disorders and 51 (57%) either received mental health services at some point in their lives or were receiving services at the time of their death. Some children and youth were also involved with

services that supported access to mental health services such as a school counsellor, a community based suicide response team or police services.

STRESSFUL LIFE EVENTS

Twenty-seven (30%) of the children and youth experienced a recent conflict with a family member and 32 (36%) experienced a recent conflict with a romantic partner. Thirteen (14%) of the children and youth had a friend or family member attempt or complete suicide.

We need to be cautious in making inferences with respect to stressful life events as the information is not generally obtained from the deceased. The degree of stress associated with a life event depends on the person's interpretation of the event. Where one person experiences a high degree of stress as a result of a life event, another person may experience less or no stress when exposed to the same or a similar life event. A person's stress level may also fluctuate in the course of experiencing a life event. It is possible, depending on the person, that the stress experienced by a life event could elevate the risk of suicide (White, 2012). Examples of such events include but are not limited to (White, 2012):

- Interpersonal conflicts;
- Rejection, failure or loss; or
- Experiencing the loss of a friend or family member to suicide

BULLYING

Bullying was experienced by 12 (13%) of the children and youth who died by suicide and one youth was reported to have a history of engaging in bullying behaviour. Research conducted around the association of bullying to suicide continues to emerge, especially in the area of cyberbullying, and suggests bullying is a risk factor for suicidality (Hinduja and Patchin, 2010; Klomek, Sourander, Gould, 2010). This research has identified the importance of acknowledging that both the children and youth who bully *and* those who are victimized are at an elevated risk for suicidality (Hinduja and Patchin, 2010; Klomek, Sourander, Gould, 2010). Therefore, efforts to address bullying behaviour should focus on the children and youth who bully and those who are targets of bullying.

SCHOOL PERFORMANCE

Stressors in school have been associated with an elevated risk of suicide (Gould, et. al, 2006). The school settings attended by the children and youth who died by suicide varied, including: independent schools, homeschooling, alternate and public schools. Some of the youth who died by suicide had either applied to or were awaiting entry into a post secondary technical school, college or university.

Thirty-two of (36%) of the children and youth experienced stress related to school performance. Examples included: poor academic performance, experiencing pressure to exceed abilities or placing high scholarly expectations on themselves. The level of engagement the children and youth had with school personnel and activities was varied; some were well known to staff or actively participated in school activities while others were not as well known to staff or participated in activities on a limited basis or not at all.

FACTORS ASSOCIATED WITH REDUCING INDIVIDUAL EXPOSURE TO SUICIDE RISK

There are a number of factors associated with reducing exposure to suicide risk by helping to foster resilience in children and youth, promote community healing and strengthen practices to maintain the well being of an individual and community (White, 2012). Like those factors associated with elevated risk of suicide, these can fluctuate across time and be experienced in various combinations of one or more resulting in different levels of influence depending on the specific child or youth (White, 2012).

Examples of factors known to reduce exposure to suicide risk include but are not limited to (Cooper and Clements, 2011; Kalafat, 2006):

- Access to assistance with physical, mental health and addictions issues;
- Connectedness to family or a caring adult;
- Spiritual or religious practices/beliefs;
- Cultural connectedness;
- Connections and contributions to school and community; and
- Adaptive coping and problem solving capacity

Experiencing one or more of these factors can promote resilience in children and youth but these do not cancel out those factors associated with elevated risk of suicide (White, 2012). It is important to understand that the existence of resilience promoting factors lowers the risk of suicide but does not negate the risk and that the research is done at a population level and is not necessarily a predictor for individual children and youth.

Fifty-nine (65%) of the children and youth who died by suicide experienced one or more factors associated with reducing exposure to risk of suicide at the time of their death.

MEDIA REPORTING SUICIDES

Media reporting on a previous suicide was not identified as a contributing factor in any of the child and youth suicides in B.C.

The Canadian Psychiatric Association (CPA) suggests that media reporting of suicides is linked to copycat suicides among youth under 24 years of age. The CPA guidelines suggest education of the media; on hand expert opinion and readily available guidelines are a means to mitigating possible copycat suicides that may be influenced by media reports of a suicide (Nepon, Fotti, Katz, Sareen, and the Swampy Cree Suicide Prevention Team, 2009). Guidelines suggesting the media take a collaborative approach with health professionals and promoting responsible reporting of a suicide to minimize sensationalism or mental health stigma have been established by the Canadian Association for Suicide Prevention (Nepon, et.al, 2009). Media professionals are not obligated to use these guidelines and their degree of use or compliance is unknown.

Social media use makes access to media reports on suicides far reaching and has given media professionals the ability to directly canvass the public, including children and youth, for information they may have about an individual who died by suicide (Collings and Niederkrotenthaler, 2012). As research on the topic of social media is emerging and there is

limited knowledge around the association of the media's use of it to elevating the risk of suicide, a sensitive and respectful approach to investigating (i.e. consideration for who is being contacted and what questions are being asked) should be applied.

PART 4: INTERVENTION

Activities addressing the issue of suicide span the areas of prevention, intervention and postvention. Prevention activities target people on a community based level or individually to reduce factors associated with increased risk of suicide and promote factors associated with reducing risk of suicide (Joshi, et.al, 2009). As the ability to identify children and youth at risk of suicide or know the factors associated with their suicidality is not always possible, prevention activities often target mental health and well being on a broader scope than just suicide prevention.

Intervention activities refer to the measures taken to identify that a person is suicidal and the treatment or care provided to reduce their risk of suicide (Joshi, et.al, 2009). Postvention activities support people bereaved by a suicide (Joshi, et.al, 2009).

The primary focus of this report is on intervention activities because these are the most directly linked to preventing a death by suicide. The information learned about intervention activities from the cases of these children and youth gave panel members the opportunity to identify and understand the intervention activities used and consider how these could be improved to prevent future suicide deaths.

INTERVENTION ACTIVITIES

The variability in circumstances and needs among children and youth who are suicidal means that no one particular intervention can be applied to everyone. For example, Aboriginal children may benefit from integrating culturally specific healing practices (White, 2012). Intervention activities include but are not limited to (White, 2012; Joshi, et.al, 2009):

- Assessing suicide risk;
- Crisis response;
- Immediate and ongoing mental health treatment; and
- Means restriction.

For intervention activities to be effective, timely and appropriately matched to meet the needs of the child or youth, the following is required (White, 2012):

- Services need to be accessible. This can be challenging when a community is rural or remote;
- Policies and protocols need to be proactive to ensure service providers respond in a coordinated manner and that respective functions and responsibilities are clearly identified;
- Services need to consider local and cultural practices, traditions, knowledge and values; and
- Efforts to actively engage children and youth in intervention activities need to be made.

INTERVENTION ACTIVITIES IN B.C.

The child and youth services involved in suicide intervention activities are primarily funded by government and developed or delivered by either government or contracted service agencies including:

- First Nations Health Authority[18];
- Health Authorities[19];
- Ministry of Children and Family Development;
- Fee for service health professionals;
- Ministry of Health;
- Ministry of Education and School Districts; and
- Local community agencies.

Access to services by the children and youth who died by suicide varied across communities. For example, urban areas offer more services that can be accessed directly compared to rural or remote communities where there is limited choice in services and direct access is either intermittent or unavailable, resulting in a child or youth waiting or having to travel to another community for service. Other considerations include the suitability of services to ensure the type of service matches the needs of the child or youth, and continuity of care. Some examples include a child or youth who requires hospitalization and may not reside in a community with a hospital or a child or youth who experiences staff turnover when attending mental health services in the community. Identification of communities where gaps in service or high staff turnover are occurring could assist in prioritizing where intervention activities are needed and mitigating access as a barrier to receiving them.

In some cases, the child or youth who died by suicide received service from more than one provider. For example, they may have simultaneously received service from a family physician, school counsellor and mental health clinician. In cases where the children and youth received services from multiple agencies, the level of service provider coordination varied. Sometimes, service providers were unaware that other services were involved or in cases where service providers were aware, information about the child or youth was not always shared. For example, a school principal or counsellor may not have been notified that a child or youth attending school was discharged from the hospital following a suicide attempt. The coordination of service providers presents opportunity to ensure that relevant information is shared to assist and support the child or youth in accessing and engaging with suicide intervention activities.

The degree of engagement with services providing intervention activities by the children and youth who died by suicide varied. For example, some youth actively participated in a mental health plan while others intermittently participated or did not participate at all. In cases where a

[18] The First Nations Health Authority is scheduled to start providing services after October 1, 2013. Funding is primarily provided to First Nations communities through health centres, nursing stations or other agencies delegated to provide services to First Nations people.
[19] There are five regional health authorities: Northern, Interior, Vancouver Island, Vancouver Coastal, Fraser and one Provincial Health Services Authority.

child or youth stopped attending or complying with a service designed to provide intervention, service agency follow up to re-engage them varied. For example, if a child or youth missed an appointment, follow up may have been immediate, delayed or may not have occurred. To determine what actions can be taken to enhance the level of child and youth engagement in intervention activities, it would be beneficial to directly ask youth for their input and ideas. Also, having child and youth service providers consider their current level of engagement may assist in identifying areas of improvement and consider steps that can be made to mitigate engagement as barrier.

PART 5: RECOMMENDATIONS

The recommendations forwarded to the Chief Coroner arose from the death review panel discussion about efforts to prevent suicide through supporting the mental health and well-being of all B.C.'s children and youth. The multidisciplinary nature of the panel allowed panel members to share their experiences and perspectives to further understand child and youth suicide and identify opportunities that could make a considerable difference within a short period of time. Specifically, the panel identified that coordination among service providers, access to services, and child and youth engagement with services are key areas to target. Additionally the panel identified areas where the BCCS could further support prevention efforts.

The recommendations arising from the death review panel were developed in a manner that was:

- Collaborative;
- Attributable to the deaths being reviewed;
- Focused on identifying opportunities for improving public safety and prevention of deaths;
- Targeted to specific parties;
- Realistically and reasonably implementable; and
- Measurable.

Recommendation 1: Service coordination

The children and youth who died as a result of suicide did not fit an easily identifiable profile. Many had vulnerabilities that are also experienced by large numbers of other young people and a significant number of young people's suicides were completely unanticipated by family, friends or those who knew the young person. Nonetheless, the panel recognized that a number of these young people had been identified as suicidal and that some specific actions could be taken to help prevent similar deaths in the future.

Specifically, the panel agreed on the importance of:

- Sharing information timely and appropriately among service providers and supporting agencies;
- Proactive follow-up and engagement of young people and their families;
- Coordination amongst service providers.

The panel also recognized that interagency coordination requires a significant commitment and that building off of existing community coordinating structures was more practical and likely to succeed than establishing new ones throughout the province.

The B.C. provincial government introduced the ERASE Strategy in 2012 to address bullying and harmful behaviours in schools and their communities. The Ministry of Education (MoE) intends to establish a provincial advisory committee comprised of senior leaders from lead social ministries involving health, justice, child welfare and education, law enforcement, and service

agencies providing care to children and youth. The intent is to create a common understanding around appropriate sharing of information and develop guidelines for violence threat risk assessment community protocols for a number of issues related to the health, well-being and safety of children and youth, including suicide.

Recommendation:

School districts will continue to bring together key community partners involved in serving youth and families to develop community risk assessment protocols in support of early intervention and prevention of harmful behaviours. Key community partners should include but are not limited to:

- Ministry of Children and Family Development;
- Delegated Aboriginal Agencies;
- First Nations Health Authority[20];
- Health Authorities;
- School Districts;
- BC Association of Aboriginal Friendship Centres;
- Police; and
- Relevant local community agencies.

That school districts and local community partners develop and implement local, protocols to recognize and respond to children and youth exhibiting harmful behaviours, including suicidal ideation, which address appropriate information sharing among agencies and proactive follow-up with young people and their families.

Furthermore, the B.C. provincial government and school districts should continue to ensure the comprehensive ERASE training regime, which provides local front line staff with education on supporting mental health and wellbeing of children and youth, including information about suicide, is available to school district staff and community participants. The Level 3 ERASE training will encourage school staff and community agencies to map services currently available locally.

Recommendation 2: Access to child and youth mental health services

A key issue raised by the panel in terms of access to child and youth mental health services was a lack of understanding regarding the scope and location of these services across the province. It is essential to make entry in the mental health system as barrier free as possible for children and youth so that their needs are met in a timely manner and they receive appropriate care.

[20] The First Nations Health Authority is scheduled to start providing services after October 1, 2013. Funding is primarily provided to First Nations communities through health centres, nursing stations or other agencies delegated to provide services to First Nations people.

The Ministry of Children and Family Development (MCFD) is undergoing a review of child and youth mental health services including the issue of access. In addition, MCFD continues to work with Ministry of Health (MoH) and the Heath Authorities to improve transitions between community mental health and acute hospital services, and from child and youth to adult mental health services.

Recommendation:

That as part of its child and youth mental health services review and partnership with MoH and Health Authorities, MCFD:

- Map MCFD and contracted agency mental health services and service levels across the province and make the information easily accessible and publicly available;
- Identify and address barriers to accessing mental health services including the perspective of what young people identify as barriers to services;
- Identify and address barriers to transitioning between community mental health and acute hospital services; and
- Identify and address barriers to transitioning from child and youth to adult mental health services.

Recommendation 3: BC Coroners Service Practice

The child death review panel discussed how the work of the BCCS could better support child and youth suicide prevention work through contributing to the knowledge base and providing timely information.

Recommendation:

The BCCS further contribute to the knowledge base of child and youth suicide in B.C. by:

- Proactively providing child death coroners reports, when deemed appropriate, to stakeholders in child welfare, law enforcement, education, First Nations health and child welfare, injury prevention, mental health and advocacy for the purposes of informing, educating and improving upon what is known about child and youth suicide;
- For a trial period of at least two years, requesting toxicological analysis and Pharmanet records for all child and youth suicides;
- Reviewing investigative questions with respect to a young person's sexual orientation to ensure the information is being gathered consistently;
- Given public interest in the topic of bullying and suicide, reviewing investigative questions with respect to bullying to see if additional light can be shed on this issue;
- Ensuring a young person's use of social media is investigated as an information source for all child and youth suicides.

PART 6: NEXT STEPS

As noted earlier in this report, there is much we do not understand about child and youth suicide in terms of why it occurs and the most effective means of preventing it. This report puts forward recommendations that will contribute to the prevention of child and youth suicide in B.C. and the report is intended to be part of a continuing dialogue on child and youth suicide.

The BCCS will hold a series of focus groups with young people across B.C. starting in the fall of 2013. The purpose of this process will be to explore the topic of suicide from the perspective of young people, including ideas to make access and engagement with services easier. Focus group outcomes will be shared with death review panel members and posted on the BC Coroners Service website at: http://www.pssg.gov.bc.ca/coroners/

The BCCS acknowledges that child and youth suicide is an ongoing and important concern for young people, their families and all British Columbians. Understanding what can be done to prevent it and supporting interventions remains an ongoing commitment.

RESOURCE LINKS

The following links refer to the reports and programs mentioned or cited in this report and are intended to provide further information about child and youth suicide.

BC Coroners Service

"Looking for Something to Look Forward to": A Five-Year Retrospective Review of Child and Youth Suicide in B.C.

http://www.pssg.gov.bc.ca/coroners/child-death-review/docs/cdru-suicidereportfull.pdf

Suicide Prevention, Intervention and Postvention (PIP) Initiative

Strengthening the Safety Net: A Report on Suicide Prevention, Intervention and Postvention Initiative for B.C.

http://suicidepipinitiative.files.wordpress.com/2009/05/suicide-pip-initiative-full-report.pdf

Ministry of Health

Healthy Minds, Healthy People: A Ten-Year Plan to Address Mental Health and Substance Use in British Columbia

http://www.health.gov.bc.ca/library/publications/year/2010/healthy_minds_healthy_people.pdf

First Nations Health Council

A Path Forward, BC First Nations and Aboriginal People's Mental Wellness and Substance Use-A Ten Year Plan.

http://www.fnhc.ca/index.php/health_actions/mental_health_wellness/

Representative for Children and Youth

Trauma Turmoil and Tragedy: Understanding the Needs of Children and Youth At Risk of Suicide and Self Harm (2012)

http://www.rcybc.ca/Content/Publications/Reports.asp

Still Waiting: First-hand Experiences with Youth Mental Health Services in B.C. (2013)

http://www.rcybc.ca/Images/PDFs/Reports/RCY-CYMHreport-Apr2013.pdf

Ministry of Education

ERASE Bullying Strategy

http://www.erasebullying.ca/

Ministry of Children and Family Development

Preventing Youth Suicide: A Guide for Practitioners

http://www.mcf.gov.bc.ca/suicide_prevention/pdf/pys_practitioners_guide.pdf

GLOSSARY

Child: Individuals who are 12 years of age or under.

Youth: Individuals who are older than 12 years and under the age of 19 years.

Suicide: Death caused by self inflicted injury with intent to cause death.

Aggregate: Presentation of individual findings as a collective sum.

Suicidal Ideation: Thoughts of suicidal acts involving oneself.

Suicidality: Suicidal thinking, behaviours and actions, including death.

Aboriginal: Reference used to encompass First Nations (status and non-status), Metis and Inuit people in Canada.

Children or youth in care: A child or youth who is in the custody, care or guardianship of a person designated under the Child, Family and Community Service Act.

Psychoactive substance use: Use or misuse of drugs (both legal and illegal) and/or alcohol.

Bullying: Aggressive behaviour that is intentional on the part of one or more persons towards another person and occurs repeatedly (Olweus, 2013). It is a power imbalance and can involve direct physical behaviour (assault and theft), direct verbal (threats, insults), indirect relational (social exclusion, rumours) and cyber (Olweus, 2013; Klomek, Sourander, and Gould, 2010; Hinduja and Patchin, 2010). Cyberbullying uses electronic communication to bully through computers, cell phones and other electronic devices (Hinduja and Patchin, 2010).

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