“Looking for Something to Look Forward To…”

A Five-Year Retrospective Review of Child and Youth Suicide in B.C.

Child Death Review Unit, BC Coroners Service
Presentation to the Keeping Kids Alive Symposium
May 2009
Overview

1. Child Death Review in B.C.

2. A five-year retrospective review of child and youth suicide

3. What we learned

4. Moving forward with our findings
Child Death Review in B.C.
Child Death Review in B.C.

**Our Process**

Our review process is based on best practice in child death review from across North America and was developed with guidance from the National Center for Child Death Review in the United States.

The CDRU takes a public health approach to death review and prevention which includes:

- Defining the problem
- Identifying risk factors
- Reviewing best practice and opportunities for action in B.C.
- Issuing recommendations for prevention
- Evaluating our impact.
Child Death Review in B.C.

Case pathway from investigation to review

- Child death occurs
- Coroner completes investigation
- Case sent to CDRU
- Case reviewer completes initial examination
- Families contacted via letter
- Additional records seized and interviews completed
- CDRU review protocol is applied
- Cases are presented at multidisciplinary review meetings
- Determination of modifiable risk factors
- Determination of preventability
- Case disposition
- Best Practice Review and Recommendation Development
- Reporting to public and other stakeholders
Looking for Something to Look Forward To…”

A five-year retrospective review of child and youth suicide in B.C.
Review of child and youth suicide

Why did we choose to review suicide deaths?

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

Both the prevalence and the high level of preventability suggested the need for an aggregate review of child and youth suicide in B.C.
Review of child and youth suicide

What we looked at

We reviewed the 81 child and youth suicide deaths that occurred over a five-year period (January 1, 2003 and December 31, 2007).

Of the 81 files, 66 were closed, meaning the coroner had completed their investigation, and 15 were open and thus still under investigation.

We focused on the 66 closed files and obtained basic information on the 15 open files.
Review of child and youth suicide

Our goal was to answer the following questions:

- Who were the children and youth how did they die?
- What risk factors were present in their lives?
- What services did they receive?
- What were the risk profiles?
- What can these children and youth teach us about preventing future suicide deaths?
Review of child and youth suicide

What we did

- Compiled all of the child and youth suicide files from the five-year period
- Developed a suicide-specific protocol
- Sent letters to families
- Obtained additional information
- Conducted multidisciplinary reviews
- Completed an aggregate review
- Identified risk factors and profiles
- Reviewed best practice
- Facilitated a death review panel to develop recommendations
What we learned

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 we learned

What factors increased the risk of suicide?

- A history of suicidal behaviour (70%)
- A history of alcohol/illicit drug use (61%)
- School challenges (50%)
- Mental health problems (45%)
- Exposure to suicidal behaviour (42%)
- Family dysfunction (41%)
- Violent behaviour (24%)
- Poverty (20%)
What we learned

- 38% of the children and youth had previously attempted suicide.

- 18% had made more than one attempt.

- 67% had spoken with someone about their thoughts of suicide. 25% in the week prior to death. They spoke to:
  - Parents
  - Siblings, cousins
  - Friends
  - Family doctors
  - Teachers and school counsellors
  - Social workers and child and youth mental health workers
What we learned

How did the children die?

<table>
<thead>
<tr>
<th>Method</th>
<th>Number of Deaths</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hanging</td>
<td>26</td>
<td>12</td>
<td>14</td>
</tr>
<tr>
<td>Jump</td>
<td>4</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Gunshot</td>
<td>7</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Poisoning</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Transport</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Drowning</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

- Hanging: 26 deaths (12 female, 14 male)
- Jump: 4 deaths (1 female, 3 male)
- Gunshot: 7 deaths (1 female, 6 male)
- Poisoning: 2 deaths (0 female, 2 male)
- Transport: 1 death (1 female, 0 male)
- Drowning: 1 death (1 female, 0 male)
- Other: 1 death (1 female, 0 male)
What we learned

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

- An acute stressful event in the 24 hours prior to death (54%)  
- The use of substances (alcohol and illicit drugs) around the time of death (17%)
What we learned

What risk profiles emerged?

Three main risk profiles emerged from a review of the research literature and an aggregate review of the 66 suicide deaths:

- Children and youth with ongoing mental health problems (45%)
- Children and youth who experienced chronic dysfunction in interpersonal relationships (44%)
- Children and youth who experienced a stressful, life-changing event in the absence of chronic family, relationship or mental health problems (26%)
Moving forward with our findings

Our findings were presented to a child death review panel composed of:

- parent survivors,
- content experts,
- researchers,
- therapists,
- educators,
- physicians, and
- representatives from law enforcement, health, mental health and Aboriginal communities.
Moving forward with our findings

The recommendations from the panel called for action along a continuum of suicide prevention strategies:

- Mental health promotion
- Prevention of mental illness
- Early intervention and detection
- Targeted clinical intervention
- Postvention
Several recommendations were directed to more than one jurisdiction. This reflects the fact that many diverse organizations (government, not-for-profit etc.) are involved in suicide prevention, intervention and postvention.

It is our hope that these recommendations will promote collaboration and communication among jurisdictions that are involved in child and youth suicide prevention.
Moving forward with our findings

Example: Recommendation 5

Ministry of Health Living and Sport, Ministry of Children and Family Development

Establish a web-based clearinghouse for B.C., which will serve as a centralized access point for resources on promotion, prevention and early intervention in mental health (including suicide prevention and postvention). Its development should include a communications plan that promotes regular and ongoing use by both professionals and the public.
Moving forward with our findings

Example: Recommendation 7

**Ministry of Education, Ministry of Children and Family Development, British Columbia School Trustees Association, Crisis Intervention and Suicide Prevention Centre of British Columbia**

Offer evidence-based peer recognition programs to youth in all B.C. school districts. This training should be offered on a continual basis and be delivered as part of a holistic school-based approach to preventing suicide that incorporates other recommendations made by the panel, including universal systemic screening and the development of crisis response protocols.
Moving forward with our findings

Example: Recommendation 14

Ministry of Public Safety and Solicitor General, Ministry of Education, Ministry of Children and Family Development, Ministry of Health Services, Ministry of Healthy Living and Sport, Crisis Intervention and Suicide Prevention Centre of British Columbia, First Nations Health Council

Establish a provincial task force that will advance suicide postvention efforts in B.C. by completing an environmental scan of crisis response teams and/or suicide response protocols that exist in B.C. municipalities, and:
Moving forward with our findings

Recommendation 14 Cont’d

- Where responses exist, determining their nature and membership, and

- In municipalities that currently lack them, supporting the establishment of crisis response teams or protocols while encouraging the use of existing postvention models that have shown success in other jurisdictions
Moving forward with our findings

The CDRU will be monitoring the implementation of these recommendations on an ongoing basis and will provide yearly progress updates in CDRU Annual Reports.

The next annual report will be released in 2009.

The purpose of monitoring recommendations is to:

- Recognize a target agency’s commitment to the problem
- Promote transparency to the B.C. public and other stakeholders
- Measure the impact of recommendations on policy, practice, program delivery and partnerships
Thank-you!

To view the suicide report on-line:

www.pssg.gov.bc/coroners/
child-death-review/index.htm#two