

# **STEMMING THE TIDE**

Strengthening youth suicide prevention  
in Ontario and in Canada

A report from Ontario Psychiatrists

**RECOMMENDATION:** The federal and provincial governments should support the development and implementation of evidence-based prevention strategies for youth suicide and work with Ontario Psychiatrists to develop a comprehensive approach to reducing the risk of death by suicide for Canadian youth.

## We can do better

Over the last decade, accidents have been the main cause of youth deaths in Canada. Most of these deaths were the result of motor vehicle accidents. But with education and safety innovations, fewer teens between the ages of 15 to 19 are dying from accidents. Not so for suicide, the second leading cause of death for Canadians under 34. In fact, the number of youth suicides across Canada has remained relatively consistent for more than 40 years.<sup>1</sup> In light of the advances made in mental health care in Ontario, this is not a statistic to laud, but rather one to correct.

The lack of funding for mental health and the lack of support for youth in crisis is doing nothing to ameliorate this situation. And periodically youth suicide reaches a point of acuity, as it has in Ontario earlier this year.

In the spring 2016, the frontline staff of the 15-bed hospital at the Attawapiskat First Nation in northern Ontario was overwhelmed when seven children between the ages of 9 and 14 were brought in for attempted suicide. Another five attempted suicide that night bringing the total number of attempts over eight months in this small community to 100.

In the summer, Woodstock, Ontario, came to national attention for its teen suicide crisis. Five teens had taken their lives over the four months prior, and by June, police reported 36 youth suicide attempts in the surrounding area.

While these events are in part regional and socio-economic particularities, they are important reminders that youth suicide will continue to be a problem if more is not done to strengthen suicide prevention.

***“We moved the needle on cancer.  
We can move the needle on youth  
mental health.”***

- Roundtable presenter  
and psychiatrist



Beyond the tragedy of young lives lost and the desperation made clear by reported attempts, these events expose the inherent weakness of the system charged with helping youth in crisis.

**The health care system must recognize suicide prevention as more than important. Youth suicide should be understood as a national public health crisis and prevention made a key health priority.**

The Coalition of Ontario Psychiatrists' roundtable, held in May, brought together policy analysts, national mental health organizations, clinicians, researchers as well as psychiatrists, survivors of suicide loss and suicide attempt survivors to discuss both suggestions and solutions to some of the problems that have hindered Ontario's delivery of care to young people at risk of death by suicide.

## Mental health and suicide in Canada

We have the third highest suicide rate in the industrialized world. Every year Canada loses approximately 4,000 of its citizens to this cause of death. A small number of these are youth, but almost all began their mental health journeys at a young age and most are likely to have attempted suicide more than once before succumbing to this outcome. In short, a youth at risk of suicide may eventually die by suicide as an adult.

Fully two thirds of Canadians who have died by suicide were found not to have received any treatment at all. This is why mental health professionals have historically championed for more robust early screening of the risk factors and warning signs of suicide, whether youth or adult.

With 70 percent of mental health issues starting in childhood, the importance of treating mental health conditions in youth, and suicidal ideations as a related condition, becomes profoundly important.

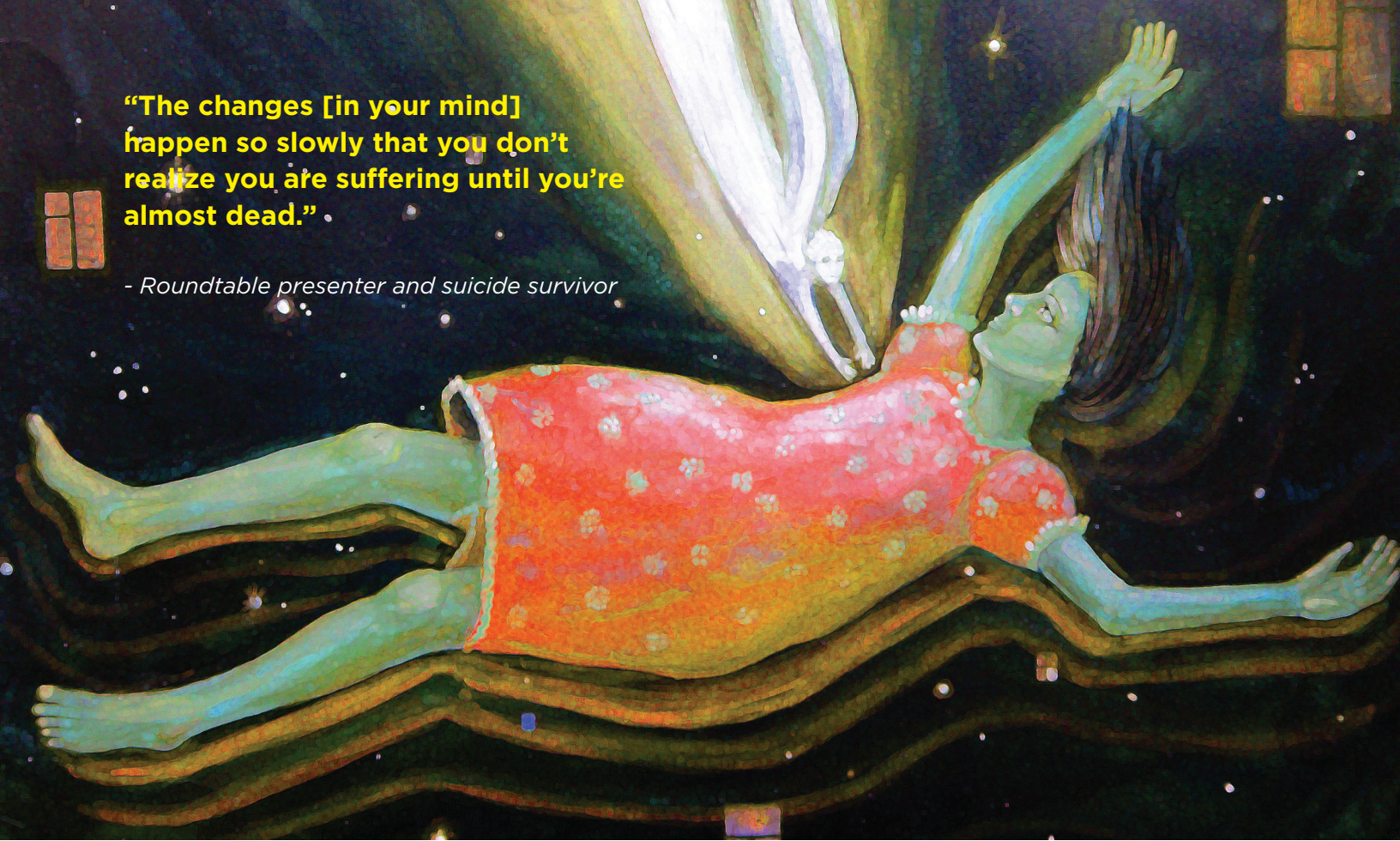
## The specific problem of youth suicide

The journey from childhood to adolescence and onto adulthood challenges young people with tremendous pressure - whether at school or at home. At this age, one lacks the life experience to know that difficult situations will not last forever. And one lacks the skills, or perhaps the skills haven't yet developed to a level proficient enough, to help manage the complex range of emotions.

According to the Canadian Mental Health Association, youth are among the highest risk populations for suicide. This proves out across several jurisdictions beyond our borders. In the U.S., the U.K., Australia and India, suicide ranks either 2<sup>nd</sup> or 3<sup>rd</sup> in causes of death for people under 25. In Canada, it is the second leading cause of death among all young people aged 15-34.<sup>2</sup>

**“The changes [in your mind] happen so slowly that you don’t realize you are suffering until you’re almost dead.”**

*- Roundtable presenter and suicide survivor*



A study on youth suicide in British Columbia provides some perspective on how closely acquainted adolescents are with this problem. With 15,000 responses from students in grades 7 to 12, the study found that 34 percent knew someone who had attempted or died of suicide and 16 percent had seriously considered suicide themselves. Most alarmingly, 14 percent had made a suicide plan, seven percent had made an attempt, and two percent had required medical attention due to an attempt.<sup>3</sup>

In Ontario, figures from the Ministry of Children and Youth Services show 10 percent of students had serious thoughts of suicide in the past year and three percent reported a suicide attempt.<sup>4</sup>

The risk of suicide frequently occurs in combination with external circumstances that seem to overwhelm teenagers who are unable to cope with the challenges of adolescence because of predisposing vulnerabilities such as mental illness. Examples of stressors that can lead to suicidal ideation include disciplinary problems, the breakup of a personal or family relationship, family violence, sexual orientation confusion, substance abuse and addiction, physical and sexual abuse and being the victim of bullying.

Several other factors can also come into play, especially in the case of First Nations, where suicide rates are five to six times higher than for non-Aboriginal youth.<sup>5</sup> Here, inter-generational trauma, socio-economic plight and hopelessness as well as experiences of discrimination serve as powerful influencers. Any of these factors, or a combination, can form such a source of pain that young people may seek suicide as a form of relief.

# Youth mental health and funding

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While provinces have developed mental health plans over the last 20 years, all lacked funding commitments. That meant that as federal transfers to the provinces for health services funding increased, very little of that money was being spent on mental health. And managing a population's mental health is a key factor when it comes to preventing suicide.

In some jurisdictions, like Ontario and British Columbia, youth mental health is funded primarily by separate children's ministries as social services. But these ministries have not benefitted from the annual funding increases allocated to larger ministries such as health.

So what is being funded at the community level? Generalized counselling services and residential placement. The cost of treatment, however, is not being funded appropriately. As well, there is a volume-driven approach to funding at the community level. The trouble is that child and youth mental health services are in desperate need of complexity-based funding, just as we've seen done for other health services such as oncology.

Another sticking point on funding is how physical and mental health services are separated, which in itself can result in a gap on the continuum of care. In some situations, physical illnesses can be diagnosed as mental illnesses (e.g. thyroid conditions assessed in the mental health sector as anxiety disorders) and mental health conditions can be diagnosed as physical illnesses (e.g. anxiety disorder being diagnosed as cardiac arrhythmia). Separating physical and mental health services reinforces stigma, hinders appropriate research of the biological underpinnings of child and youth mental health, and can impede appropriate diagnosis and treatment.

## A coordinated approach

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Commendable work has already begun to address youth suicide risk, but it has lacked a coordinated health system approach. The roundtable on youth suicide prevention, organized by the Ontario Psychiatrists in May, hosted a number of system players, many of whom presented research and initiatives offering valuable insight on the problem and important momentum in certain areas.

Among the attendees and presenters were frontline experts from St. Joseph's Hospital and London Health Sciences Centre, The Royal's Institute of Mental Health Research, SickKids, Hincks-Dellcrest Treatment Centre, The Canadian Association of Suicide Prevention, The Mental Health Commission of Canada, Lutherwood Children's Mental Health Services and Waypoint Centre for Mental Health Care. Attendees were also provided with insight from a survivor of suicide loss and a suicide attempt survivor and offered an analysis of suicide from a First Nations' perspective.

As the presentations and subsequent discussion made clear, there are a number of important initiatives already underway. Among these:

- **The Ontario government** is building on its youth suicide prevention plan and continues to support communities by providing funding for local initiatives, organizing annual mobilization programs to help communities build plans, and additional support for groups through coaching.
- **The Canadian Association for Suicide Prevention** continues to provide information and resources to reduce the suicide rate and minimize the harmful consequences of suicidal behaviour.
- **SickKid's Youth Suicide Prevention Working Group** developed the *Speak Up...We're Listening*, campaign to provide accessible and reliable information to families, patients and staff. The group uses online resources, community engagement events and an annual endowed lectureship to educate and advocate for youth suicide prevention.
- **SickKids** and **Hincks-Dellcrest Treatment Centre** in Toronto announced their intention to explore the integration of the two organizations to improve hospital and community-based mental health services for children and youth with complex mental health needs in June 2016.
- **St. Joseph's Health Care London** and **London Health Sciences Centre** are leading a Zero Suicide program that sets a bold, aspirational goal of reducing suicides and attempted suicides for individuals within the area's mental health program, and eventually throughout the London community.
- **The Ontario Hospital Association** has a task force developing new suicide prevention standards for hospitals to help improve care for patients dealing with a mental illness crisis.
- **The Ontario Centre of Excellence for Child and Youth Mental Health** works with health agencies in Ontario to strengthen services and build an effective and accessible system of care, offering tools, services, products and training.
- **The Mental Health Commission of Canada** created a youth version of its national mental health strategy, a document designed to make mental health policy more accessible to anyone advocating for improvements to the mental health system.
- **School Mental Health ASSIST** helps Ontario school boards promote student mental health and well-being, providing school mental health leadership, resources and coaching support.

# Challenges and Recommendations

Work on suicide prevention across Canada has seen important investment and advancement both as a corollary of provincial mental health strategies and as a function of the initiatives currently underway to address this problem.

While the momentum of these programs helps to draw youth suicide prevention services forward and enhance funding, youth suicide remains undoubtedly its own category. It is neither exclusively a mental health issue (although a history of mental health is a strong determinant of risk) nor are its contributing factors always similar to those which underlie adult suicide. It is different and so requires different attention.

Canadian youth at risk of suicide deserve a system that is ready and capable of meeting their needs – whether they are in crisis, at risk of a crisis or have averted a crisis. Suicide is a condition unto itself and must be treated.

**The Coalition of Ontario Psychiatrists has outlined seven recommendations where focused effort can make a difference. Action must be taken immediately to move forward and address the problem of youth suicide.**

## 1. INVEST IN BETTER MENTAL HEALTH SUPPORT FOR CHILDREN.

There are currently too many children waiting for mental health care. And kids with mental health issues become teens with mental health issues. Kids who have identified mental health issues and who have not received any treatment are at greater risk of suicide than their peers who are in treatment. Despite the need to rectify this situation, provincial reporting on wait times for psychiatric care remains weak, according to the National Wait Time Alliance.

Additionally, children's mental health services are volume funded as social services; a better understanding of the complexity of the conditions associated with suicidality is required at the policy level and a shift to have children's mental health services funded as health services, with complexity based funding models, is required. This takes into account the intensity of services, the integration of mental health treatment with physical health treatment, and the critical importance of an interdisciplinary, team-based approach to treatment (e.g. psychiatry, social work, clinical psychology, mental health nursing, child and youth counselling).

### Recommendations:

- Federal government should work with the Mental Health Commission of Canada and the Canadian Institute of Health Information to measure wait times to see a child psychiatrist.

- Ontario government should invest in a wait-time strategy for mental health services that sees accelerated access to appropriate, inter-disciplinary treatment in the same way surgery and imaging wait-time strategies have helped to improve access to physical health care services.
- Child and youth mental health services should be funded by the ministries of health at the provincial level to ensure appropriate funding levels, complexity-based funding models, and improved integration with physical health services.
- Mental health crisis beds for youth should be made available in local hospitals or in the community. There should also be expanded and improved access to ambulatory mental health services.

## 2. INVEST IN CHILD AND YOUTH MENTAL HEALTH RESEARCH.

There is an urgent need for rigorous research in this area. Careful trials must be conducted to determine whether common practices are helpful, harmful, or benign (e.g. suicide awareness training for high school students).

Funding for a coordinated system of research in the area of suicide prevention in Canada is needed. It must include learning directly from our youth populations and communicating with them about evidence-based practices. There are well-intentioned individuals and groups engaged in practices that are not supported by evidence while high-yield practices like focusing on transitions from hospital following a suicide attempt merit more attention and widespread understanding.

### **Recommendations:**

Federal and provincial governments should...

- Invest in research to support the building of the evidence for effective mental health treatments and innovations to support the reduction of the risk of self-harm and suicide, as well as develop a better understanding of the complex interplay between biology, psychology, environment and other factors that impact child and youth mental health.
- Improve parents' and the public's understanding of youth suicide, including early signs and symptoms and who can help.
- Ask for youth input and bring more youth into the planning conversations so that services can be designed in ways to encourage access (e.g. crisis text lines).



### 3. CLOSE THE SYSTEM GAPS.

Our health care system is organized vertically, but a patient's health journey is longitudinal. It crosses providers and communities and traces a line through a number of administrative gaps. These gaps can be especially problematic for young mental health patients. A gap can cause an interruption in treatment that can prompt a patient to leave care altogether.

Some gaps identified in the Ontario Psychiatrists' roundtable discussion include where a patient moves from the responsibility of the Ministry of Children and Youth Services to the Ministry of Health and Long-term Care, for example. Youth in crisis who go to emergency departments can also encounter gaps. Researchers at Queen's University found that while emergency rooms see as many as 40 percent of the system's mental health patients, staff were missing important suicide risk factors.<sup>6</sup>

#### **Recommendations:**

- Mental health treatment and support for children and youth should follow the patient. The Ontario government must make a commitment to undertake more rigorous screening that will not only identify youth at risk of suicide in the community, but closely follow them, ensuring that they are engaged and re-engaged throughout their health care journey.
- Hospitals should employ thorough emergency department suicide risk assessments. This should include the development of a broadly accepted suicide attempt triage scale for providers to record the acuity and severity of the event. There should also be an improved referral process and improved follow-up protocols if a patient is not admitted, ideally with referral to appropriate inter-disciplinary treatment services in the community for continuing care.
- The Ontario government should conduct better basic screening for suicide risk that involves schools and other community providers and well as in clinical settings and with primary care providers.

## 4. BUILD BETTER CARE COORDINATION AND SERVICE ALIGNMENT.

We lack a centralized, publicly funded coordination of services when it comes to suicide prevention. Work is conducted regionally and nationally by volunteer-based associations and government in different capacities on different areas of the problem. For example, the Canadian Association for Suicide Prevention, the Canadian Distress Line Network and the National Collaborative for Suicide Prevention coordinate resources and efforts across the country while a number of federal and provincial agencies have launched projects addressing aspects of youth suicide. No single agency is responsible for overseeing consistency, eliminating duplication of effort and sharing best practices across all suicide prevention initiatives.

### Recommendation:

- The federal government should create an agency or fund an existing national agency making it specifically responsible for suicide prevention. This would minimize overlap and duplication of services and promote a better use of resources. Provincial ministries could coordinate their efforts through this national agency and benefit from a larger pool of expertise.

## 5. IMPROVE THE COLLECTION AND QUALITY OF DATA.

There is work to be done both in terms of standardizing reporting and in accessing data. With better research will come a better understanding of the problem, but to get there, we must generate continuous data flow so that health system providers can learn from everything that is happening. How data is recorded is also critically important. A suicide attempt, for example, may be captured and reported as a case of anxiety when it is clearly more complex. Data collection and sharing must extend across a range of stakeholders, from educators to coroners.

### Recommendation:

- There is a mental health quality group currently doing work on benchmarks in hospitals. We would like to see this initiative grow and form the basis for data collection in other health system providers.

***“We know very little about how to prevent death by suicide if we base it on current studies.”***

*- Roundtable presenter and epidemiologist specializing in youth mental health research*



## 6. PROVIDE BETTER ACCESS TO FUNDING.

Just as the system should follow the patient across providers and in the community, the funding would be better spent following the patient. Other solutions here include employing a complexity-based funding and evaluation model so that providers are not just accessing funding based on patient volume.

### Recommendations:

The Ontario government should...

- Improve access to an array of practitioners and integrate other mental health professionals into the system in a way that can help share the load and improve access to child- and family-centred services.
- Support innovations that allow treatment teams to enhance access to services using technology across the province. (For example, SickKids, CAMH and the University of Toronto use live video conferencing to connect mental health experts in Toronto to family doctors across the province.)
- Have the funding follow the patient and ensure mental health services are made available locally so that youth can access care in their communities.
- Enable providers to seek out those who fail to show up for appointments.

## 7. PROVIDE BETTER SUPPORT FOR FAMILIES, SCHOOLS AND COMMUNITIES.

Two-thirds of Canadians who died by suicide never received any treatment. Their risk went unnoticed. If there is a concern over suicide risk, families and people working with kids need to understand where and how to access the care they need. As youth spend much of their lives in schools, school boards must be included as suicide prevention education partners along with families and other elements of the community.

And for education on the risk of suicide to be effective, the health system has to do a better job at understanding how patients and families view the problem rather than educating them on how to navigate the system.

## **Recommendations:**

Federal and provincial governments should...

- Discover and develop a family-based lens we can bring to this problem.
- Develop a partnership voice by engaging youth in system planning.
- Improve support for survivors of suicide loss, including family, friends and bystanders.
- Build consistent messages that help to distinguish between youth anxiety, depression and critical crisis points.
- Connect with the community, including with faith-based organizations and funeral homes.
- Fund programming in schools and communities to help kids build social emotional skills and encourage help-seeking. Bolstering protective factors and reducing the risk of developing mental health problems will reduce the risk for suicidal behaviour.

## **Attendees to the Coalition of Ontario Psychiatrists' Youth Suicide Prevention Roundtable held on May 2nd, 2016, in Toronto included:**

Granville Anderson, Parliamentary Secretary, Ministry of Children and Youth Services

Dr. Kathy Bennett, Professor, Department of Clinical Epidemiology and Biostatistics and Offord Centre for Children Studies, McMaster University

Dr. Ian Dawe, Chair, Program Chief & Medical Director, Mental Health at Trillium Health Partners; OHA Suicide Prevention Standards Task Force

Nicole German, Founder, The Maddie Project (attended via teleconference)

Mark Henick, Program Manager, Canadian Mental Health Association (Ontario Division)

Dr. Daphne Korczak, Chair, Youth Suicide Prevention Working Group, Centre for Brain and Mental Health, SickKids

Dr. Marshall Korenblum, Psychiatrist-in-Chief, Hincks-Dellcrest Treatment Centre

Dr. Paul Links, Chair/Chief of Psychiatry for both St. Joseph's and London Health Sciences Centre

Dr. Ian Manion, Director, Youth Mental Health Research Unit, The Royal

Ada Maxwell, Health Policy Staff, Ontario Medical Association

Dr. Paul Mulzer, Staff Psychiatrist Waypoint Centre for Mental Health Care

Tana Nash, Executive Director, Waterloo Region Suicide Prevention and Executive Director, Canadian Association for Suicide Prevention

Kathy Payette, Director, Mental Health Services, Lutherwood Children's Mental Health

Karla Thorpe, Director, Prevention and Promotion Initiatives, Mental Health Commission of Canada

Dr. Janice Tomlinson, Implementation Coach, School Mental Health ASSIST

Roxana Sultan, Vice President, Strategy and Clinical Operations, Hincks-Dellcrest Treatment Centre

Dr. Purnima Sundar, Director, Knowledge Mobilization, Ontario Centre of Excellence for Child and Youth Mental Health

Kassandra Woods, Policy Analyst, Assembly of First Nations (attended via teleconference)

Facilitated and Moderated by:

- Patrick Nelson, Principal, Santis Health Inc.
- Ross Wallace, Principal, Santis Health Inc.
- Jessica Stepic, Consultant, Santis Health Inc.
- Yvan Marston, Writer, Santis Health Inc.

## Attendees from the Coalition of Ontario Psychiatrists

- Dr. Gary Chaimowitz
- Dr. Sonu Gaiind
- Dr. Sarah Jarmain
- Dr. Diana Kljenak
- Dr. David Koczerginski
- Halyna Troian

## About the Coalition of Ontario Psychiatrists:

The Coalition of Ontario Psychiatrists is a formal partnership of the Ontario Psychiatric Association and the Section on Psychiatry of the Ontario Medical Association, and was formed in the late 1990s to facilitate coordination and cooperation between these two associations. It represents over 1,900 psychiatrists who provide high quality mental health services for Ontarians.

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<sup>1</sup> <http://www.statcan.gc.ca/pub/82-624-x/2012001/article/chart/11696-02-chart6-eng.htm>

<sup>2</sup> <http://www.statcan.gc.ca/pub/82-624-x/2012001/article/11696-eng.htm>

<sup>3</sup> [http://toronto.cmha.ca/mental\\_health/youth-and-suicide](http://toronto.cmha.ca/mental_health/youth-and-suicide)

<sup>4</sup> <http://www.children.gov.on.ca/htdocs/English/professionals/specialneeds/suicideprevention.aspx>

<sup>5</sup> [http://www.hc-sc.gc.ca/fniah-spnia/pubs/promotion/\\_suicide/prev\\_youth-jeunes/index-eng.php#s2121](http://www.hc-sc.gc.ca/fniah-spnia/pubs/promotion/_suicide/prev_youth-jeunes/index-eng.php#s2121)

<sup>6</sup> <http://www.psychcongress.com/article/important-suicide-risk-factors-missing-emergency-department-assessments-22473>