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Please accept the below as written evidence to the Standing Committee on Social Affairs, Science and Technology, regarding child and youth mental health in Canada. Requests for additional information or questions can be directed to Marie Adèle Davis, Executive Director of the Canadian Paediatric Society at maried@cps.ca or at 613-526-9397, ext. 226.


**Context**

Suicide is the second most common cause of death among Canadian adolescents, representing one-quarter of all deaths among youth 15 to 19 years of age in 2011.[1] The incidence of suicide attempts peaks in adolescence. It is estimated that for every completed suicide there are at least 20 suicide attempts.[2] Males are more likely to die from suicide; however, females are three to four times more likely to attempt suicide.[3] First Nations, Métis and Inuit adolescents are at particular risk of suicide, with four to five times greater rates of suicide in these populations compared with non-Aboriginal youth.[1][3] Suicide among prepubescent children is rare,[1] although suicidal thoughts and attempts occur.

**Risk Factors**

*Mental illness*

Mental illness is an important risk factor for adolescent suicide.[4][5] A history of mental illness is present in up to 90% of adolescents who have died by suicide.[6][7] Depression is most strongly associated with suicidal ideation and behaviour; however, other mental disorders, including substance use disorders, conduct disorder and other less common disorders (for example, bipolar disorder, psychotic disorders) also confer increased risk of suicide.[6][7] Although onset of mental illness frequently occurs in the adolescent years, it may be ≥10 years before identification and treatment initiation.[8]

*Prior deliberate self-harm or suicide attempt*

A previous suicide attempt is one of the strongest predictors of suicide during adolescence, and lifelong.[6][7][9]-[11] The presence of deliberate self-harm behaviour (e.g. cutting, burning) has also been associated with increased suicidal risk.[12] However, self-harm behaviours may or may not be associated with suicidal intent.
Impulsivity

Adolescents who act impulsively are at greater risk of acting on suicidal thoughts and using more lethal means to attempt suicide.[12][13]

Precipitating factors

It is important to understand the factors that precipitated the suicidal thoughts or attempt to be able to address these stressors, or the adolescent’s reaction to them, directly. Stressors leading to feelings of rejection, inadequacy, humiliation, shame and loss are particularly salient. Common precipitants of suicidal behaviour among adolescents include conflict with family or peers, recent or impending academic disappointment, bullying (including cyberbullying over social media), relationship break-up, disclosure of homosexual orientation, and legal involvement or impending court proceedings. Among adolescents with a history of physical or sexual abuse, situations or interactions that have triggered memories or feelings associated with past abuse are also associated with increased suicidal behaviour.[14]-[16] Finally, exposure to suicide via the media or people known to the adolescent is also associated with increased suicidal behaviour.[17]

Family factors

Family conflict, and poor child-parent communication in particular, are associated with increased suicidality among adolescents.[15][18][19] Parental mental illness and family history of suicide are also risk factors for adolescent suicidal behaviour.[16]

Lack of connection to psychosocial support

A supportive environment is essential to stabilize an adolescent’s mental state. Evaluation of psychosocial context includes consideration of environmental factors (for example, adolescents living in First Nations, Inuit and Métis communities are at increased risk for suicide) and availability of support systems.

Support

Adolescents experiencing suicidal ideation or behavior who are appropriate for outpatient management require clear instruction regarding the importance of communicating suicidal thoughts or behaviours to identified trusted adults; the need for mental health follow-up care; the availability of local crisis services and telephone lines; and use of the emergency department if necessary.

Parents and/or guardians should be encouraged to allow open communication with the adolescent, particularly regarding negative feeling states and suicidal thoughts, and to ensure the home environment is safe. In addition to supportive family and friends, mental health supports may include a counsellor at school, a health clinic or community health centre (including urgent mental health services), a physician or a private therapist. Because adolescent-specific mental health supports are limited in some communities, clinicians must assess the type and availability of mental health support available to the adolescent in their community and ascertain that (i) the adolescent is willing to follow up with this individual, and (ii) the adolescent views the connection as positive and supportive.
**Recommendations**

Suicide is a leading and preventable cause of death among Canadian children and youth. Of adolescents who die as a result of suicide, most are struggling with mental illness. Strengthening child and youth mental health and mental health care across Canada is therefore critical. This objective can be achieved in part by enhancing the ability of health professionals to:

- Prevent, diagnose and treat mental health disorders in children and youth
- Prevent and treat misuse of marijuana, alcohol and other substances
- Promote supportive relationships and safe homes, school and communities as fundamental to healthy child development

Federal, provincial/territorial and local governments can directly help to achieve this objective by:

- Expanding access to evidence-based publicly funded treatment for child and youth mental illness, including psychology, school-based mental health and development services, and specialized inpatient and residential programs.
- Ensuring that these services have the clinical coordination and oversight necessary to deliver the right treatment to the right child in the right setting and at the right time, with commensurate monitoring of improvements in child mental health outcomes.
- Improving existing mechanisms for service coverage and delivery, particularly in remote and/or rural areas and for adolescents who are most at-risk, including First Nations, Inuit and Métis and members of the LGBTQ2 community
- Investing in public education, and publicly-funded resources and supports to address and respond to risk factors for suicidal ideation and behavior including bullying, academic support, substance use and addiction, and physical, sexual or emotional abuse.

**References**


