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TEEN SUICIDE IN CANADA

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INTRODUCTION

Suicide rates in Canada have been increasing since the 1970s. In order to address the problem, the Canadian government appointed the National Task Force on Suicide in Canada in 1980. In a report released in 1987, the Task Force identified seven groups as being at high risk, including young people aged 15 to 19. The report was updated by Health Canada in the early 1990s. In the update, Health Canada noted that while "adolescents in the general population (age 15-19) complete suicide at a lower rate than many other age groups, they represent a group of special concern because of a dramatic upward trend in their rate over the past forty years."(1)

This paper looks at the phenomenon of teen suicide.

SOME STATISTICS

In Canada, 13.5 per 100,000 youth kill themselves each year. This makes Canada the nation with the third-highest teen suicide rate in the industrialized world, behind only New Zealand, which had a teen suicide rate in 1991 of 15.7 per 100,000, and Finland, which had a teen suicide rate in 1991 of 15.0 per 100,000.(2) A study of ten countries found that, between 1991 and 1993, Canada had the third-highest suicide rate for male youth (behind Australia and the Russian Federation) and also for female youth (behind Sweden and the Russian Federation).(3)

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(1) Health Canada, *Suicide in Canada: Update of the Report of the Task Force on Suicide in Canada*, Health Canada, Ottawa, 1994, p. 21.

(2) Roger J. Tierney, "Youth Suicide Prevention in Schools and Community: A Progress Report," in *Suicide in Canada*, ed. Antoon A. Leenaars *et al.*, University of Toronto Press, Toronto, 1998, p. 291.

(3) Federal, Provincial and Territorial Advisory Committee on Population Health, *Toward a Healthy Future: Second Report on the Health of Canadians*, Health Canada, Ottawa, 1999, p. 24.

In the United States, the rate of teen suicide is lower, at 11.1 per 100,000; in Great Britain it is lower still, at 4.3 per 100,000. The difference between Canada and these countries may be explained, in part, by a difference in attitudes towards suicide. In a study completed in 1989, Canadian teens stated that they tended to view suicide as a "private matter" and "more frequently saw suicide as an acceptable and normal response to problems, compared with their U.S. peers."(4) In addition, Canada is one of the few industrialized countries without a national strategy on suicide prevention.

Youth suicide is the second leading cause of death (behind motor vehicle accidents) for Canadians aged 15 to 19, while suicide attempts are the third leading cause of hospitalization in the same age group.(5) Each year, nearly 300 youth in Canada choose to take their own life.(6) It is important to note that a death is recorded as suicide only if the victim's intent is made clear. It is estimated that for every suicide completed, between 10 and 100 suicides are attempted.(7)

Although the national suicide rate in Canada increased dramatically after 1960, surpassing the suicide rate of the United States in the 1970s, teen suicide has been a separate phenomenon. Between 1952 and 1992, the national suicide rate increased by 78%. By comparison, the teen suicide rate for the same period increased more than *600%*.(8)

Suicide rates in Canada differ, in some cases dramatically, from province to province. In recent years, Quebec has had the highest suicide rate of all the provinces while Newfoundland has traditionally had suicide rates well below the national average. While there are no concrete answers, the differences in suicide rates "likely reflect social, economic and cultural factors."(9)

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(4) Ronald J. Dyck, Brian L. Mishara and Jennifer White, "Suicide in Children, Adolescents and Seniors: Key Findings and Policy Implications," in *Canada Health Action: Building on the Legacy*, Papers Commissioned by the National Forum on Health, Éditions MultiMondes, Sainte-Foy, 1998, p. 328.

(5) Health Canada, *For the Safety of Canadian Children and Youth*, Health Canada, Ottawa, 1997, p. 268.

(6) Canadian Mental Health Association, Mental Health Pamphlet Series, *Reflections on Youth Suicide*, http://www.cmha.ca/english/index.html (retrieved 13 November 2002).

(7) Dyck, Mishara and White (1998), p. 311.

(8) Rae Corelli, "Killing the Pain," *Maclean's*, 29 January 1996, p. 55.

(9) Stéphanie Langlois and Peter Morrison, *Suicide Deaths and Attempts*, Canadian Social Trends, Autumn 2002.

These statistics have prompted attention from federal and provincial governments in the form of task forces, royal commissions, national conferences, centres for the prevention of suicide, and community, regional and provincial suicide prevention strategies.(10) Despite the concern, Canada – as mentioned above – has no national strategy on suicide prevention. Suicide prevention and education, therefore, are left to provinces, territories, municipalities, organizations and agencies, and programs vary from jurisdiction to jurisdiction. Currently, "some provinces/territories have well-developed programs in place that have endured over time; others are in the process of developing province-wide or regional approaches; and other provinces could best be described as engaging in a variety of suicide prevention-specific activities without necessarily having a provincial structure to guide them."(11)

Figure 1 – Suicide Rates in Canada, 1950-1998

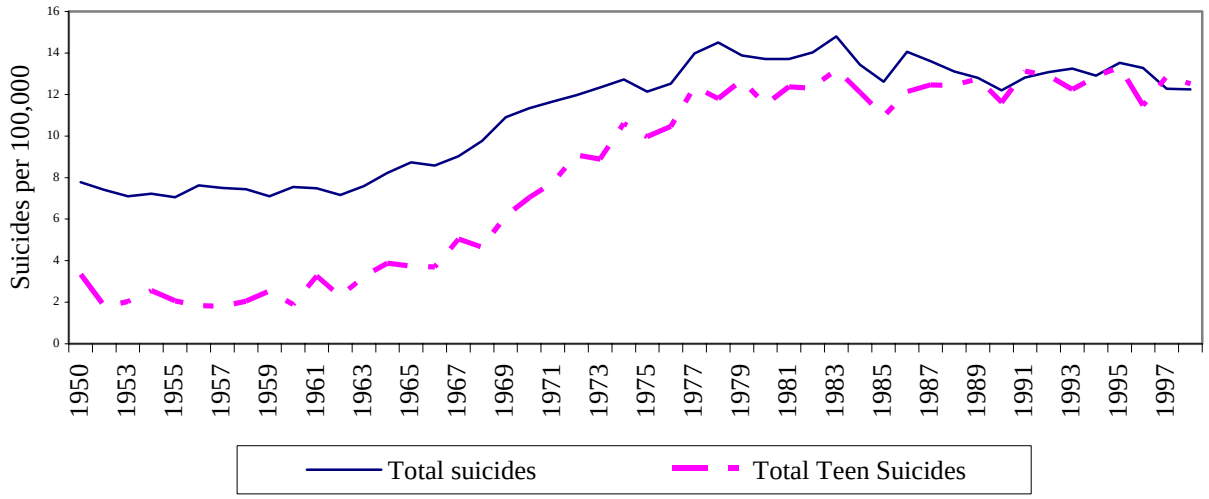

Table 1 – Suicide Rates in the United States and Canada, 1970-1990

Year	United States		Canada	
	Total Suicides per 100,000	Teen (15-19 yrs) Suicides per 100,000	Total Suicides per 100,000	Teen (15-19 yrs) Suicides per 100,000
1970	11.6	5.9	11.3	7.02
1980	8.5	8.5	13.7	11.5
1990	12.4	11.1	12.2	11.61

(10) Dyck, Mishara and White (1998), p. 319.

(11) Ronald J. Dyck and Jennifer White, "Suicide Prevention in Canada: Work in Progress," in *Suicide in Canada*, ed. Leenaars *et al*. (1998), p. 256.

THE COSTS OF SUICIDE

Suicide affects society in a number of ways. One way is in the potential years of life lost (PYLL). This mortality indicator "measures the number of years of life potentially lost by someone who dies prior to age 75."(12) In 1996, the overall PYLL due to suicide were estimated at 110,210. Of this total, 12,128 years were lost due the suicide of persons aged 15 to 19.(13)

In economic terms, suicides are very costly. The precise cost of a suicide is difficult to estimate because of the number of factors involved, including the PYLL, lost income, and the effects on survivors.(14) Although no Canadian statistics are available that include both direct and indirect costs of suicide, the total estimated cost ranges from $433,000 to $4,131,000.(15)

In human terms, of course, there are immense costs that cannot be quantified, such as "the emotional and psychological burden experienced by the friends and family members of suicide victims. Nor does it [the per capita cost] encompass the value of that part of a person's life that cannot be estimated simply by a loss in productivity (e.g. the value of being someone's friend)."(16)

REASONS

Many theories attempt to explain why teenagers are committing suicide at such alarming rates. It is important to note that "youth suicidal behaviour is clearly complex, and like

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(12) Health Canada, *Potential Years of Life Lost: Suicide*, http://www.statcan.ca/english/freepub/82-221-SIE/00502/high/region/hpotential5.htm (retrieved 22 January 2003).

(13) Statistics Canada, *Statistical Report on the Health of Canadians*, http://www.statcan.ca/english/freepub/82-570-XIE/free.htm (retrieved 5 February 2003).

(14) Canadian Mental Health Association, Alberta Division, *Education*, http://www.cmha.ab.ca/education/stats.htm (retrieved 5 February 2003).

(15) *Ibid.*; see also Dale Clayton and Alberto Barceló, *The Cost of Suicide Mortality in New Brunswick, 1996*, http://www.hc-sc.gc.ca/pphb-dgspsp/publicat/cdic-mcc/20-2/e_e.html (retrieved 22 January 2003); and *Lifting the Silence on Suicide: Together we can make a difference*, 6-7 February 2002 Conference Report, http://www.amhb.ab.ca/chmh/whatwedo/aboriginal/page.cfm?pg=Aboriginal%20Youth%20Suicide%20Prevention (retrieved 5 February 2003).

(16) Clayton and Barceló.

other human behaviours, it must be understood within a multidimensional framework that takes the individual, familial, social, economic and cultural contexts into account."[17]

One authority on suicide, sociologist Emile Durkheim, identified three types of suicidal behaviour: altruistic suicide, egoistic suicide and anomic suicide. It is anomic suicide that is thought to be the best explanation for teenage suicide. Anomic conditions exist when an individual is not properly integrated into society. Social integration is important; Durkheim "identified associations between rates of suicide and levels of social integration in certain populations and concluded that increased community involvement reduces suicidal risk."[18] Anomic suicide is characterized by a weak value system, which means that norms become meaningless to the individual. Feelings of isolation, loneliness and confusion typify anomic suicide; these are often provoked by a major disruption in a person's life, such as the loss of a relationship.

Isaac Sakinofsky blames the rise of youth suicide on the increase of depression in young people,[19] which he argues is linked with excessive social change. The period after World War II saw significant upheavals in traditional norms and values. The break-up of the conventional family and a dissociation from religion are factors that have been linked to the increase in suicide rates. These "tumultuous social changes that occurred have been associated with the anomic conditions that Durkheim thought were the primary causes of suicide."[20]

Anomic conditions play a significant role in a person's decision to commit suicide. For example, it is estimated that 70 to 80% of Canadian youth consider suicide before they graduate from high school.[21] While it is not uncommon for young people to think about suicide, a study found differences between "youth who think about suicide but do not attempt, and those that go on to actually attempt suicide. Youth who attempt suicide report less connectedness to family and school."[22]

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(17) Dyck, Mishara and White (1998), p. 332.

(18) Erica Weir, "Suicide: the hidden epidemic," *Canadian Medical Association Journal*, Vol. 165, 2001, p. 634.

(19) Isaac Sakinofsky, "The Epidemiology of Suicide in Canada," in Leenars *et al*. (1998), p. 39; see also Corelli (1996), p. 56.

(20) Sakinofsky (1998), p. 39.

(21) Youth Suicide Prevention Web site, "Canadian Statistics," http://www.youthsuicide.ca/misc/stats.htm (retrieved 15 January 2003).

(22) *Violence in Adolescence Fact Sheet: Suicide*, The McCreary Centre Society, Burnaby, B.C., 2002.

RISK FACTORS

The high number of teen suicides led the federal Task Force on Suicide in Canada (1987) to identify young people as a population group at high risk for suicide. Aspects such as negative early family experiences, school problems, environmental disruptions during a critical transition period, peer difficulties, cultural attitudes towards suicide (i.e., accepting suicide as an appropriate coping mechanism), and the effects of low income and poverty all contribute to the increase in youth suicidal behaviour. Furthermore, "several additional conditions specifically related to adolescent suicidal behaviour include the break-up of relationships, suicidal behaviour among peers and significant others, substance abuse, and reticence to seek help for oneself or one's peers."(23) Recent studies have suggested that suicide tends to run in families. While it has not been determined whether this is a genetic or environmental factor, suicide in families is an important risk factor of youth suicidal behaviour.(24)

Although teen suicide cannot be easily understood, some influencing factors have been identified and categorized as follows: predisposing factors, precipitating factors, contributing factors and protective factors.

Predisposing factors are historical or long-term factors that may increase an individual's risk of suicide. They may include mental illness, abuse, family history of suicide and difficulty with peers.

Precipitating factors are often referred to as "trigger events" and can occur suddenly. For adolescents, these factors often occur in an interpersonal context, such as rejection by a peer group or the loss of an important relationship.

Contributing factors can either be historical or transpire suddenly. When combined with predisposing and precipitating factors, contributing factors can increase an individual's risk for suicidal behaviour. They may include sexual identity issues, unstable family relationships, the influence of the media and access to lethal means.

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(23) Dyck, Mishara and White (1998), p. 312; see also Health Canada, *For the Safety of Canadian Children and Youth* (1997), p. 270.

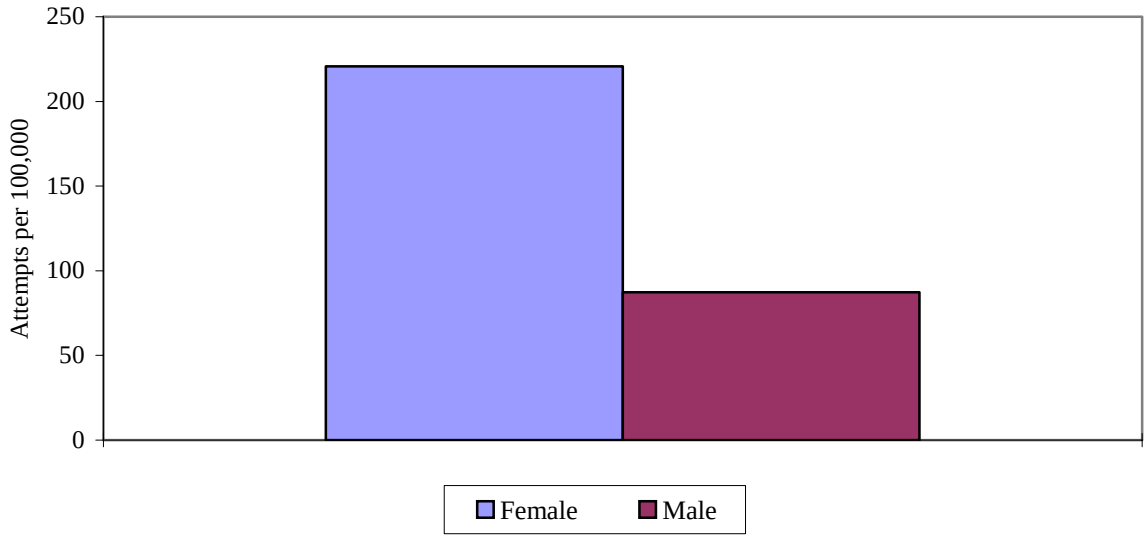
(24) Health Canada, *For the Safety of Canadian Children and Youth* (1997), p. 271; see also Ping Qin, Esben Agerbo and Preben Bo Mortensen, "Suicide risk in relation to family history of completed suicide and psychiatric disorders: a nested case-control study based on longitudinal registers," *The Lancet*, 12 October 2002, pp. 1126-1130.

Protective factors can reduce an individual's risk of suicide. Examples are the ability to tolerate frustration, personal resilience, adaptive coping skills and at least one healthy family relationship.(25)

GENDER DIFFERENCES

Another notable aspect of teen suicide is the difference in the number of male teenagers and female teenagers who commit suicide. Although girls are more likely than boys to attempt suicide (the hospitalization rate for female teens who attempt suicide is twice that of male teens),(26) the rate of suicide for boys aged 15 to 19 is four times higher than that for girls in the same age group.(27)

Figure 2 – Teen Suicide Attempts in Canada, 1998-1999



Source: Table adapted from Langlois and Morrison, *Suicide Deaths and Attempts* (2002), p. 24.

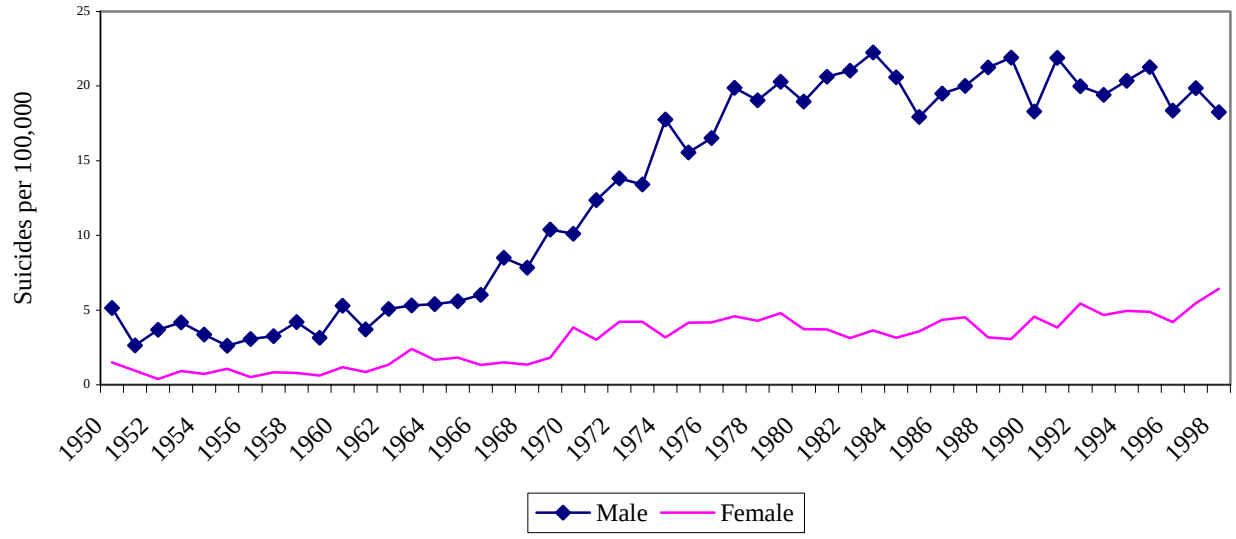
(25) Jennifer White, "Comprehensive Youth Suicide Prevention: A Model for Understanding," in *Suicide in Canada*, ed. Leenaars *et al*. (1998), pp. 281-285.

(26) Child and Family Canada, *Fact Sheet: Suicide*, http://collections.ic.gc.ca/child/docs/00000012.htm (retrieved 6 November 2002).

(27) Health Canada, *For the Safety of Canadian Children and Youth* (1997), p. 270.

The difference between genders in this regard is often attributed to the choice of methods used. While girls usually choose methods such as a drug overdose, which may not be immediately lethal and may allow for the possibility of resuscitation, boys use more immediately lethal means such as strangulation or firearms.(28)

Figure 3 – Male and Female Teen Suicide Rates in Canada, 1950-1998



ABORIGINAL YOUTH

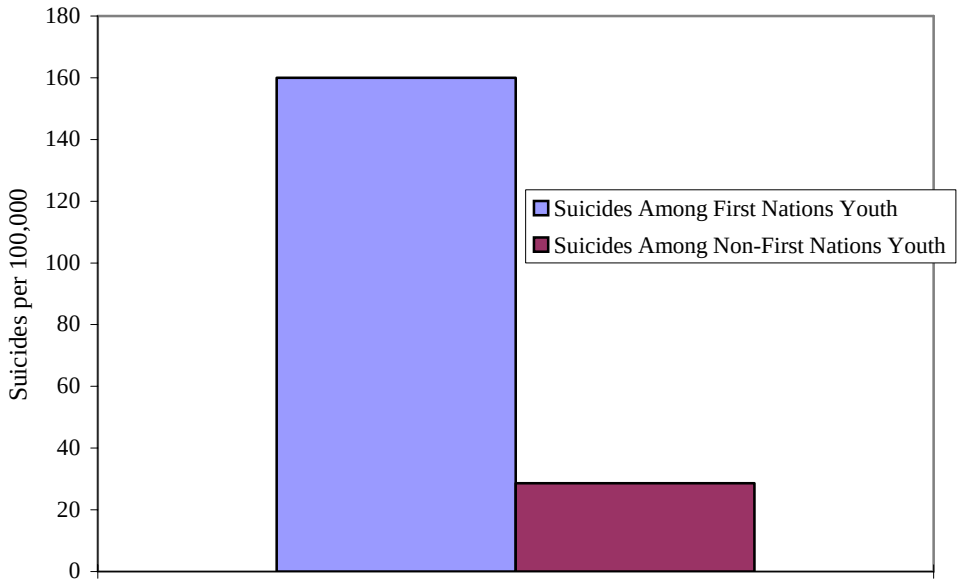
The suicide rate for Aboriginal youth aged 15 to 24 is five to six times higher than that of their non-Aboriginal counterparts.(29) This is all the more significant because in 1995 the Royal Commission on Aboriginal Peoples (RCAP) found that 38% of Canada's Aboriginal population was under 15, meaning the most vulnerable years were yet to come.(30)

(28) *Ibid.*

(29) Marlene Poitras, "AFN's summary of the report 'Choosing life' Royal Commission on Aboriginal Peoples suicide report," *First Perspective*, Vol. 3, No. 10, March 1995.

(30) *Ibid.*

Figure 4 – Youth Suicide Rates, 15-24 years, 1989-1993



Source: Information adapted from *Trends in First Nations Mortality, 1979-1993*, http://www.hc-sc.gc.ca/fnihb-dgspni/fnihb/cp/ipc/pdf/Crude_Suicide_Rates.pdf.

It is important to note, however, that this rate does not apply consistently across all Aboriginal communities. While suicide is virtually unknown in certain communities, it can be as high as 800% above the national average in others.(31) Studies have shown that suicide rates for Aboriginal peoples living off reserves may be similar to rates among the general population, whereas rates on reserves may be twice as high.(32)

A study of First Nations youth in British Columbia found that suicide in First Nations communities is highest when there is a loss of connectedness to one's future. The study explored links between self-continuity and cultural continuity in First Nations communities. It found that some community control over education, police, fire and health services provided markers of cultural rehabilitation that helped activate cultural continuity. Other markers included evidence that bands were working on securing title to traditional lands, evidence of

(31) Michael Chandler and Christopher Lalonde, "Cultural Continuity as a Hedge Against Suicide in Canada's First Nations," *Transcultural Psychiatry*, Vol. 35, 1998.

(32) Health Canada, *Suicide in Canada: Update of the Report of the Task Force on Suicide in Canada* (1994), p. 23.

seeking self-government and evidence of having established cultural facilities within communities.(33)

In addition to the problems that all young people face, many Aboriginal youth are part of communities and families that are crippled by unemployment, alcohol and drug abuse, family violence and sexual abuse. While many people of all capacities are forced to deal with these factors, they "occur with greater frequency and intensity among Aboriginal people than in the general population."(34) With an estimated 38% of the Aboriginal population under the age of 15, the situation could prove much more deadly if it does not receive proper attention.(35) Aboriginal youth told the RCAP that the causes for suicide "are around them all the time: in the confusion they feel about their identity, in the absence of opportunity to make a good life, in the bleakness of daily existence where alcohol and drugs sometimes seem to offer the only relief."(36) Suicide offers a way out of these "seemingly insurmountable conditions and yawning spiritual emptiness."(37)

According to the RCAP, for Aboriginal peoples adolescence is complicated by the lack of supports and strong role models in their families and communities, and a surrounding non-Aboriginal society that "devalues their identity as Aboriginal persons."(38) This identity crisis is reinforced by: neglect or misinterpretation of Aboriginal history and culture in education curricula and the media; the portrayal of racist images of Aboriginal people; the loss of land, language, cultures and spiritual grounding; the general domination of public discourse and public policy by "European" norms and values, imagery and heroes; and individual experience of ridicule, stereotyping, discrimination and racism.(39)

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(33) Harriet MacMillan *et al.*, "Aboriginal Youth," draft chapter submitted on 14 December 2001 as contracted by the National Aboriginal Health Organization for inclusion in a forthcoming book, "Integrated Health Policy for Canadian Youth," to be produced by the Canadian Centre for Studies of Children at Risk, affiliated with McMaster University and Hamilton Health Sciences, Hamilton, Ontario; see also Chandler and Lalonde (1998).

(34) Poitras (1995).

(35) Rupert Taylor, "Wasted Lives and Wounded People," Canada and the World Backgrounder, No. 61, 1995; see also Poitras (1995).

(36) Royal Commission on Aboriginal Peoples, *Choosing Life: Special Report on Suicide Among Aboriginal People*, Minister of Supply and Services, Ottawa, 1995, p. 8.

(37) *Ibid.*, p. 8.

(38) *Ibid.*, p. 29.

(39) *Ibid.*

PREVENTION

Suicide is rarely a spontaneous decision. The Canadian Mental Health Association (CMHA) states that "suicide is most often a process, not an event. Eight out of ten people who die by suicide gave some, or even many, indications of their intentions."(40) Therefore, it is important to be aware of the warning signs, although the CMHA notes there is no "ultimate list" of such signs. Some include:

- sudden change in behaviour (e.g., withdrawal from friends and activities);
- increased use of alcohol and other drugs;
- recent loss of a friend or family member, especially if they died by suicide;
- mood swings, emotional outbursts, high level of irritability or aggression;
- feelings of hopelessness;
- preoccupation with death;
- talk of suicide; and
- hero worship of people who have died by suicide.(41)

Evaluating the effect of suicide prevention strategies is difficult for a number of reasons. Despite the increase in suicide prevention programs in recent decades, program evaluations are scarce and bound by methodological limitations. Furthermore, there is the "inherent difficulty of measuring the impact of preventive measures aimed at any phenomenon whose roots are so complex."(42) There are, however, some strategies that appear to reduce suicidal behaviour.

School programs that focus attention on coping and life skills can help young people learn the problem-solving skills needed to deal with issues such as depression and anxiety. In addition, peer support programs help to foster relationships and coping skills in troubled youth and have shown success in reducing high-risk behaviour.(43)

Suicide prevention strategies have typically included efforts to increase awareness about suicide and how to recognize and assist a suicidal person. The goal of these programs is to

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(40 Canadian Mental Health Association, *Reflections on Youth Suicide*.

(41) Canadian Mental Health Association, Mental Health Pamphlet Series, *When a Young Person is Suicidal*, http://www.cmha.ca/english/index.html (retrieved 13 November 2002).

(42) Health Canada, *Suicide in Canada: Update of the Report of the Task Force on Suicide in Canada* (1994), p. 57.

(43) *Ibid*., p. 59.

increase the likelihood that a suicidal person will be identified early on and will receive help. This approach alone limits success, however, as it relies on information dissemination as a way to prevent suicide. In addition, one must be careful not to associate suicide prevention solely with crisis intervention. While these methods of suicide prevention are important, suicide prevention strategies should go beyond them to focus on preventing a crisis situation in the first place.(44)

For example, mental health promotion is an important aspect of teen suicide prevention, as it can identify and enhance the effects of protective factors in young people. By focusing on the goal of a generally healthy population, it helps promote adaptive behaviours before the risk of suicide has been established.(45)

It is important to take a comprehensive approach to the challenge of preventing suicide. A comprehensive program "has a framework, goals and objectives and a commitment to adequate funding."(46) For a list of strategies that make up a comprehensive program, see Appendix A.

CULTURE-SPECIFIC APPROACHES

The RCAP report identified seven elements that it considered to be important in preventing suicide in Aboriginal communities. These principles are community control, cultural and spiritual revitalization, the strengthening of family and community bonds, a focus on children and youth, holism, whole community involvement, and partnership with governments and non-Aboriginal organizations. Chandler and Lalonde note that cultural rehabilitation is an important factor in decreasing suicide rates among Aboriginal youth. Communities that have taken steps to regenerate their culture have seen a decrease in such rates.(47)

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(44) White (1998), p. 277.

(45) *Ibid*., p. 286.

(46) Health Canada, *A Report on Mental Illnesses in Canada*, http://www.hc-sc.gc.ca/pphb-dgspsp/publicat/miic-mmac/chap_7_e.html (retrieved 27 November 2002).

(47) Chandler and Lalonde (1998), p. 21.

CONCLUSION

Although suicide rates in Canada have stabilized in the past several years, the high number of teens who take their own life is still a serious problem. Several factors contribute to teen suicide. Feelings of alienation, low self-esteem and lack of the necessary coping skills to adapt to problems are all contributing causes. The complexity and sensitivity of the issue of teen suicide should not discourage attention and action. Only with understanding and education can the problem of teen suicide be effectively addressed.

APPENDIX A

STRATEGIES FOR A COMPREHENSIVE SUICIDE PREVENTION PROGRAM*

1. Increase public awareness and decrease the stigma associated with suicidal behaviour.

2. Address determinants of health, including housing, income, education, employment and community attitudes.

3. Implement prevention programs for youth, for individuals at high risk for suicidal behaviour, and for family members post-suicide.

4. Provide and ensure equitable access to co-ordinated, integrated services, including crisis phone counselling and treatment of mental illnesses.

5. Reduce access to lethal means of suicide, particularly firearms and lethal doses of prescription drugs. Since suicidal behaviour is often crisis-oriented and impulsive, restricting access to lethal means can substantially reduce the risk of the completion of a suicide attempt. This includes reducing access to firearms, bridges and dangerous sites, and medication.

6. Train service providers and educators in the early identification of predisposing factors and crisis management.

7. Conduct research and evaluation to inform the development of effective suicide prevention programs. These research efforts need to address the causes of suicidal behaviours, factors that increase risks for these behaviours, and factors that are protective and that may facilitate resiliency in vulnerable persons. Research must also evaluate the effectiveness of health and social services.

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* Source: Health Canada, *A Report on Mental Illnesses in Canada.*

APPENDIX B

POLICY DIRECTIONS FOR REDUCING SUICIDE RATES

Policy Implications*

The key findings from the literature and the outcomes of success stories suggest a number of policy directions.

First, it is clear that to continue to reduce rates of suicide among seniors and to influence the rate of children and youth suicide, attention must be given to

- The issues of low-income [families] so that the cycle of poverty can be broken
- The manner in which suicide is depicted in the electronic and print media
- The creation of environments and living conditions that increase social support, promote healthy coping and reduce the negative effects of loss
- The development of guidelines, regulations and legislation that ensure the safe storage of or reduce access to firearms and medications
- The ongoing commitment to community participation and involvement in improving the quality of life of its citizens.

Second, to enhance the potential for achieving health and well-being and to improve early identification, crisis intervention and treatment of people who are suicidal (or potentially suicidal), it is necessary to

- Implement appropriate and effective strategies for teaching cognitive and social-emotional skills to all people
- Increase the awareness among adults of the potential for children to take their own life
- Provide suicide prevention training for all gatekeepers
- Include suicide awareness education for students within a comprehensive school health approach
- Ensure that professional facilities (health related) at universities and community colleges provide training in suicide intervention skills and in suicide prevention.

Third, service delivery issues need to be given attention and emphasis. Specifically, it is important that

- Mental health professionals be given specialized training in the assessment and treatment of people at risk for suicide, interventions in first-episode affective illness and the assessment for comorbidity of affective illness and substance abuse
- A thorough assessment of possible drug interactions, especially for seniors, be undertaken
- Seniors be made more aware of available resources
- Appropriate and accessible services be available to the youth population.

Fourth, emphasis needs to be given not only to the evaluation of prevention and health promotion programs designed to reduce vulnerabilities to suicide, but also to multidisciplinary research to examine this multidetermined behaviour.

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* Source: Dyck, Mishara and White (1998).