



**THE CHANGING FACE OF YOUTH SUICIDE IN MANITOBA
and the Narrow Window for Intervention**

PHASE ONE REPORT

**A SPECIAL REPORT BY THE
OFFICE OF THE CHILDREN'S ADVOCATE
April 2015
MANITOBA**

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Special thanks to the Adolescent PsychHealth research group from the University of Manitoba and the Health Sciences Centre who helped inspire this project and who generously continue to provide their expert consultation to our office as we develop this project.

Cover image source: iStock photo

dreams

written by joey lecoy

i have a dream, that one day
i will leave all the negativity that has defined me
behind me.

and that one day,
i'll be living proof of successful change
and pave my own way.

i have a dream that positivity is reality
i have a dream, inspired by someone before my time.
my dream is to not survive but strive and be alive
rather than existing day to day with constant struggles
caught in a hustle with a negative mind.

i have a dream, that i'm reaching deep in the streets,
not necessarily preaching, but teaching - speaking my poetry
and telling youth that a broken home isn't the way it's supposed to be.
and that they deserve better.

i have a dream that there is light amidst the darkness
of the hearts of these children
that they don't have to be lonely, and that one day, they will realize that someone cares.

i have a dream that one day i will be there,
offering a helping hand as hope is rising.

i have a dream...

MANITOBA'S CHANGING FACE OF SUICIDE and the Narrow Window for Intervention

PHASE ONE REPORT

While suicide is the ninth leading cause of death for people of all ages in Canada, suicide is the second leading cause of death among young Canadians aged 15-24 (Canadian Mental Health Association Toronto, 2015; Navaneelan, 2012). This high rate of premature death in young people has been on the rise for many years. In 1974, suicide accounted for 9% of all deaths of young Canadians, by 2009, that had risen to 23% of all deaths of Canadian youth (Navaneelan, 2012).

Manitoba youth face life stressors that are similar to their peers across Canada. These can include balancing family relationships, schedule commitments, changing bodies, making decisions for future schooling and employment, peer dynamics and dating, self-discovery, increasing independence and responsibility, historical or ongoing trauma, and much more (Healthy Child Manitoba, 2014). While many youth are able to navigate through these common areas of stress, sometimes the resiliency needed for positive outcomes is more challenging for children and youth involved with child welfare who may have been exposed to Adverse Childhood Experiences (ACEs) that their peers have not had to face. As a result, risk of suicide deaths and suicidal behaviours can be more prevalent in the population of young people who are involved with child welfare. Within the province of Manitoba, the Office of the Children's Advocate closely follows, intervenes, and reports on the experiences of children and youth involved with Child and Family Services (CFS).

"Adverse Childhood Experiences (ACEs) is the term given to describe all types of abuse, neglect, and other traumatic experiences that occur to individuals under the age of 18."
http://vetoviolence.cdc.gov/apps/phl/resource_center_infographic.html

WHAT IS THE OFFICE OF THE CHILDREN'S ADVOCATE?

The Office of the Children's Advocate (OCA) is an independent office of the Manitoba Legislative Assembly that represents the rights, interests and viewpoints of children and youth throughout Manitoba who are receiving, or who should be receiving, services under *The Child and Family Services Act* and *The Adoption Act*. The OCA does this by advocating directly with and for children and youth, and by reviewing public services after the death of any young person where that young person or his or her family received child welfare services in the year preceding the death of the child. The Children's Advocate is empowered by legislation to review, investigate, and provide recommendations on matters relating to the welfare and interests of children and youth.

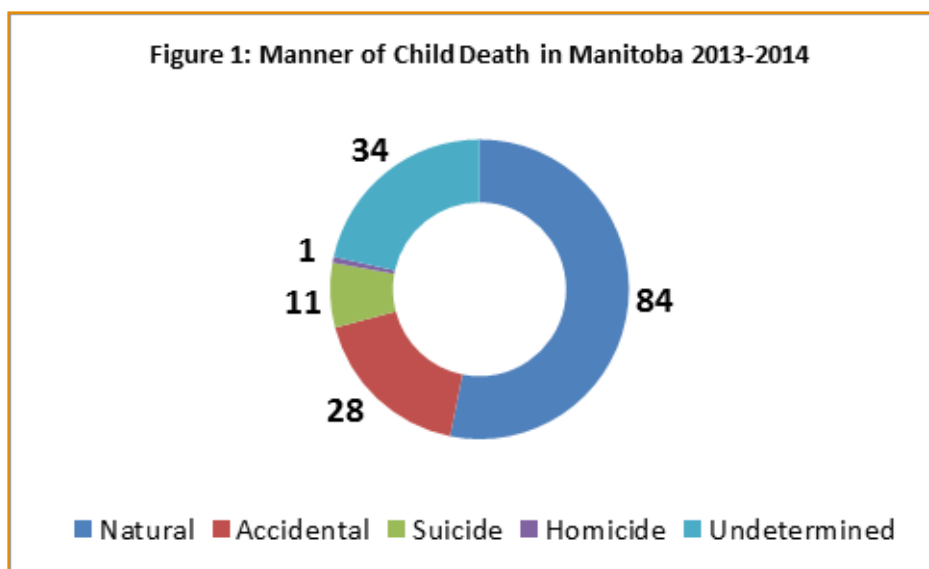
The OCA strongly believes that it is important to encourage public education and dialogue about the experiences and issues facing children and youth whose lives are impacted by public systems. Although much of the work undertaken by the OCA must remain confidential to protect vulnerable young people, significant time and resources are dedicated by the Children's Advocate to public education. Much of the public education material produced by the OCA is developed using the lens of children's rights, and specifically promotes The United Nations Convention on the Rights of the Child (UNCRC). The UNCRC, which Canada ratified in 1991, describes more than 40 central human rights which have been promised by to children and youth by worldwide governments, including the government of Canada.

The OCA also fulfills its mandated role according to the **best interests** provisions of both *The Child and Family Services Act* and *The Adoption Act*. This means that in all of the activities carried out by the staff of the OCA – from advocacy, to special investigations, to public education - the best interests of the young person are the top consideration.

WHAT IS THE SPECIAL INVESTIGATION REVIEW UNIT?

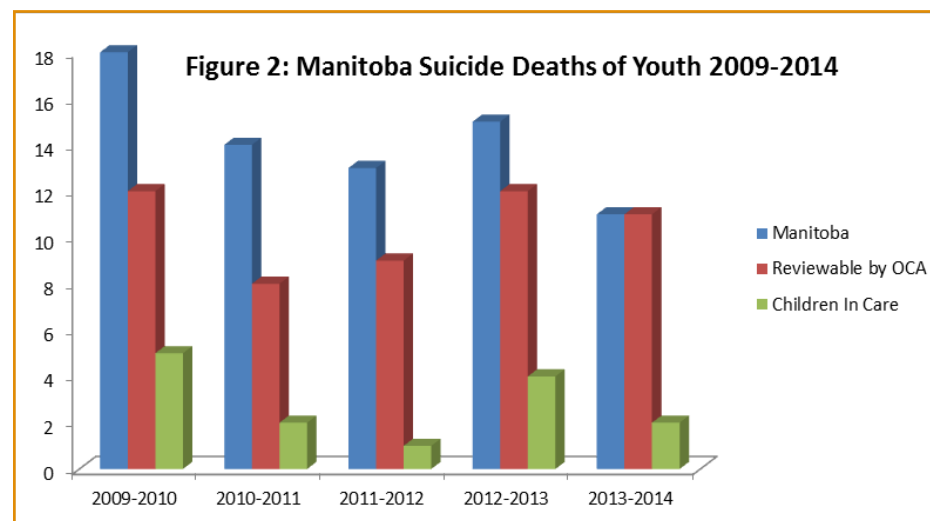
By law in Manitoba, the Children’s Advocate is notified of all deaths of young people under the age of 18. As described above, the Children’s Advocate is responsible for reviewing services that were delivered in the life of a child or youth if that young person or their family received child welfare services in the 12 months before the death of the child. This process is known as a Special Investigation Review (SIR). The purpose of a SIR is to identify ways in which the programs and services under review may be improved to enhance the safety and well-being of children and to prevent deaths of children in similar circumstances in the future.

There are five categories of manners of death that the chief medical examiner (CME) can assign following the death of any person. These include natural, accidental, suicide, homicide, and undetermined. On average, there are about 160 deaths of children and youth each year in the province and the majority of these deaths are deemed natural by the CME. Figure 1 provides the breakdown of manners of child death in Manitoba from April 1, 2013, to March 31, 2014.



Suicide deaths of children and youth, while not statistically common, are of significant concern as these deaths can be the outcome of significant and unresolved trauma in the life of a young person and can signal where gaps and

challenges exist in how public systems are adequately responding to the needs of young people. Since gaining the responsibility for child death reviews in 2008 through a change in provincial legislation, the OCA has initiated several research projects and analyses on the issues associated with youth who die by suicide. Figure 2 notes the rates of suicide deaths in Manitoba between 2009 and 2014, and describes those numbers in terms of overall suicide deaths of youth, those deaths which qualified for review by the Children’s Advocate based on child welfare involvement in the year preceding the death, and the numbers of suicide deaths that involved children who were in care at the time of their death.



While it might be tempting to look for trend analysis over the five years in which the OCA has had this reporting responsibility, caution is encouraged due to the relatively small sample size and the value of possible interpretations. For example, the rise in overall suicide deaths from 13 in 2011-2012, to 17 in 2012-2013 does not necessarily mean that youth were at greater risk in the second year. Similarly, the drop from 17 suicide deaths to 11 such deaths in 2013-2014 did not mean that Manitoba youth were safer. Instead, it may be more prudent to examine the factors common between these youth and the varying contexts in which they lived their lives.

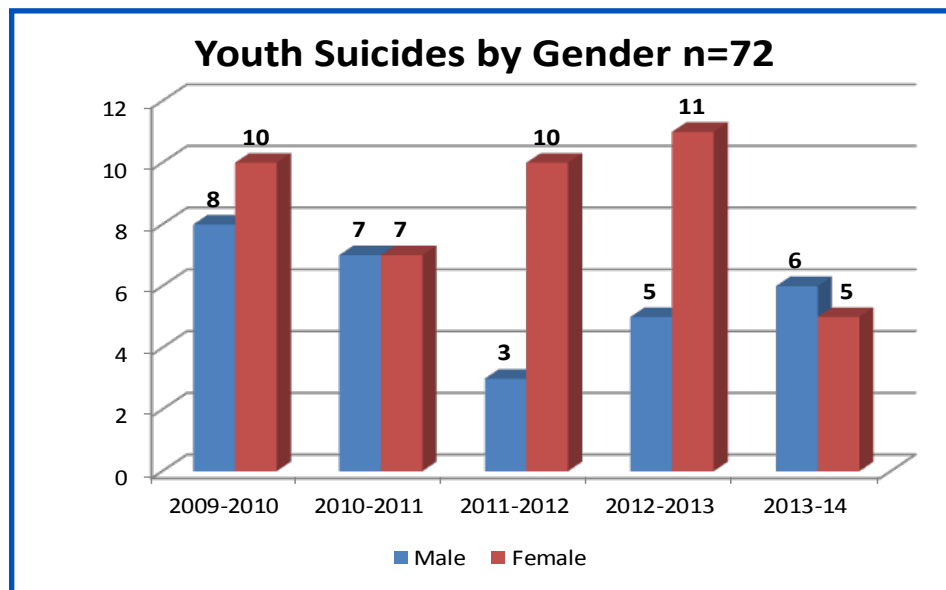
Commonly held beliefs about suicide often include that males die by suicide more often than females, that overdosing is a frequent method of suicide deaths, that friends and families may notice a significant change in personality or demeanor of the youth, and that often people will give away their possessions and signal that they are thinking about ending their life. In 2006, the OCA published a

report on child deaths in Manitoba called *Honouring Their Spirits*.¹ The report included analysis of certain issues associated with youth suicide, including confirming an established pattern that although females attempted suicide more frequently, their male counterparts were three times more likely to die by suicide. Since that report, these beliefs have not continued to be consistently reflected in what occurs in Manitoba. In the nearly ten years since that report was published, there has been a significant shift to suicides among female youth outnumbering those of male youth in many years (Figure 3). Hanging is the most common method of death and in Manitoba, this has been the cause in 94% of the 72 suicide deaths of youth that occurred between 2009 and 2014. Age at death is another area where the numbers are particularly concerning as the age at death is trending younger. For example, in the age group of 14 years and younger, there were four deaths by suicide in 2009-2010, three in 2010-2011, four in 2011-2012, five in 2012-2013 (including four 12 year olds), and 4 in 2013-2014.

The changing pattern of suicides that is seeing an increasing proportion of girls, a significant trend toward deaths by hanging, and possibly a younger demographic all speak to the need to re-evaluate our approach to youth suicide. These emerging changes may have significant implications for both the development and the delivery of prevention resources and intervention programs.

The OCA is strongly committed to public education and the belief that increased awareness by the general public of the experiences of children and youth will result in improved public systems and therefore better outcomes for young people.

Much of the work of the OCA occurs behind necessary confidentiality in order to protect the safety of children and youth. However, there are multiple resources published by the OCA to encourage wider public awareness, including an annual report summarizing all of the activity of the office. In addition, regular newsletters on youth rights, suicide prevention, plus information sheets that cover a range of topics for many audiences arise from the systemic themes and trends present in the work of the office. Several of the OCA's resources are available not only in English, but also in Cree, Ojibwe, and French.



Public presentations are a regular part of the OCA's activities and cover not only youth suicide, but also topics including youth rights and the UNCRC, CFS and social media, the intersection of education and child welfare, and many others.

THE CURRENT PROJECT

In 2013, the OCA presented at the Canadian Association for Suicide Prevention conference on the statistics and general trends emerging from 61 youth suicide deaths that occurred between 2009 and 2012. The presentation was well received and caught the attention of a member of the Adolescent PsychHealth research group from the University of Manitoba. The OCA was approached by the researcher to present to the university group. Those meetings began with a general presentation to the research lab and a subsequent brainstorm about possible areas for collaboration. Through meetings and ongoing communication, what developed was the idea for a three phase project examining youth suicide in Manitoba. Phase One of the research project would examine suicide risk factors that were present in the lives of 50 youth who died by suicide between January 1, 2009 and December 31, 2013, and who had been receiving child welfare services at their time of death or had received services in the year prior to their death. To further strengthen any findings, Phase Two would examine a randomized control group of 100 youth who had been receiving child welfare services in the time frame that the deaths had occurred: 2009-2013, allowing the OCA to examine factors common

¹Available online <http://www.childrensadvocate.mb.ca/wp-content/uploads/Child-Death-Review-2006.pdf>

between the two groups. Finally, Phase Three of the project would consist of the development of evidence-informed resource materials to be disseminated to community-level groups for their use in preventing youth suicide.

It is important to note that throughout each of the phases of this project, the OCA will continue to protect the identities of each of the youth and the OCA has also determined it will not make public the names of communities. There are a number of reasons for not including a geographical lens and one of those considerations is that a community noted to be where the youth originally lived may not have been a place where the youth spent significant time. Many youth, especially those involved with child welfare, experience inequity in access to services and are therefore relocated outside of their home communities. Some of these youth never return home, and this can be despite their clear desires to do so. This issue of equitable access to services is something that the OCA has consistently risen publicly and with the government and is worth dedicated study. The impact on young people to be taken out of home communities in order to find support, is examined in the present report within the context of the numbers of placement or residence changes that the 50 youth experienced. It would be a valuable examination to work with youth currently receiving child welfare services to examine their perceptions of the impact and demonstrated outcomes on established criteria.

PHASE ONE – EXPANDING AN UNDERSTANDING OF YOUTH SUICIDE IN MANITOBA

Between January 1, 2009, and December 31, 2013, there were 72 suicide deaths of Manitoba youth. As previously mentioned, the Children’s Advocate is responsible for conducting a Special Investigation Review of services that were delivered in the life of a child or youth if that young person or their family received child welfare services in the year before the death of the child. During the course of a Special Investigation Review, the Children’s Advocate must review the child welfare services provided to the youth and/or their family. In addition to reviewing the child welfare services provided to the youth and/or their family, the Children’s Advocate may also review the services provided by any publicly funded social service. What results from a review of these services is an in-depth look into the lives of these children and how services may be improved to enhance the safety and well-being of children.

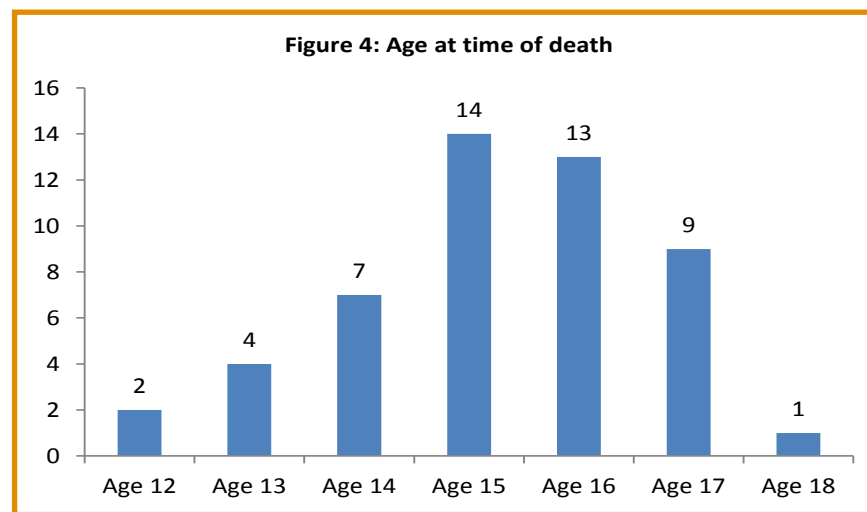
Of the 72 suicide deaths between January 1, 2009 and December 31, 2013, 50 met the criteria for a Special Investigation Review. Those 50 youth were included in the current study. The study explored a number of documented risk

factors for suicide (for a complete list of the risk factors included in this study, please see Appendix A). This Phase One status report examines those risk factors that emerged as significant.

YOUTH DEMOGRAPHICS

Age

Of the 50 youth who died by suicide between January 1, 2009, and December 31, 2013, the average age was 15. While the OCA is not typically informed of deaths of individuals over the age of 18, one youth aged 18 who had been receiving child welfare services within a year of their death was included in this sample. The decision to include this youth in the current project was based on the fact that the risk factors present in their life did not differ from the rest of the youth. Thirteen of the fifty total youth were 14 years of age or younger at the time of their death.



Sex

Research and statistics tend to show a higher number of males than females dying by suicide (Statistics Canada, 2013). The general belief has been that while females may attempt suicide more often, males would more often die by suicide as they would typically choose a more lethal method. In Manitoba, the OCA has noticed a trend of more female youth dying by suicide compared to males. Of the 50 youth included in this study, 36 were female. Kirmayer (2012) noted that “suicide rates among Canadian male adolescents have fallen in recent years, but they have risen for girls and female adolescents – trends that are reflected in other Western countries” (p. 1015).

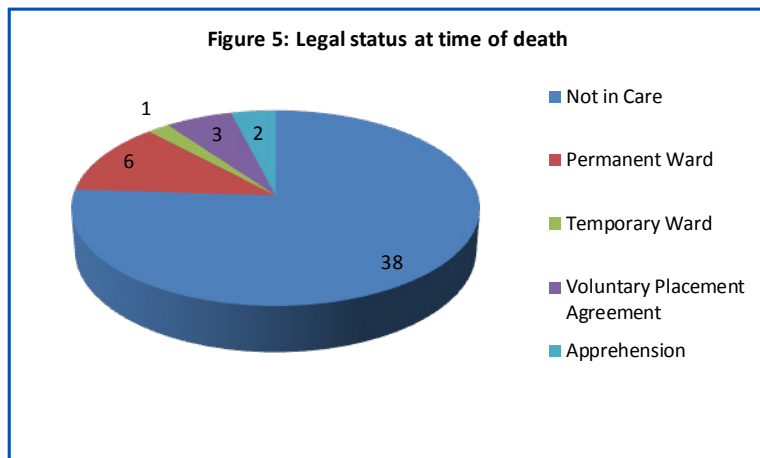
Legal Status

While all were involved with the child and family services system, the majority of youth within this sample were not formally in care at the time of their death. Twenty four percent (24%) of the youth were in care (e.g., Permanent Ward, Temporary Ward, Voluntary Placement Agreement, Apprehension). Children and youth involved in the child welfare system have frequently been exposed to an array of adverse childhood experiences, placing them at higher risk for suicide. Katz, Au, Singal, Brownell, et al. (2011) found that:

...among children and adolescents who were placed into the care of child and family services in Manitoba, rates of suicide, attempting suicide, hospital admission and physician visits were greater than among the general population of children and adolescents who were never in care (p. 1979).

Significantly, the authors found that the rate of suicide attempts, admissions to hospital, and physician visits were lower in the years following entry into care when compared to two years before entry into care. This may be due to a stabilizing effect in the wake of events that led to a youth entering into care.

Anderson (2011) noted that youth who enter the child welfare system and placed in out-of-home care may be "...at an increased risk for depressive symptoms, which in turn may increase their risk for suicide ideation" (p.795).



Method

Forty-eight (48) of 50 youth died by hanging. Historically, suicide by firearm or poisoning was common amongst adolescents, but has since shifted and hang-

ing is now found to be the most common method (Skinner & McFaull, 2012). This shift has also been seen in the United States and other countries (Kirmayer, 2012). While it is not possible to determine what has caused this shift, it is plausible that legislation surrounding firearms and safe storage has made it increasingly difficult for youth to have access to firearms. Hanging, on the other hand, is harder to prevent as the means that may be used are more commonly found and difficult to restrict. Hanging as a method is further concerning as the window for intervening to stop a suicide death by hanging is significantly narrower when compared to other methods such as a self-inflicted poisoning (i.e. overdose).

PHASE ONE – KEY THEMES THAT EMERGED

Poor School Attendance

Research has noted poor school attendance and school difficulties to be a risk factor for suicide (Bridge, Goldstein, & Brent, 2006; Joe & Niedermeier, 2008). Thirty-one (31) of the 50 youth included in this study were noted to have poor school attendance. Youth who are not attending school or other educational programming are disconnected from peers and the support system that the school environment offers, therefore placing them at increased risk (Bridge, Goldstein, & Brent, 2006; Joe & Niedermeier, 2008). Thompson, Connelly, Thomas-Jones, & Eggert (2013) note that youth at risk of dropout are more likely to be involved in behaviours (i.e. drug use, fighting) that elevate the risk of adolescent death including suicide. Thompson et al. (2013), further note that these youth "experience more depression, serious mental illness, and risk for suicide, yet have less access to health care and fewer personal and social resources" (p.74).

History of Hospitalization

For the purposes of this study, a history of hospitalization included admissions to hospital for reasons including mental health admissions (i.e., suicide attempts, ideation, depression, psychological evaluation), suspicious injuries, and assaults. Hospital admissions for non-urgent issues were not included. Sixty-six (66) percent of the youth included in this study had a history of hospitalization.

Zambon, Laflamme, Spolaore, Visentin, & Hasselberg (2011), conducted a study investigating the extent to which previous hospitalization for injury of any intent and the risk of subsequent suicide. The authors found that hospitalization for both intentional (i.e., self-harm) and unintentional (i.e. falls, motor vehicle accidents) injuries "were highly associated with the risk of future youth suicide, regardless of sociodemographic factors in the family" (p.178). The study noted that the risk of suicide was 40 times higher among subjects previously hospital-

ized for self-inflicted injuries, when compared to subjects without previous hospitalization. The study further found that “...previous hospitalization for assaults and unintentional injuries – such as falls or road traffic crashes – increases the risk of suicide among young people by 9 and 3 times, respectively, compared with young people without history of injury” (p.180).

Criminal Justice Involvement

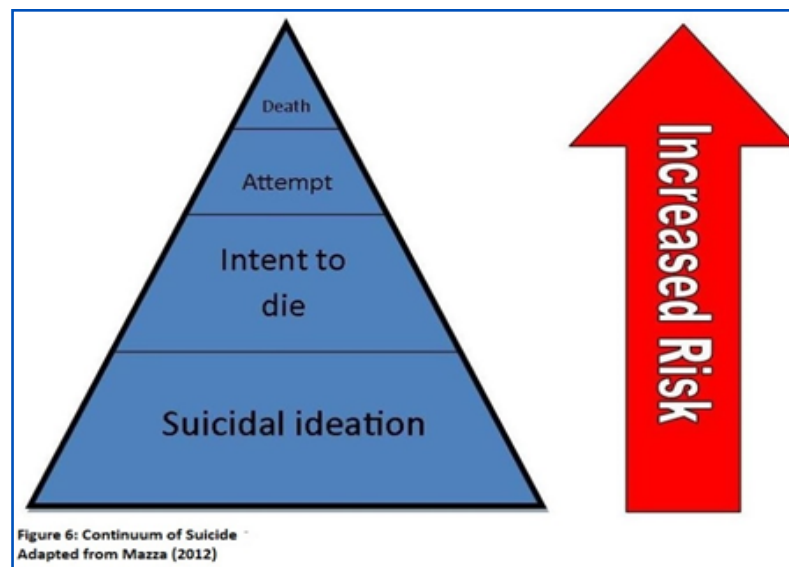
Criminal justice involvement is a broad category and was defined as any documented involvement with police officers, band constables, or the court system. Of the 50 youth included in this study, 34 had varying levels of involvement with the criminal justice system. Youth involvement with the criminal justice system ranged from less serious offenses such as public intoxication to more serious offenses such as second degree murder.

Casiano, Katz, Globerman, and Sareen (2013) found that the risk of suicide for incarcerated youth was three to 18 times higher than the risk in an age-matched control group and noted that the stressful nature of being confined could amplify risk in this population. The high rate of mental health needs of incarcerated youth in Canada was also examined by Gretton and Clift (2011), who found that for youth in some of British Columbia’s juvenile detention facilities 91.9% of males and 100% of females met assessed criteria for at least one mental health disorder. The researchers noted that in the months that preceded their study, 14.3% of the boys in this population, and 29.8% of the girls “experienced clinically significant levels of suicide ideation” (p. 113), and that this rate was two to four times higher than in the general population of Canadian youth. The links between youth justice and suicide risk is not new. Morris et al. (1995) assessed suicidal ideation in approximately 2,000 youth incarcerated in the United States and found that 22% had seriously considered suicide, 20% had made a plan to die by suicide, 16% had made at least one attempt, and 8% had been injured in such an attempt. A Quebec study found that adolescent girls involved in the justice system were at high risk for suicide due to their high rate of co-occurring conduct and affective disorders (Farand & Renaud, 2004).

Self-Harm, Suicidal Ideation, and Prior Suicide Attempts

The act of suicide can be seen as a behavior among a continuum of suicidal behaviours which include suicidal ideation, suicidal intent, and suicide attempts (Figure 6). “Suicidal behavior includes and incorporates a much larger set of behaviors than suicide alone. The behaviors along this continuum are not mutually exclusive, nor do all suicidal youth advance sequentially through them” (Miller & Eckert, 2009, p.154). As youth move along the continuum, the frequency of each behavior tends to decrease, however, the level of lethality and probability of death increases.

Self-harm can be defined as behavior that is self-directed and deliberately results in injury to oneself, for example, cutting oneself with a razor. It is important to note that self-harm behavior is not generally associated with thoughts of death and dying, but rather the intent is to alleviate stress (Andover, Morris, Wren, & Bruzzese, 2012). While the intent associated with self-harm may not be to die, the act of harming oneself as a coping method is concerning and is an opportunity for professionals to intervene. Thullen, Taliaferro, & Muehlenkamp (2015) noted that repetitive self-harm behavior may increase the risk of suicide as an individual’s fear of pain and injury is reduced over time, thus, “removing a barrier to completing suicide when they perceive themselves as a burden and feel disconnected from others in their lives” (p. 1). Research has noted that self-harm “has emerged as a strong predictor of both attempted and completed suicide” (Brent, McMakin, Kennard, Goldstein, Mayes, & Douaihy, 2013, para. Introduction). Twenty-two (22) youth included in this study had a documented history of self-harming. Self-harm is noted to be more common in female adolescents than male adolescents (Hawton, Saunders, & O’Connor, 2012). Of the 22 youth who had a history of self-harm behaviour, 19 were female.



Thirty-two (32) out of 50 youth in this study had a documented history of suicidal ideation. Suicidal ideation is the preoccupation with suicide and may include thoughts of suicide or verbally expressing suicidal thoughts or the wish to die. Fraser, Geoffroy, Chachamovich, and Kirmayer (2014) note that “suicide ideation and attempts are part of a continuum of suicidal behaviors and are among the strongest predictors of death by suicide” (para.2). Suicidal ideation not only increases a “youth’s risk of suicide attempts and of death by suicide, it is an important marker for an array of significant mental health needs, sexual risk behavior, substance use, and delinquent behavior” (Thompson, Connelly, Thomas-Jones, & Eggert, 2013, p.2).

Research has consistently noted that a previous suicide attempt is the single best predictor of suicide (Bridge, Goldstein, & Brent, 2006; Kirmayer, Brass, Holton, Paul, Simpson, & Tait, 2007). Brent, Baugher, Bridge, Chen, & Chiapetta (1999) noted that following a suicide attempt, the risk of a subsequent completion is elevated 10-60 fold. In their 2009 study, ten Have et al. noted that “attempted suicide is one of the strongest risk factors for death by suicide, and 60% of planned first attempts occur within the first year of ideation onset” (p.825). Twenty-four (24) youth included in the current study were documented to have prior suicide attempts. Due to data limitation, it is possible that more youth had prior attempts. The youth who were documented to have prior attempts were noted to have one to three prior attempts. One youth was noted to have attempted approximately 25 times, however, it is difficult to determine the accuracy of this information.

Substance Use – Youth and Parent

Parental substance abuse frequently precedes child welfare involvement. This category was examined in the present study by looking at the lifetime child welfare file information available. A number of studies have documented parental substance use (alcohol, drugs) as a risk factor for youth suicide (BC Coroners Service, 2008; Randell, Wang, Herting & Eggert, 2006; Rossow & Moan, 2012). Research has noted that parental substance use is a source of chronic stress for children as parental substance use can result in inadequate parenting and poor parent-child relationships (Sher, 1997).

A history of substance use has been noted to be a significant factor for youth suicide (Bridge, Goldstein, & Brent, 2006; Joe & Niedermeier, 2008; Walsh & Eggert, 2007; Esposito-Smythers et al., 2011), In addition to the direct effect that alcohol and other drugs have on one’s central nervous system and mood, a history of substance use may be indicative of personal, family, and commu-

nity distress, which may also have an impact on the decision to end one’s life. Esposito-Smythers et al. (2004) noted that alcohol and other drug use is associated with a three- to four-fold increase in the likelihood of suicide attempts.

Of the 50 youth in this study, 36 had parents who were noted to struggle with substance use, and 37 of the youth themselves had struggles with substance use documented in their child welfare files.

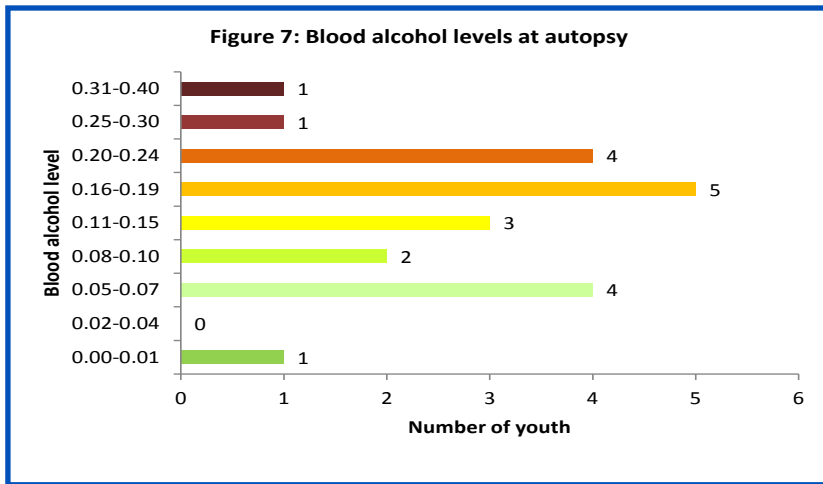
Alcohol or Drug Use at Time of Death

Unlike the previous category which reflects a longer view of a child’s historical experience, this risk factor refers to findings at autopsy and is therefore a snapshot in time. In suicide deaths, autopsies can yield significant findings with respect to the context in which decision-making was occurring in the final hours or minutes of the youth’s life.

As stated in Sher (2005), “Impulsivity and aggression are strongly implicated in suicidal behavior... Impulsivity has been related to suicidal and self-destructive behaviours within different psychiatric conditions, including alcohol and substance use disorders, mood disorders, conduct disorder, impulse control disorder, antisocial personality disorder, and borderline personality disorder” (para. 8). The use of alcohol and other drugs can be a frequent contributing factor in suicide and its use can impair one’s cognition, reduce inhibitions, increase impulsivity, and intensify negative emotions.

Twenty-one (21) youth had alcohol present in their system at the time of autopsy. The levels of alcohol in their systems ranged from 10 mg/dL (blood alcohol level of 0.01%) to 344 mg/dL (blood alcohol level of 0.344%). A blood alcohol level of 0.01% would typically leave an individual feeling lightheaded and would have a minor impact on one’s judgment. Affects at 0.344% may include onset of coma, acute alcohol poisoning, with 50% chance of death (Centre for Alcohol Studies and Education, 2013). The majority of youth fell within the 0.16%-0.19% range, meaning they may have been experiencing a state of system depression, were nauseous, disoriented, experiencing blurred vision, and with their judgment significantly impaired (See Figure 7, next page).

Twenty-one (21) youth had licit or illicit drugs present in their system at the time of autopsy. The majority of drugs found in youth’s systems were licit drugs, typically of the benzodiazepine classification (i.e., Xanax, Valium). Eight (8) youth had both alcohol and drugs in their system discovered at the time of autopsy.



Physical Abuse

Research has noted a history of physical abuse as a risk factor of suicide. Exposure to non-sexual child maltreatment such as physical abuse “is associated with increased risk of a wide range of psychological and behavioural problems, including depression, alcohol abuse, anxiety, and suicidal behavior” (Norman, Byambaa, De, Butchart, Scott, & Vos, 2012, p.2). Norman, Byambaa, De, Butchart, Scott, & Vos (2012) conducted a meta-analysis of studies analyzing the associations between non-sexual child maltreatment and outcomes related to mental and physical health. They found “robust evidence of significant associations between exposure to non-sexual child maltreatment and increased likelihood of a range of mental disorders, suicide attempts, drug use, [sexually transmitted infections], and risky sexual behavior” (p.23). Twenty-one (21) youth in the current study were documented to have experienced physical abuse.

Exposure to Suicide

A family history of suicidal behavior (i.e. ideation, attempts, suicide deaths) is noted throughout the literature as another significant risk factor for suicide (Bridge, Goldstein, & Brent, 2006; Joe & Niedermeier, 2006). While it is not fully understood why a family history of suicidal behavior increases one’s risk for suicide, some research suggests that there is a genetic factor in familial suicidal behavior (Agerbo et al 2002; Bridge, Goldstein, & Brent, 2006; Qin, Agerbo, & Mortensen, 2002). Another possible explanation is that “adverse circumstances could be familially transmitted by shared environment rather than by genetic mechanisms” (Brent & Mann, 2005, p. 22).

Consistent evidence indicates that children and youth who are already vulnerable to suicidal behavior are at greater risk of suicide if they are exposed to

suicide or suicidal behavior (Velting & Gould, 1997). Research shows that children and youth are often more susceptible to the suicidal behavior of family and peers than are adults (de Leo & Heller, 2008).

Twenty-two (22) of the 50 youth in this study were documented to have had family or friends who expressed suicidal ideation and/or had attempted suicide. Twenty-four (24) had experienced the loss of a family member or friend to suicide. Some of these youth knew each other and had been impacted by those previous deaths.

Placement Changes

The most common theme emerging across the youth files was that of placement changes. For the purpose of the current project, a change in placement was defined as a change in the youth’s living residence. This includes all documented placements throughout the youth’s life but does not include unplanned absences from placement (also known as AWOLs). It is important to reiterate here the various legal statuses of the youth at the time of their deaths. Twelve of the 50 youth were in care (6 permanent wards, 1 temporary ward, 3 voluntary placement agreements, and 2 apprehensions), and 38 of the 50 youth were not in care at the time of their deaths, although some had previously been in care, had returned home, but had been receiving child welfare services in the year that preceded the date of their death. The category of placement changes, then, refers to the changes in residence that were documented not only while the youth was in care but any placement change that was documented by child welfare during the life of the youth.

Seventy-eight (78) percent of youth in this sample group experienced placement changes. It is important to note that of the 38 youth who experienced placement changes, the number of placement changes ranged from 1-55 changes in residence. Instability and disruption in relationships is experienced differently by individual youth but may add to their levels of trauma and can lead to significant challenges in their lives. As one Berkley study noted:

There is a wealth of research attesting to the importance of sustaining placement stability because experiencing multiple placement changes can have important ramifications for children’s development...Frequent placement moves not only compounds the issue of being separated from one’s parents, but can also result in separation from siblings, relocating to a new geographical area, and experiencing a sense of not belonging; all of which can lead to distress and have a profound negative impact (University of California, 2008, August, p. 4).

The correlation between multiple placement changes and negative outcomes for youth has been well documented. These negative outcomes include behavioural problems (Rubin, O'Reilly, Luan, & Localio, 2007), poor academic performance (Pecora, Williams, Kessler, Hiripi, O'Brien, & Emerson, 2006), difficulty forming attachments, and greater risk factors including substance use, suicide attempts, and psychiatric hospitalization (Farmer, Mustillo, Burns, & Holden, 2008). This concern is also acknowledged by the Manitoba child welfare system. Social workers receive alerts through the mandatory computer file information system (known as CFSIS) when the file for a child or youth in care documents eight changes over the life of a file, or five within a 12-month period.

Placement instability “affects young people’s outcomes in part by undermining existing support networks and minimising opportunities to develop new relationships” (Stevens, Munford, Sanders, Liebenberg, & Ungar, 2014, p.448).

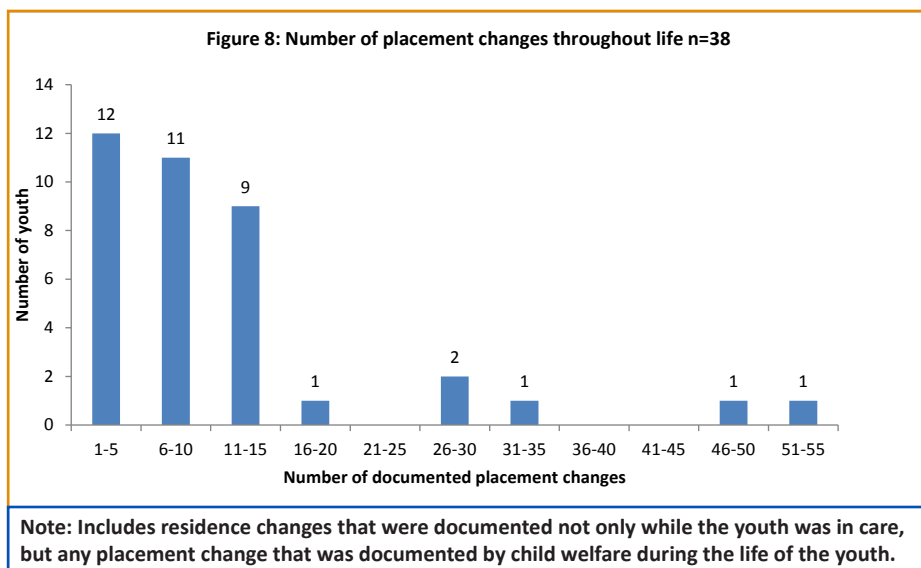
successful those services were in weaving a strong net of support for the child or youth who had been identified as in need of protection and extra care.

While the majority of child deaths in Manitoba are from natural causes, each year there are preventable suicide deaths of children and youth, which not only end a young life prematurely, but also leave in their wake a devastating impact on surviving family, friends, professionals who provided services, and more broadly, a society that shines a little less brightly for losing one of its young lights. While the numbers of suicide deaths may be relatively small each year, suicide deaths of children and youth sadden us all as they can sometimes be the outcome of significant and unresolved trauma in the life of a young person.

There are lessons that can be learned. This report represents the first of three planned phases examining youth suicide in Manitoba. In this Phase One report, the suicide deaths of 50 youth who died between 2009 and 2013 were examined. The child welfare files for these 50 youth, which theoretically should offer a comprehensive snapshot of their lives during the period that child welfare was active in their lives or the lives of their family, were closely examined for general demographics as well as several established risk factors for suicide in youth populations. Of the 50 files examined, the average age at death was 15 years old, there were more females than males, and the dominant method of suicide was hanging.

This demographic profile echoes what the OCA and other sources have begun saying: that the classic view of suicide and who is at highest risk is no longer accurate. Instead of a majority of males, a more common incidence of self-inflicted overdoses, or the belief that people will verbalize - even subtly - their intentions to die, these beliefs may no longer be reliable. In fact, what the data show in Manitoba is a greater proportion of females, an increasingly younger demographic, greater impulsivity, and a dominant method of hanging. This method - which accounted for 48 of the total 50 suicide deaths of this sample group is of significant concern as the means are particularly difficult to control. In addition, death by hanging greatly decreases the window of opportunity for outside intervention or a change in the person’s intent.

Major themes that emerged from the data collection included poor attendance at school, previous hospitalization, involvement with the criminal justice system, documented suicidal ideation, parental or youth substance abuse, and a high rate of placement instability in the lives of these 50 youth. All of these factors have implications for the development of teaching and training resources that can provide accurate information to youth as well as to prepare



CONCLUSION

The Office of the Children’s Advocate has a unique vantage point on the views, voices, and experiences of children and youth. In its ongoing advocacy work with youth involved in child and family services, OCA staff are able to develop deep understanding of the efficacy of public system delivery in Manitoba and how those systems respond to the needs of the youngest and most dependent citizens. Special Investigation Reviews (SIRs) under the direction of the Children’s Advocate represent a unique opportunity to step back and view the entirety of service delivery in the life of a child, and how

and train professionals and caregivers for assessing, intervening, and supporting the youth for whom they are responsible.

The next phase of this project is to compare the 50 youth who died with a control group of their peers who also were involved with child welfare in the established time frame. That phase, which is currently underway, is expected to be completed in several months and will allow for greater analyses of some of the risk factors that emerged in Phase One. Phase Three of this project will see the development of evidence-informed community resources that will be designed to support the ongoing efforts of family members, peers, and community organizations to reach out and help young people who are struggling and at risk of suicide death.

The topic of suicide can feel overwhelming. When a young person dies, those who knew the youth are often left wondering what more they could have done to save a life. The general public is left saddened by the premature loss of a life that had not yet reached its full potential. The examination of the factors involved in a young person's choice to die is an important one for many reasons. Changing trends can signal a need to update interventions and support services. Deeper conversation about the nature of death and the struggles that some youth endure is an important one since Manitobans are invested in continuing to strengthen communities and build more resilient populations. This is an issue that impacts us all. When one family loses a child we all experience a loss of what that child might have grown to contribute. Youth are incredibly resilient and it is a collective responsibility to continue creating safe and healthy communities that hear, include, value, and protect all children and youth...

...because even the smallest voice has the right to be heard.



LIMITATIONS OF THE DATA

The data obtained for this research project were obtained from the review of child welfare files, which are completed and compiled by social workers and others involved in the care of children and youth. Child welfare files may contain formal assessments, case notes, descriptions of interventions and case plans, abuse investigations, consultations with external experts, and more. Autopsy reports, when available, also formed part of the data reviewed for this phase of the project. Some sources of data, for example social worker case notes, can be created by well-trained, yet still subjective interpretations of observed incidents and behaviours. Further, as consistent levels of training across the provincial child welfare system in Manitoba has been a common area of concern raised not only by the Children's Advocate but echoed by others, it is important to note that documentation on some files was plentiful, while documentation on others was sporadic or contained a number of gaps. As such, the rates reported here may be lower than the actual rates of the various risk factors present in the lives of these youth. An additional limitation of the data is that a number of the risk factors examined (i.e., suicide attempts, suicidal ideation, abuse) may be under-reported by youth or social workers due to the sensitive nature of these issues. Finally, related to levels of training or a local understanding of risk, certain established risk factors may not be assessed at a community level as significant enough to document.

APPENDIX A

List of suicide risk factors explored in Phase One:

Physical abuse
Sexual abuse
Sexual exploitation
Youth substance use
Parental substance use
Domestic violence in the home
Poor school attendance
Bullying
History of hospitalization
Criminal justice involvement
Placement changes
Self-harm
Suicidal ideation
Suicide attempts
Attempts and/or ideation by family and/or friends
Suicide death of family member and/or friends
Recent conflict
Alcohol use at time of death
Drug use at time of death

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ARTICLE 6



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