



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

PHASE TWO REPORT

**A SPECIAL REPORT BY THE
OFFICE OF THE CHILDREN'S ADVOCATE
MANITOBA
2016**



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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 provided their expert consultation to our office as we developed this project.

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you try

being depressed
having no place to call home
being in care of CFS
wondering how many days you'll actually survive...
...getting your hopes up and then the world feels like it's gonna end
being promised something
by someone
you thought you could trust
but it was all lies.

being moved all over
having to live with strangers everywhere you go
even at home

you don't know this pain unless you've been through it.

-from a poem submitted by a youth in care, age 16

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

PHASE TWO REPORT

INTRODUCTION

Trauma changes children. When children grow up in environments of abuse and neglect, and when their home lives do not offer opportunities for them to form healthy attachments to healthy adults, the ways in which children view and understand the world changes. Much research has been dedicated to understanding the effects of trauma - early childhood trauma can manifest in adolescence and on into later years through things such as mood, anxiety, and behavior disorders, mental health issues, and more, which can lead – among other outcomes - to compromised social and cognitive abilities, self-inflicted injuries, and suicide.

It is not only the trauma itself that can be important, but also the environment in which the trauma is experienced. Multiple layers of trauma will also compound and amplify the impact on a child. With multiple traumas, the weight and burden a child is forced to carry grows larger. Findings published in *Children's Mental Health Research Quarterly* (Schwartz, Waddell, Barican, Garland, Gray-Grant, & Nightingale, 2011) indicate:

Researchers have found an unequal burden, with children living in disadvantaged circumstances experiencing significantly more trauma than those who are more advantaged. For example, living in poverty or living with a parent who has a mental illness or a criminal record can quadruple a child's risk of being exposed to trauma. These data suggest that much more needs to be done to protect vulnerable children, particularly those who are doubly disadvantaged by first experiencing significant adversity, then experiencing added trauma. These children clearly suffer from unacceptable levels of compounding — and often preventable — hardship (p. 3).

Manitoba families sometimes come to the attention of the child welfare system for reasons that are beyond child protection matters. Inequitable access to support services such as mental health assistance or addiction treatment can severely compromise a parent's ability to provide care for their child(ren) and can lead to critical events that compel child welfare officials to intervene in the best interests of children. Within Manitoba, issues such as poverty, inadequate housing, and a lack of clean water disproportionately affect indigenous families and are some of the factors that can result in a family coming to the attention of the child welfare system. Due to historical racism and targeted government attempts at cultural destruction, Manitoba's indigenous children live in some of the most challenging social environments, are more likely to experience early trauma, are more likely to enter care, and are subsequently more likely to experience additional trauma through involvement in the child welfare system, including separation from family and community, educational disruptions, a lack of therapeutic interventions, frequent placement changes, and uncertain futures. These and other factors have resulted in the current reality that in Manitoba, nearly 90% of the 10,295 children in care are indigenous, even though indigenous children comprise only about 26% of the child population of the province (Brownell et al, 2015).

It can be difficult to view the world through the eyes of a child. From an adult perspective, we may have the benefit of forethought, hindsight, and first-hand knowledge of trusting relationships, each of which builds our resiliency and assist us in facing disappointments and personal tragedies with the knowledge that despair and sadness are finite experiences that can be successfully overcome. When children and youth have experienced multiple traumas and a lack of adults who are consistently caring, nurturing, and emotionally available to them, their ability to view the world with hope can be severely compromised. For some youth, their accumulated trauma creates such significant sadness and despair that they feel there is no way to move beyond the pain. The critical role for all Manitobans, as caring members of our many interconnected communities, is to hear the stories of youth, nurture their abilities to navigate through that pain, and to create public systems that respond with meaningful action which reinforce their family structures and their individual self-worth.

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 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.

HISTORY OF THE MULTI-YEAR SUICIDE STUDY

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 inner strength needed for positive outcomes is more challenging for children and youth involved with child welfare who may have been

exposed to varying degrees of trauma that their peers have not had to face. As a result, risk of suicidal behaviours and suicide deaths can be more prevalent in the population of young people who are involved with child welfare.

In 2014, the Office of the Children's Advocate (OCA) embarked on a three-phase project examining youth suicide in Manitoba. Phase One of the research project was completed in 2015, and examined suicide risk factors that were present in the lives of 50 youth who died by suicide in Manitoba between January 1, 2009, and December 31, 2013, and who had been receiving child welfare services at the time of their death or had received such services in the year prior to their death (Office of the Children's Advocate, 2015b). Phase One found that the traditional beliefs of suicide and who is at risk may no longer be accurate. The data from Phase One showed that in Manitoba, a greater proportion of females die by suicide, at an increasingly young age, and hanging was found to clearly be the dominant method by which youth are dying by suicide. Major themes consistent between the 50 youth who died included inconsistent attendance at school, previous hospitalization for suspicious injuries, involvement with the criminal justice system, documented suicidal ideation, parental and youth substance abuse, and frequent placement moves.

This current report is intended to serve as a brief update on the multi-year study underway at the OCA and focuses primarily on the data obtained in Phase Two of the study. Phase Two compared a randomized control group of 100 youth who had been receiving child welfare services between 2009-2013 but who did not die by suicide, with the data obtained in Phase One from the 50 youth who were involved with child welfare in that same time frame and who died by suicide. The third and final phase of this research study will begin in spring 2016, and will focus on the development of evidence-informed community resources that will be designed to support the ongoing work of family members, peers, and community organizations to reach out and help young people who are struggling and at risk of suicide.

The information gathered to this point through Phases One and Two of this research study indicate that the vast majority of children and youth involved in child welfare present with some manner of known risk factors for suicide. As will be described in this report, the youth who made up our control group experienced abuse, were exposed to domestic violence, experienced addiction, self-inflicted injuries, suicide attempts, difficulty at school, and more. However, what we also observed is that the youth in Phase One who died by suicide often experienced these and other risk factors more frequently and for longer durations.

METHODOLOGY

In consultation with an adolescent psych-health research group at the University of Manitoba, it was determined that a sample size of 100 youth (2:1 ratio) who had been receiving child welfare services between 2009 and 2013 would be compared to the original sample of 50 youth. Phase Two file examination focused on data recorded within child welfare files and would exclude supplementary sources such as external health records, education files, and others. As the Manitoba child welfare system is administered through the oversight of four cultural child welfare authorities in addition to the government department, the process of establishing the randomized control group was discussed with the Child and Family Services Standing Committee, which is comprised of the provincial director of child and family services and the four chief executive officers of the four child welfare authorities.

The Child and Family Services Division (the government arm of the child welfare system in Manitoba, also known as “the Division”) was approached to assist the OCA in selecting the randomized control group and subsequently provided a database of young people between the ages of 12-17 who had involvement in the provincial child welfare system between January 1, 2009, and December 31, 2013. The Division provided a database of more than 24,000 children and youth who were either in care or had open protection files during the time period under review. The database was further narrowed to match the original group of 50 on legal in-care status and to mirror the percentage per child welfare authority of the numbers of children in care reported by the province in 2014. Of those files which met all criteria, a random number generator was used to ensure a truly randomized sample was achieved. The provincial mandate governing the Office of the Children’s Advocate (OCA) in Manitoba empowers the Advocate to access information and file materials from a wide variety of sources. Once the control group was established, letters calling for the selected control group files were distributed to agencies and authorities throughout the province.

Although the control group contained 100 youth, files documenting child welfare interventions related to a single youth may include multiple physical files. This can be influenced by the length of service involvement, the complexity of the issues identified, and the size of the family. For the established control group, a total of 381 physical files were reviewed. These included family files, child in care files of the youth, as well as files related to siblings of youth included in the control group. In addition to reviewing physical files, information available on the Child and Family Services Application computerized database system was reviewed. This provided a more complete picture of the lives of these youth. A total of 184 Child and Family Services Application files were reviewed. When reviewing files, information after December 31, 2013, was excluded. In addition, some youth in the control group reached the age of majority during the 2009-2013 period of review. In these circumstances, information on file after the youth turned 18 years of age was not reviewed.

The youth included in Phase Two of the research were between the ages of 12 and 17 during the time period of 2009 to 2013. Thirty-six (36) of the 100 youth reached the age of majority during this time period. The sample size included 78 females and 22 males. 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 communities involved.

The objective of the file review was to create a broad picture of the life of each youth and look for the presence of established risk factors and to then compare the data from the control group to the youth from Phase One who died by suicide. We used the same definitions of risk factors in both phases of the study. All 381 physical files and 184 database files were carefully reviewed and coded as we looked for documentation of the following factors in the lives of each of the youth:

1. History of physical abuse	7. History of being bullied	13. History of suicide attempts
2. History of sexual abuse	8. History of hospitalization: suspicious injuries	14. Number of suicide attempts
3. Sexual exploitation	9. Substance use- youth	15. Involvement in the criminal justice system
4. Witness/exposed to domestic violence	10. Substance use – parent	16. Placement changes
5. Poor school attendance	11. Suicidal ideation/attempts: family members	17. Number of placement changes
6. Behavioural problems in school	12. Self-harm	

LIMITATIONS

The data obtained for this research project were obtained from the review of child welfare files and information found on the Child and Family Services Application system. The information contained in files and information found on the Child and Family Services Application system is completed and compiled by social workers and others involved in the care of children and youth. This research project did not examine medical files or criminal justice files which would have led to additional data. Child welfare files may contain formal assessments, case notes, descriptions of interventions and case plans, abuse investigations, consultations with external experts, and more. Some sources of data, for example social worker case notes, can be created by well-trained workers, yet are 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.

FINDINGS - HIGHLIGHTS FROM THE FILE REVIEWS

The control group displayed many of the same risk factors as the youth who died by suicide. Many of the youth had grown up facing early trauma through abuse, addiction in the home, witnessing domestic violence, and being surrounded by adult caregivers who were struggling to parent them safely. This is not dissimilar from many children and youth in care who face the same barriers to success. In the control group, as in the group of youth who died by suicide, witnessing domestic violence, substance misuse, and exposure to suicidality were major themes linking the many youth we examined. The stark contrast between data from Phases One and Two is in the frequency and prevalence of the risk factors – youth who died by suicide talked about dying more often, more of them struggled with addiction, they had more hospitalizations for suspicious injuries, and more family members who had previously died from suicide. In the sections that follow, we provide an overview of some of that data and those comparisons to findings from Phase One.

THE IMPACT OF DOMESTIC VIOLENCE

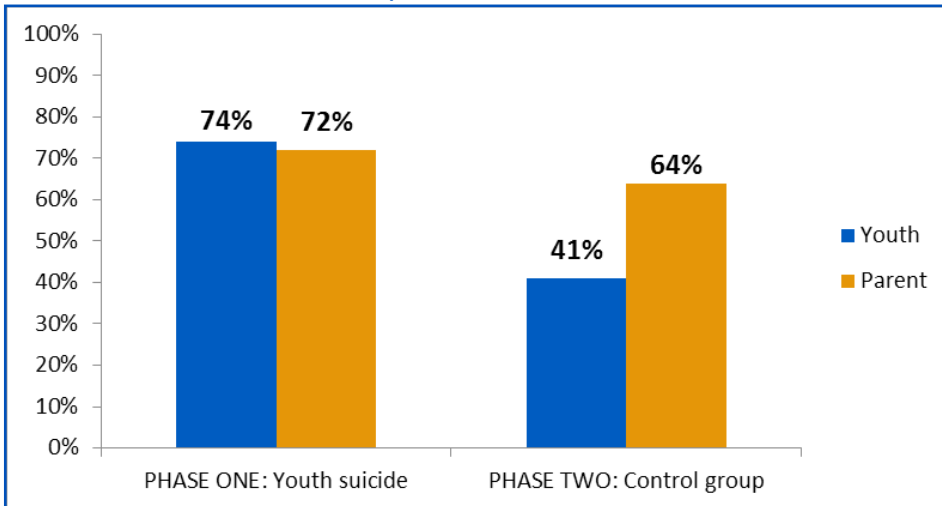
In 2013, Manitoba had the second highest rate of domestic violence in Canada (Statistics Canada, 2015b). The devastating effects of domestic violence on women who are survivors are well researched and widely acknowledged (for example, UNICEF, 2006). Recently, there has been increased focus on the impact of domestic violence on children. Witnessing and experiencing domestic violence can include **seeing** the actual incident, **hearing** threats or fighting from another room, and **observing** the aftermath of the violence such as blood, bruises, tears, and broken items (Domestic violence roundtable, 2008). The impact of seeing, hearing, or observing the aftermath of domestic violence can harm a child's physical, emotional, and social development and have lasting negative effects on the child's ability to grow and develop. When infants and children are exposed to violence in the home the additional stress has been shown to harm their brain development, impair cognitive and sensory growth, and jeopardize their physical and emotional functioning (Bellis & Zisk, 2014). "It is now understood that children who are growing up in homes with IPV [intimate partner violence] are being directly and indirectly exposed to a myriad of harms that may impact them in both the present and the future" (Lwin, Head, Wedeles, & Nikolova, 2015). As they enter school, children who have been exposed to domestic violence tend to have greater troubles with school work, show poor concentration and focus, and do not do as well in school in general (UNICEF, 2006). Children exposed to domestic violence have been shown to display personality and behavioural problems including depression, suicidal ideation, and bed-wetting (Children exposed, 2012).

Forty-five (45) of the 100 youth included in this study were known to have been witnesses to domestic violence. In Manitoba, *The Child and Family Services Act* (CFSA) does not expressly recognize domestic violence as a child protection concern. Currently, the *CFSA* provides several illustrations of a child in need of protection, under Section 17(2), which include incidents where the parent or caregiver is "unable or unwilling to provide adequate care," and where the child "is likely to suffer harm or injury due to the behaviour, condition, domestic environment or associations" of the parent or caregiver. While the possibility exists, this provides a narrow set of circumstances and does not explicitly acknowledge domestic violence as a child protection concern. Despite this gap in legislation, many child protection workers have come to recognize the impact witnessing domestic violence has on children and view domestic violence as a child protection concern, which allows workers to ensure appropriate services are put in place in the home environment that can help ensure children and youth are protected from living in violence.

SUBSTANCE MISUSE - YOUTH AND PARENT

The Manitoba Youth Health Survey Report (Partners in Planning, 2014) found that while 51% of youth reported having ever had a drink of alcohol, 25% reported drinking at least once in the previous month, and of those who had consumed alcohol in the previous month, 21% reported they had consumed alcohol on at least six days in the previous month. The researchers defined binge drinking as the consumption of five or more drinks in a session of drinking. They found, for example, that 30% of grade 11 students and 42% of grade 12 students had reported binge drinking during the previous month.

Figure 1-Substance misuse: Youth and parent



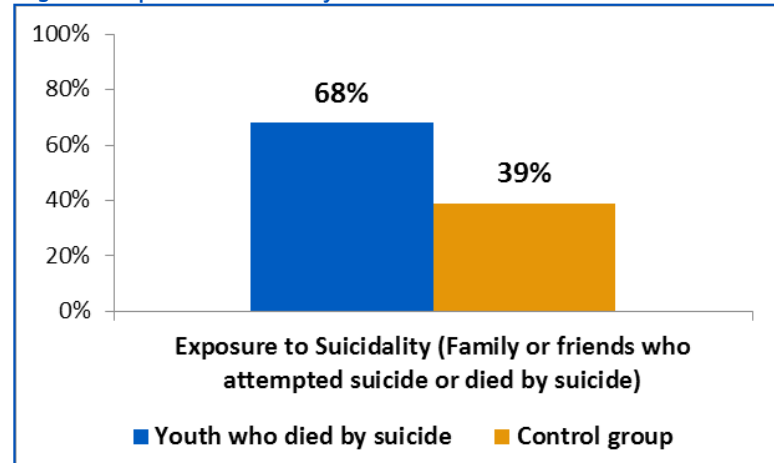
Marijuana is the most commonly used illicit drug within the Manitoba youth population. “Overall, 13% of students reported using marijuana/hashish one or more times in the past month, and 19% of students reported using it in the past year” (Partners in Planning, 2014, p. 46). Parental substance use frequently precedes child welfare involvement. When parents or caregivers misuse substances, this can increase risk to children and youth and can precipitate issues such as violence in the home, child neglect, and a lowered capacity for parents or caregivers to provide adequate care and protection to children and youth. “Family life for children with one or both parents that abuse drugs or alcohol often can be chaotic and unpredictable” (Parental substance, 2014, p. 3). Quite often these families are experiencing a number of other challenges such as mental health issues, domestic violence, unemployment, and housing instability which can create further stress (National Abandoned Infants Assistance Resource Center, 2012). Parents struggling with substance use often are unable to regulate

stress and emotion which can lead to impulsive and reactive behaviour which can in turn increase a child’s risk of abuse (Parental substance, 2014). Out of the 100 youth included in this study, forty-one (41) were documented to have used alcohol and/or illicit drugs. Sixty-four percent (64%) of the youth included in this study had parents who were documented to have a history of substance misuse. In Phase One of this research study, the youth and their parents exhibited even higher levels of substance misuse with 74% of youth and 72% of parents that had documented substance misuse issues (Fig. 1).

EXPOSURE TO SUICIDALITY

Thirty-nine (39) out of the 100 youth included in the control group had family members known by child welfare to have expressed suicidal ideation or family members who had attempted or died by suicide in the past. This compares to 68% of youth in Phase One who had experienced family member suicidal ideation, attempts, or the death of a family member from suicide (Fig. 2). When youth grow up in an environment hearing siblings, parents, and extended family members expressing their wish to die or attempting suicide when faced with adversity, they themselves may come to view suicide as a viable option when they are faced with adversity. This maladaptive coping style can then become the norm for these youth.

Figure 2- Exposure to suicidality



The Centre for Suicide Prevention is a national non-profit organization focused on prevention of suicide through research and public education. As part of their Info-Exchange series, they examined the issue of suicide contagion and suicide clusters. The researcher, citing well-respected social and transcultural psychiatric researcher, Laurence J. Kirmayer, described the increased vulnerability to

suicide of Canada’s indigenous communities as a result of the cultural genocide of previous government policies such as residential schools and the 60’s Scoop:

These wounds continue to fester in many areas today, often called “acculturative stress”, and inhibit the growth of a healthy environment. The young will be increasingly vulnerable as aboriginals are the fastest growing ethnic group in Canada...Indeed, suicide can become a “normalized” response to a seemingly hopeless existence, and these dire circumstances can further be exacerbated if the community formally chooses not to address the situation. In some areas the stigma of suicide is so strong that there is no word for it in the [local] language, and there is a pronounced reluctance to mention the word “suicide.” This state of denial makes the implementation of suicide prevention measures extremely difficult. Silence and a lack of suicide prevention initiatives in the lives of children and youth can be the strongest reinforcement of the message that what they are doing is not only normal, but also, on some level, expected (Kirmayer, 2007, as cited in Olson, 2013, p. 4.)

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. Therefore, it captured formal proceedings and incidents where child welfare officials were alerted and also determined the situation necessary to document in child welfare files. Of the 100 youth included in this study, 33% had varying levels of involvement with the criminal justice system. Youth involvement with the criminal justice system in the control group ranged from less serious offenses such as public intoxication, to more serious offenses such as assault with a weapon. Comparably, of the youth who died by suicide, 68% had documented involvement with the justice system with issues ranging from public intoxication to more serious charges of second degree murder (Fig. 3).

“Criminologists have noted that vulnerable youth, particularly those who have experienced trauma, poverty, discrimination, or abuse, are more likely to be arrested and charged with criminal behaviour” (Healthy Child Manitoba, 2012, p. 142). Healthy Child Manitoba’s 2012 Report on Manitoba’s Children and Youth indicates that “the most common violent Criminal Code violations by Manitoba youth are level 1 assault (without a weapon), uttering threats, and level 2 assault (with a weapon)” (p.143). According to Statistics Canada (2015a), Manitoba’s youth crime severity index has decreased from previous years, however, along with Saskatchewan remains the highest amongst Canadian provinces. In regard to the violent youth crime severity index, despite a 25% decrease, Manitoba recorded the highest youth violent crime severity index among all provinces in 2014 (Statistics Canada, 2015a).

POOR SCHOOL ATTENDANCE

Poor school attendance has been linked to a number of negative outcomes for youth (Baker, Sigmon, & Nugent, 2001; Henry, Knight, & Thornberry, 2012). These include substance misuse (Henry, & Thornberry, 2010), involvement in the criminal justice system (Weerman, Harland, & van der Laan, 2007), and poor mental health outcomes, including a higher risk of suicide (Bridge, Goldstein, & Brent, 2006; Joe & Niedermeier, 2008). Youth who are not attending school or other educational programming can be more disconnected from peers and the support system that the school environment can offer, therefore placing them at increased risk of suicide (Bridge, Goldstein, & Brent, 2006; Joe & Niedermeier, 2008). Thirty-three (33) of the 100 youth (33%) included in this study were noted to have poor school attendance. In comparison, 62% of the youth who died by suicide struggled with consistently attending school (Fig. 4).

Figure 3- Criminal justice involvement

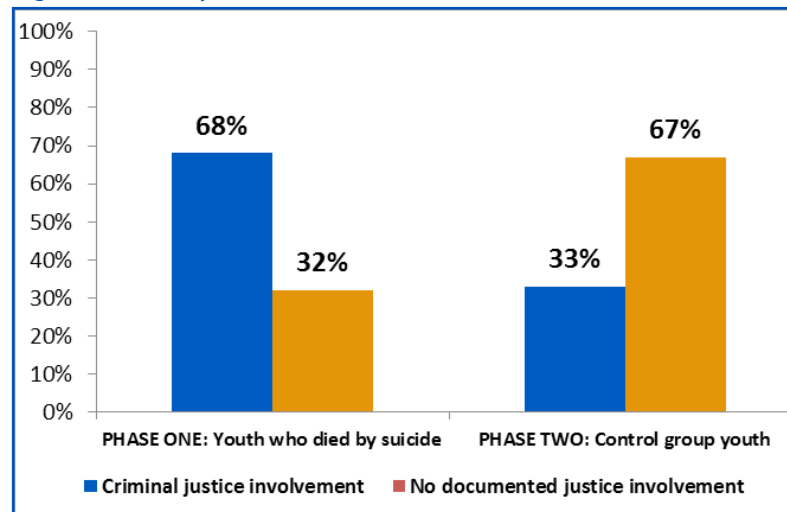
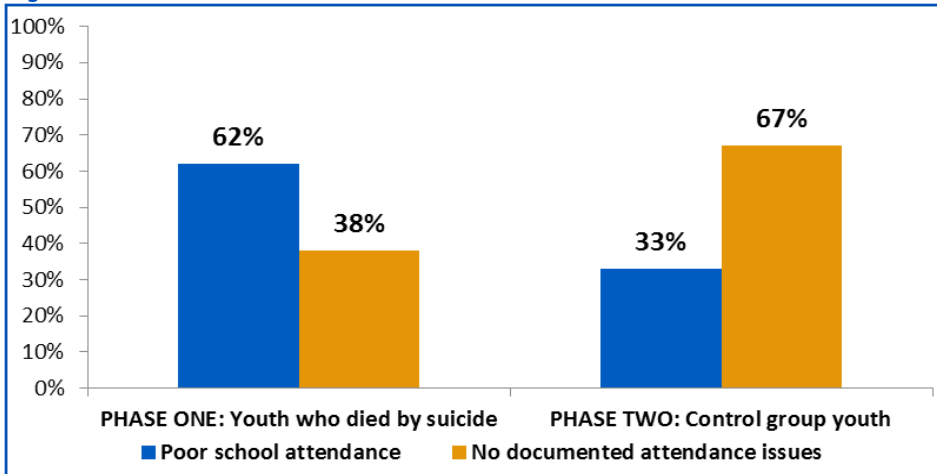


Figure 4- School attendance



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. Twenty-six (26) of the 100 youth included in this study had a documented history of suicidal ideation. In the Phase One group of 50 youth who died by suicide, there was nearly a three-fold increase of documented suicidal ideation within that population, with 64% of the youth who died by suicide having previously expressed their wish or intent to do so (Figs. 5,6). Fraser, Geoffroy, Chachamov-

Figure 5- Phase One: Suicidal ideation

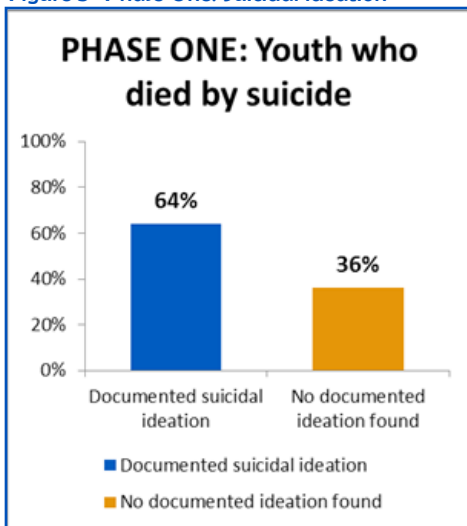
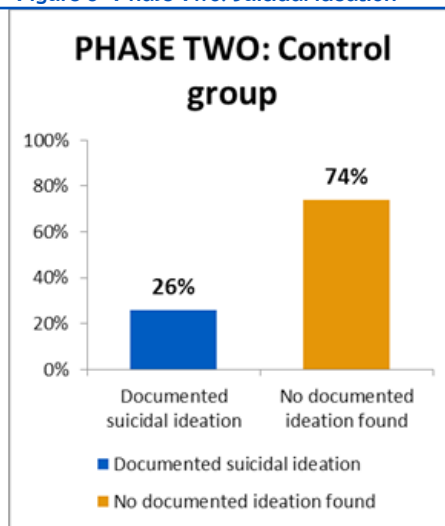


Figure 6- Phase Two: Suicidal ideation



ich, 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).

PHYSICAL ABUSE

Physical abuse can have a lasting impact on a child’s development. The 2012 Canadian Incidence Study of Reported Child Abuse and Neglect found that in 20% of substantiated child maltreatment investigations, the primary concern was physical abuse (Government of Canada, 2012). 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).

Figure 7- Phase One: Physical abuse

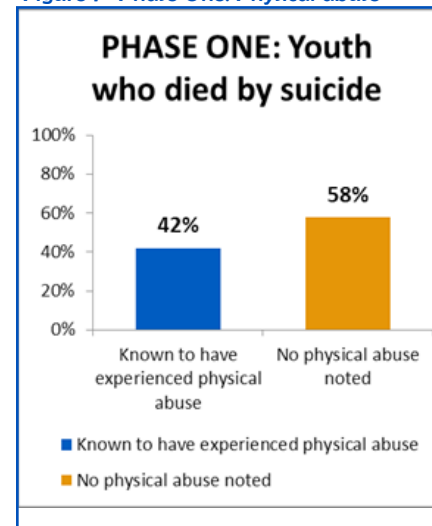
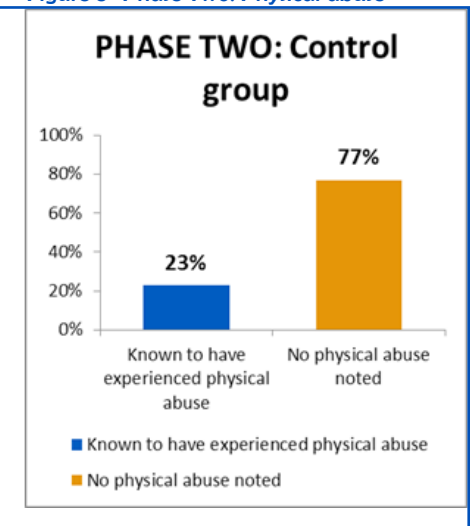


Figure 8- Phase Two: Physical abuse

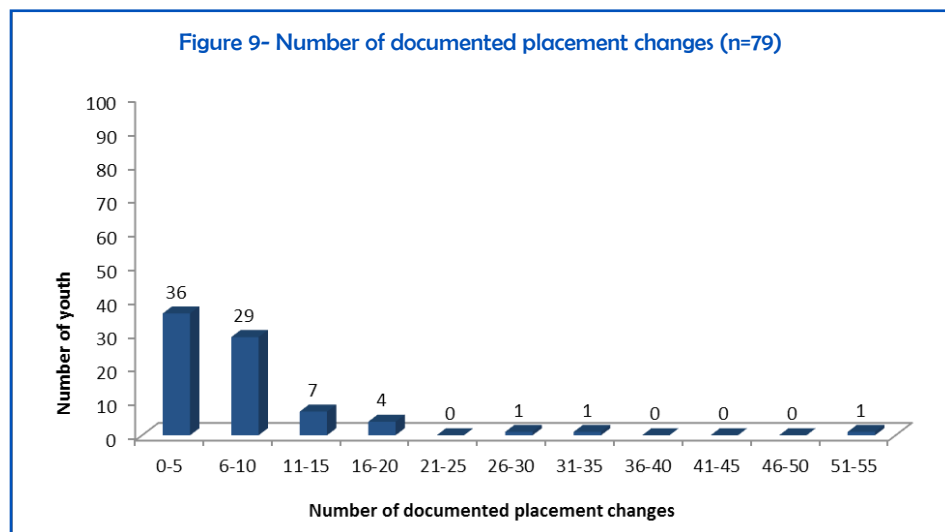


Norman, Byambaa, De, Butchart, Scott, and Vos (2012) conducted a meta-analysis of studies analyzing the associations between non-sexual child maltreatment and outcomes related to mental and physical health. They found “robust evidence of significant associations between exposure to non-sexual child maltreatment and increased likelihood of a range of mental disorders, suicide attempts, drug use, [sexually transmitted infections], and risky sexual behavior”

(p.23). Twenty-three (23) out of 100 youth included in this study were documented to have experienced physical abuse. In Phase One, which examined histories of youth who died by suicide, 42% of those 50 youth had been known to have experienced physical abuse in the home (Figs. 7, 8).

PLACEMENT INSTABILITY

A 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). 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, including entries and exits from care. Seventy-nine (79) out of one hundred youth experienced placement changes. It is important to note that of the 79 youth that experienced placement changes, the number of placement changes ranged from 1-54 changes in residence. The average of placement changes experienced by this group of youth was 8.



The correlation between multiple placement changes and negative outcomes for youth is well documented and is an issue about which the OCA has been outspoken. This is also a key concern raised with our office by youth. Sadly, many youth have come to understand that if they are in care, they will be moving often and that these moves tend to happen with little to no notice and little, if any

opportunity for the youth to participate in the decision. Negative outcomes associated with placement changes 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).

Placements can break down for myriad reasons – if a family ceases to foster, if the needs of the child are not adequately met by the placement resource, if siblings previously separated are being reunited in a different home, if there are allegations of abuse that are under investigation, if a caregiver becomes ill, as the needs of the child change over time, if a child enters secure custody or treatment and the bed cannot be held empty awaiting their return, and many others. While in theory, the child welfare system is committed to the least number of placement disruptions as is possible, the lived reality for many children and youth shows clearly that placement stability is not the priority it should be. In our work around the province with children and youth, they frequently tell us that from their perspectives placement instability and never feeling like they can unpack and relax is one of the most important issues the system needs to address.

DIFFERENCES BETWEEN PHASE ONE AND PHASE TWO

While there were a number of shared risk factors between the groups, a number of differences are apparent (Fig. 10). Poor school attendance, criminal justice involvement, exposure to suicidality, substance use (youth and parent), and placement instability emerged as key themes in both groups.

Placement instability emerged as a key theme in both groups with a significant number of youth experiencing placement changes. While the average number of placement changes was 8 for the control group and 9 for the suicide group, both groups had youth who had experienced a significant number more. Within the suicide group, the highest documented placement change experienced by a youth was 55 moves before their death. Within the control group, the result was similar, with one youth experiencing 54 documented placement changes.

Within the suicide group, self-harm, suicidal ideation, and prior documented suicide attempts were key themes. However, within the control group suicidal ideation emerged as a secondary theme with self-harm and prior suicide attempts not emerging as significant. Had medical records been reviewed as part of Phase Two, more information surrounding past suicide attempts may have

been revealed. However, this may also speak to the significance of past suicide attempts as a risk factor for suicide. 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).

Other differences included domestic violence emerging as a key theme within the control group, however, not within the suicide group; physical abuse was noted to be a key theme within the suicide group yet emerged as a secondary theme within the control group; a past history of hospitalization did not emerge as a theme within the control group; and sexual abuse emerged as a secondary theme within the control group but was not a theme within the suicide group.

It is also important to note that nine (9) youth in the control group presented with no documented risk factors. This result shows that not all youth involved with the child welfare system present with risk factors for suicide; sometimes youth are involved with child welfare for reasons such as a parent requiring additional support due to complex life circumstances.

Figure 10 - Comparing key themes between Phases One and Two

PHASE ONE: Suicide Group	PHASE TWO: Control Group
Poor school attendance	Poor school attendance
Criminal justice involvement	Criminal justice involvement
Exposure to suicide	Exposure to suicide
Substance misuse – youth and parent	Substance misuse – youth and parent
Placement instability	Placement instability
Self-harm, suicidal ideation, & prior suicide attempts	Domestic violence
Physical abuse	Suicidal ideation
History of hospitalization	Physical abuse
Alcohol or drug use at time of death	

DISCUSSION

Resilience is not a trait that a child has or does not have. Resilience is a learned behavior and develops through environmental influences especially in childhood such as attuned caregivers, healthy and attached relationships, and opportunities to practice navigating stressors (Perry 2006). “Many studies show that the primary factor in resilience is having caring and supportive relationships within and outside the family” (American Psychological Association, 2016). It is a myth to believe that children are inherently resilient or are born with the natural ability to withstand all the effects of traumatic events.

Sometimes children are mistaken for resilient when they are quiet or do not react in expected ways to events or circumstances which are believed to be traumatic. Individual reactions to traumatic events may vary wildly in children and include feeling helpless, anxious, guilty, ashamed, angry, and paralyzed with fear. Commonly, children may lack the ability to articulate their feelings and may withdraw or conversely, act aggressively as ways to cope with the event. It is important, especially within the context of child welfare work, to probe the presenting behaviours and reactions so as to best support the individual child. As Grogan (2013) suggests:

It’s comforting to think of children as immune to negative events. It’s terrifying to think that we might not optimize their brain development, and that we might impair their capacity for emotional intimacy, social harmony, and even genuine happiness (para. 10).

Many children who enter care have experienced trauma. The types of trauma can include incidents of physical, sexual, or emotional abuse, neglect, exposure to domestic violence, and many of the risk factors already discussed. For some children and youth, the event of coming into care itself can be a traumatic event. When a person under the age of 18 experiences any of these forms of trauma, it is known as an adverse childhood experience (ACE). For many of these children, the unstable and potentially volatile environments they are exposed to can leave them in a state of chronic psychological stress. In 2015, the OCA released Safe for Today, a report that examined how the Manitoba child welfare system is meeting the needs of youth in care with complex needs (Office of the Children’s Advocate, 2015a). In the report, the OCA examined the issue of ACEs and the impacts on children and youth:

A number of studies have examined the cumulative and interactive impact of adverse child events (ACEs) on child, adolescent and adult functioning... Some particular adverse life experiences have been correlated with both short-term and long-term detriments in health and functioning, all of which are relevant to child protection work: physical abuse, sexual abuse, emotional abuse, and exposure to family violence, as well as parental substance misuse and parental mental health issues, an incarcerated parent, and parental separation or divorce, are all associated with an increased risk of mental health issues, behavioural problems, and risk-taking behavior. For those who experience six or more of these adverse life experiences, the risk of premature death is twice as high. The number of adverse life experiences also contributes to initiation of alcohol use earlier in adolescence, which increases the risk of adult substance dependence (Dube, Miller, Brown, Giles, Felitti, Dong, & Anda, 2006, as cited in Office of the Children’s Advocate, 2015a).

According to researchers from Adults Surviving Child Abuse (ASCA), ACEs can impact a wide range of internal systems and result in: decreased brain cortex activity (rational behaviours), increased limbic system sensitivity (emotional behaviours), decreased hippocampal volume (informational processing and spatial context of memories and events), underdevelopment of left brain (language centre), a smaller corpus callosum (the pathway connecting brain hemispheres), neuro-endocrine alterations (responsible for regulation of stress responses, moods, immune strength) and more (Impact on the physiology, n.d.). In addition, the ASCA confirmed what many researchers note, that children and youth who experience abuse and neglect can often live in a state of “hyper-arousal” (para. 17) because their bodies are flooded with cortisol, or stress hormones. The researchers note that, “The nervous systems of children who are abused run on a constant high because they are constantly anticipating further danger” (ibid., para 17). And further, that:

...Children and adults with histories of child abuse often respond excessively to minor triggers. Traumatized children (and adult survivors) become increasingly responsive to relatively minor stimuli as a result of decreased frontal lobe functioning (learning and problem solving) and increased limbic system (amygdala) sensitivity (impulsiveness) (Streeck-Fischer & van der Kolk, 2000, as cited in Impact on the Physiology of the Brain, n.d., para. 1).

Research over the last two decades confirms that experiencing ACEs can lead to significant negative health and social outcomes for children (Centers for Disease Control and Prevention, 2014). ACEs increase the vulnerability of an individual to issues regarding future health and well-being. Abuse and other ACEs are strong and overlapping risk factors for significantly poorer health outcomes in adult years (Chartier, Walker, & Naimark, 2010). Further, because they are at a critical stage of development, young children may be particularly vulnerable to early adversity. In conditions of chronic psychological stress, there is evidence that this stress can impact a child’s brain development. This, in turn, can contribute to significant learning and behaviour problems (Barr, Boyce, Fleming, Mac-Millan, Odgers, Sokolowski, & Trocme, 2012).

After years of neglect, abuse, family and community breakdown, violence, and risk-taking behaviours, some adolescents are among the most challenging clients an agency may have on its caseload. All too often these youth who have experienced significant trauma in their lives present with challenging behaviours and a degree of defiance. Too often these youth are labelled “manipulative” “resistant” “self-absorbed” or “selfish.” At a basic level this perceived selfishness or manipulation is simply self-preservation. These early childhood ACEs have left these youth feeling as though they cannot depend on adults to protect

them and provide for them. At some point along the path of their involvement with professionals, some youth lose the empathy of their workers, who no longer seem to recognize the challenging behaviours as symptoms of unresolved trauma and unmet needs. Instead, these youth become viewed as resistant to support and the onus for change seems to come to rest firmly on the shoulders of the child, who was given neither an example of positive development, nor a consistent, caring adult with whom they could form a healthy and flourishing attachment. The culture of blame comes to focus on the youth and their trauma histories are forgotten or dismissed.

Rather than blaming youth for displaying predictable behaviours which emerge from the trauma they have experienced, our focus needs to be on nurturing their feelings of self-worth and inner strength. We need to make sure that youth know they are important members of families and of their communities. Youth can be incredibly resilient and it is our 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.*





When I was very young, I did not have good role models in my family.

It is easy for a young Aboriginal teen to look around and believe there is no hope for a great future. While in care I had many people who have cared about me and guided me down the right path. When I finish school and am no longer in care I would like to become a mentor myself. I would like to...show other young Aboriginals that there is hope. That no matter where you come from or your past history you can be successful. I feel like I could be an example of how support, hard work and dedication can allow you to overcome obstacles and allow you to become anything you put your mind to.

I would like to become the positive role model I looked for before coming into care.

Youth in care, age 17



WHAT'S NEXT

The release of this Phase Two update report also signals the beginning of Phase Three of this research study. The third and final phase of the project will include additional analysis of the data we have collected, focus groups, and community discussions. It is our goal to use all of the knowledge gathered during the project to guide the development of evidence-informed resources that can be shared throughout the province. These resources are intended to be multi-media and aimed at diverse audiences, including resources for youth and their peers, for families supporting youth, for professionals responsible for critical interventions and ongoing support, and for the general public, with an aim to better educate all people in Manitoba on the changing nature of youth suicide in our province.

One clear finding from this study has been that youth most at risk of suicide are struggling to be consistent in school attendance, and may not currently be exposed to some of the suicide prevention materials and campaigns available to them as traditionally, we rely on school systems to deliver much of that information. It is our hope to find such gaps and offer made-in-Manitoba solutions that are tailored to our provincial youth population and those who surround and support them.

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