"Stop Giving Me a Number and Start Giving Me a Person"

How 22 Girls Illuminate the Cracks in the Manitoba Youth Mental Health and Addiction System

PHASE FOUR REPORT

A special report of the Manitoba Advocate for Children and Youth 2020

TRIGGER WARNING

This report includes discussion of mental illness, addiction, child abuse and neglect, violence, and death by suicide. In telling the stories of the 22 youth in this report, we have carefully considered each detail included in this final version. Be advised, however, that some information in this report may not be appropriate for all readers.

> If you or someone you know is struggling, help is available. In Manitoba, call the Manitoba Suicide Prevention & Support Line 1-877-435-7170, or visit <u>www.ReasonToLive.ca</u>

In order to protect the privacy of the 22 youth whose stories inspired this report and to respect the privacy of their families, no names or other identifying information have been included. Although the Manitoba Advocate is legally permitted to publicly release personal information, including personal health information, in this report those details are anonymized and pseudonyms are used.

About Our Office

The Manitoba Advocate for Children and Youth is an independent, non-partisan office of the Manitoba Legislative Assembly. We represent the rights, interests, and viewpoints of children, youth, and young adults throughout Manitoba who are receiving, or should be receiving, provincial public services. We do this by providing direct advocacy support to young people and their families, by reviewing public service delivery after the death of a child, and by conducting child-centred research regarding the effectiveness of public services in Manitoba. The Manitoba Advocate is empowered by legislation to make recommendations to improve the effectiveness and responsiveness of services provided to children, youth, and young adults. We are mandated through *The Advocate for Children and Youth Act,* guided by the *United Nations Convention on the Rights of the Child* (UNCRC), and we act according to the best interests of children and youth.

Copyright[®] 2020 Manitoba Advocate for Children and Youth All rights reserved. Printed in Canada. ISBN (online): 978-1-9995410-7-1 ISBN (paperback): 978-1-9995410-8-8

For information concerning this report contact: **The Manitoba Advocate for Children and Youth Office** 270 Osborne Street North Winnipeg, Manitoba R3C 1V7 **Email:** info@manitobaadvocate.ca

This report can be reproduced, in whole or in part, provided the source is cited.

Suggested Citation

Manitoba Advocate for Children and Youth. (2020). "Stop giving me a number and start giving me a person": How 22 girls illuminate the cracks in the Manitoba youth mental health and addiction system. Online: <u>https://manitobaadvocate.ca/wp-content/uploads/MACY-Special-Report-Suicide-Aggregate-2020.pdf</u>



An aggregated Special Report published after 22 individual child death investigations conducted in accordance with Part 4 and Part 5 of *The Advocate for Children and Youth Act*

For the purposes of this document, all identifying information with respect to individuals, including the child/youth/young adult, services, and places has been modified or removed to protect their confidentiality and privacy.

TABLE OF CONTENTS

TABLE OF CONTENTS	7
Our Commitment to Reconciliation	9
Dedications	9
EXECUTIVE SUMMARY	10
ONGOING SUICIDE RESEARCH AT MACY	13
METHODOLOGY	15
BACKGROUND	19
THE COMPLEXITY OF SUICIDE	28
An Analysis of Suicide Risk Factors	29
Social Determinants of Health and Risk Factors for Suicide	32
HOW CAN WE PREVENT YOUTH SUICIDE IN MANITOBA?	35
A Tiered Model, Where Services Match Needs	35
There Are Still Too Many Gaps and Barriers	37
Steps in the Right Direction: Recent Provincial Investments	42
RECOMMENDATION ONE: CONDUCT A GAP ANALYSIS	46
RECOMMEDNATION TWO: DEMONSTRATE EQUITABLE ACCESS TO SERVICES	47
Early Trauma Requires Targeted Intervention	48
There Are So Many Benefits to Investing in Children	51
From Trauma-Informed Care to Healing-Centred Engagement	55
RECOMMENDATION THREE: TRAIN WORKERS ON TRAUMA AND ITS EFFECTS	57
RECOMMENDATION FOUR: HELP FAMILIES LEARN WHERE THE RIGHT RESOURCES ARE	59
Rural Youth Have the Right to Equal Service Quality and Availability	60

Youth Service Hubs and Focal Points: Increasing Service Integration across the Continuum	64
RECOMMENDATION FIVE: CREATE MORE YOUTH HUBS	68
RECOMMENDATION SIX: CREATE FOCAL POINTS OUTSIDE OF WINNIPEG	69
Recommendation in Action: Enhancing Community Wellness with a Continuum of Essential Services	70
Families Need System Navigators, or Co-Pilots	72
The Top Tier on the Continuum Requires Special Investments	79
Persistent Underfunding of the Youth Mental Health and Addictions System	83
RECOMMENDATION SEVEN: CREATE LONG-TERM TREATMENT FOR YOUTH WITH THE HIGHEST NEEDS	85
Interventions Improve when Services Talk to Each Other	86
APPENDICES	93
Appendix A: Findings and Recommendations Summary	93
Appendix B: Acronyms	95
Appendix C: Terms of Reference	96
Appendix D: References	98

Our Commitment to Reconciliation

The mandate of our office extends throughout the province of Manitoba and we therefore travel and work on a number of treaty areas. Our offices in Southern Manitoba are on Treaty 1 land, which is the traditional territory of Anishnaabeg, Cree, Oji-Cree, Dakota, Ojibwe and Dene peoples, and the beautiful homeland of the Metis nation. Our Northern office is on Treaty 5 land, and the services we provide to children, youth, young adults, and their families extend throughout the province and throughout Treaty areas 1, 2, 3, 4, 5, 6, and 10.

As an organization, we are committed to the principles of decolonization and reconciliation and we strive to contribute in meaningful ways to improve the lives of all children, youth, and young adults, but especially to the lives of First Nations, Metis, and Inuit young people, who continue to be disproportionately impacted by systemic inequalities and other barriers in our communities. With a commitment to social justice and through a rights-based lens, as an office, we integrate the *United Nations Convention on the Rights of the Child*, the *United Nations Declaration on the Rights of Indigenous Peoples*, and the national Truth and Reconciliation Commission's *Calls to Action* into our practice. Our hope is that the scope of our work on behalf of children, youth, young adults, and their families contributes to amplifying these voices and results in tangible improvements to their lives and outcomes.

Dedications

This report is dedicated to those who have been harmed or lost their lives as a result of a mental illness. It is our hope that in sharing the stories included in this report, readers will understand the pervasiveness of this issue. The symptoms of mental illness can impact every aspect of one's life and can result in a great deal of pain and suffering. People living with a mental illness must be afforded equitable access to appropriate treatment that would improve their life and wellbeing. The *United Nations Convention on the Rights of the Child* dictates that every child and youth has the right to quality health care, which includes mental health care. In Manitoba, *The Advocate for Children and Youth Act* empowers the Manitoba Advocate "to take steps to raise awareness and understanding of the *United Nations Convention on the Rights of the Child.*"

We all have a role to play in eliminating the stigma of mental illness, to ensure that when people are hurting they know help is available and that they are loved and valued members of the community. The power of language is immense and can have a significant impact on those struggling with mental illness as well as their families. We hope that those reading this report take a few minutes to watch a YouTube video by the Manitoba Advocate for Children and Youth titled 'The Language of Suicide' and keep the suggestions made in this video in mind while reading this report.

The Language of Suicide: https://www.youtube.com/watch?v=n4jYcUHtu_g If you or anyone you know is struggling with a mental illness, please reach out for help. You are not alone. Manitoba Suicide Line (toll free): 1-877-435-7170 Kids Help Phone (toll free): 1-800-668-6868 24-hour Youth Crisis Services in Winnipeg: 204-949-4777 24-hour Youth Crisis Services outside Winnipeg: 1-888-383-2776

EXECUTIVE SUMMARY

Awareness of suicide is rising, especially deaths by suicide of children, youth, and young adults. In 2017, the Mental Health Commission of Canada reported that suicide was the second leading cause of death for young people ages 10-24 in Canada (Mental Health Commission of Canada, 2017). Alarmingly, in Manitoba, suicide is the leading manner of death for young people ages 10-17 (Figure 1).

As the Manitoba Advocate for Children and Youth, and in accordance with provincial law, I am notified by the Office of the Chief Medical Examiner of all deaths of children, youth, and young adults across the province up to the age of 21. Using those official death notifications, my office determined that in the last five years, as reflected in the chart below, Manitoba has lost 79 youth to suicide, an average of nearly 16 each year.

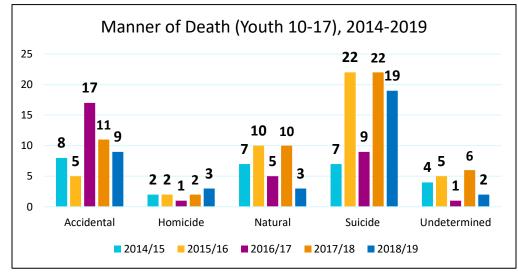


Figure 1 – Manner of Death for Youth ages 10-17 from 2014 to 2019 (5 year trend).

I first shared this information publicly in February 2020, when I released a report, *The Slow Disappearance of Matthew: A Family's Fight for Youth Mental Health Care in the Wake of Bullying and Mental Illness*.¹ The investigation my office conducted into the suicide death of 16 year old Matthew showed how difficult it can be for children and youth in our province who live with profound mental illness and how desperately frustrating it is for their families who often struggle to lace together the available patchwork of interventions. Matthew's story added volume to the ongoing calls by many youth, families, and health care experts in our province about just how hard it

is to get effective mental health services if you are a child or youth. While we have excellent clinicians and individuals working within the system,

¹To read Matthew's story, please see: <u>https://manitobaadvocate.ca/wp-content/uploads/MACY-Special-Report-The-Slow-Disappearance-of-Matthew-Feb2020.pdf</u>

it is the structure of the system itself that is not child-friendly or youth-focused. Because services have long waitlists and restrictive entry criteria, while also reporting ironically high vacancy rates, many children and youth languish and it is their families who are tasked with holding them together, sometimes for many months, before help is offered. This system profile was described again in the government-commissioned full-scale review of the mental health and addiction system in Manitoba, *Improving Access and Coordination of Mental Health and Addiction Services: A Provincial Strategy for all Manitobans* (Virgo Planning, 2018; also known as "the Virgo Report"). The authors of the Virgo Report underline how underfunded and underperforming the youth mental health system is here and they make key recommendations calling on the provincial government to address the gaping cracks in service delivery. The authors write:

Needs are extremely high: Manitoba stands out as the highest or very high on almost all SUA/MH need indicators, including those related to health, social and justice-related factors. Behind the "numbers" lies a huge financial drain on the province as well as an often tragic physical and emotional drain on communities, families and individual Manitobans. Taken together, the overall level of need clearly signals a call to action (Virgo Planning, 2018, p. x, emphasis in original).

And further, "Rates of complex SUA/MH [substance use/mental health and addictions] challenges are high amongst Manitoba's children and youth – and are in stark contrast to the comparatively low levels of funding for SU/MHA services" (Virgo Planning, 2018, p. xx). The report also notes that "About 7.2% of government health expenditures in Canada went to SUA/MH services; this percentage ranking well below several other high-income countries...In 2016/17, Manitoba only allocated 5.1% of the health budget to SUA/MH services" (Virgo Planning, 2018, p. 9).

While some investments have finally, slowly, begun to roll out from the Department of Health, Seniors and Active Living, it is clear it is the adult system that currently has the eye of the government and as a result, youth are being forced to wait for a future phase of government investments. As needed dollars for youth mental health and addictions care are being spent on other government priorities, Manitobans must understand the impacts these decisions are having on kids. Again, suicide has become the leading manner of death for youth in Manitoba.

That startling revelation has been heard by Manitobans. In the weeks since I released Matthew's report, staff at my office and I have received countless messages, phone calls, and other contacts from people who want to share about a youth they know who is also struggling, like Matthew. Many of you have reached out to tell me that you are frustrated with the lack of available services when children and youth need

mental health and addictions supports. You read Matthew's story and how hard his family worked to save their son, and you are telling me that you fear you know a Matthew too.

The report I am sharing today builds on Matthew's story. Today's special report is about the lives of 22 Manitoba girls who died by suicide while seeking mental health and addiction services in our province. Through the experiences of these girls, our province has an opportunity to commit to changes and a course of action that can improve young lives and reduce the likelihood of future suicides. Today, I make seven recommendations that reflect 22 individual investigations, an analysis of the current youth mental health and addiction system, recent taxpayer-funded publications such as the Virgo Report (Virgo Planning, 2018), The Peachey Report (Health Intelligence, 2017), and relevant government announcements and investments. My team consulted with system experts and community leaders and we studied best practices in other jurisdictions. Importantly, we spoke with youth to best understand what they need in their lives when they are struggling and require support. Their lives and their voices are reflected in the seven recommendations I am making today – recommendations designed to increase government transparency, accountability and effectiveness. Of note, their overall message was clear: when they need help, what they want is to be connected to knowledgeable people who care and who can show them the way from pain and loneliness to healing and connection.

The issue of suicide has long been an area of focus for my office and my team and I are driven, as advocates for children and youth, to continue to deepen our understanding of the stories of all youth who are hurting in order to improve our knowledge of what supports and interventions might make the difference for a youth in crisis. I invite all Manitobans to read this report and consider its messages, especially if you, like me, have children and youth in your life whom you love and for whom you dream a brighter future. If you are concerned about a situation involving children, youth or young adults who are in need of public services, I also invite you to contact my office for advocacy services. Reach out to us also online if you want to learn more about all of the areas of our work: from youth engagement, to advocacy, to investigations, research, and recommendations tracking. Our ongoing work and activities are widely available through our website and social media.

It is an honour and my ultimate privilege to serve the children, youth, and young adults of Manitoba as their Advocate.

Respectfully,

Daphne Penrose, MSW, RSW Manitoba Advocate for Children and Youth

ONGOING SUICIDE RESEARCH AT MACY

The Manitoba Advocate for Children and Youth (MACY) office, previously known as the Office of the Children's Advocate, has released several reports concerning youth suicide. Such reports include *The Changing Face of Youth Suicide in Manitoba and the Narrow Window for Intervention, Phase One* (Manitoba Advocate, 2015) and *The Changing Face of Youth Suicide in Manitoba and the Narrow Window for Intervention, Phase Two* (Manitoba Advocate, 2016). Both of these are chapters within a multi-phase study of youth suicide in Manitoba underway at MACY. This report released today is *Phase Four* of that ongoing work.

Phase One of the research project was completed in 2015, and examined risk factors for suicide 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 within the year prior to their death. *Phase One* found that the conventional beliefs of suicide and who is at risk may not be true here in our province. The data showed that in Manitoba, a greater proportion of females die by suicide, at an increasingly young age. Major themes consistent between the 50 youth who died included inconsistent attendance at school, previous hospitalization for suspicious injuries, involvement with the youth justice system, documented suicidal ideation, parent/caregiver and youth substance misuse, and frequent placement moves.

The *Phase Two* report, released in 2016, examined a randomized control group of 100 youth who had also been receiving child welfare services in the same time frame in which the deaths included in *Phase One* had occurred. Common risk factors among the control group from *Phase Two* included poor school attendance, youth justice involvement, exposure to suicidality, parent/caregiver substance misuse, youth substance use, placement instability, witnessing or exposure to violence in the home, suicidal ideation, and physical abuse. While these risk factors were present in nearly all of the 100 youth, the same risk factors were amplified almost two-fold in many of the youth who died by suicide.

What emerged from our first two phases was the importance of early intervention in the lives of youth. For instance, our data showed that the youth who were most at risk for suicide began to struggle with consistent school attendance after age 12. This is significant since Manitoba, like many other jurisdictions, relies heavily on the public school system to deliver the bulk of suicide prevention information. Because our study suggested that the youth who might benefit the most from those prevention messages may not be in the classroom to receive them, we looked further upstream for solutions.

In 2016, MACY partnered with the Canadian Mental Health Association (Manitoba and Winnipeg) to develop *Phase Three* of the ongoing suicide study: an innovative, population-level mental health promotion program for children ages 8-12. Thrival Kits[™] is a classroom-based curriculum, led by teachers over the span of a school year. Its goals are to embed mental health and mental wellness into everyday life, teach coping strategies, and build self-identity and self-confidence through the lens of good mental health. Over the course of a school year, students build their Thrival Kit[™] – a shoe box-sized kit students fill with small, meaningful items as they complete classroom challenges and mental health promotion activities throughout the school year. Thrival Kits[™] use creativity, reflection, and interpersonal skill development to help children understand who they are and what makes them special and unique. In October 2019, the Government of Manitoba invested in enhancing mental health programming available to Manitoba children and youth and announced that it would be providing substantial funding to the Thrival Kits[™] project over the next three years so that every grade 4-6 student in Manitoba can participate.

This report released today acts as *Phase Four* of our multi-phase research project and also utilizes those established risk factors from *Phase One* and *Phase Two* of the project as mechanisms to quantify risk for suicide for the youth whose stories informed this report. These risk factors are supported by research examining suicide risk and include both individual and environmental factors. It should be noted, however, that based on trends observed by MACY, school behaviour problems has been added to the 19 risk factors included in *Phases One* and *Two*.

Risk factors for suicide

Alcohol use at time of death	Pare
Bullying	Plac
Drug use at time of death	Роо
Exposure to violence in the home	Prev
History of hospitalization for suspicious	Rec
injuries or mental health admissions	Scho
History of sexual abuse	Self

- Parental substance misuse Placement changes/housing instability Poor school attendance Previous known suicide attempts Recent conflict (close friend or partner) School behavioural problems Self-harm
- Sexual exploitation Suicidal ideation Suicidality of family/friends (attempts or ideation) Suicide death of family member and/or friends Youth substance use

METHODOLOGY

Through child death notifications received in the 12-month period between April 1, 2018, and March 31, 2019, 32 children, youth, and young adults under age 21 died by suicide in our province. Since September 15, 2008 (when the responsibility for child death reviews was transferred to the Manitoba Advocate), 159 children and youth (ages 9-17) have died by suicide in Manitoba. These numbers are particularly staggering when we consider that suicide is preventable, if appropriate interventions are targeted and available early. This report aims to add to the growing body of evidence and insight into youth suicide by analyzing themes and trends in the stories of 22 female youth (ages 10-17) who died by suicide in Manitoba between 2013 and 2019.

As mentioned, the Manitoba Advocate is notified of all deaths of children, youth, and young adults up to age 21 in Manitoba. The Advocate holds both the legal responsibility to assess each death and the discretion to further review or investigate the public services that were providing support to the child, youth, young adult, or their family.²

The Manitoba Advocate for Children and Youth was notified by the Office of the Chief Medical Examiner of the deaths of the 22 female youth included in this report, between the years of 2013 and 2019. It was determined that those deaths were in scope for review as the youth, or their family, were receiving child welfare services at the time of the death or in the one year prior to their death. As such, formal notifications of the Manitoba Advocate's intent to conduct a review of services were sent to the child welfare agency involved and the appropriate Child and Family Services Authority. In this case, 12 youth who died had received services from the First Nations of Northern Manitoba Child and Family Services Authority, five received services from the Southern First Nations Network of Care, three from the General Child and Family Services Authority, and two from the Metis Child and Family Services Authority.

Following the review phase, the cases where female youth had died by suicide were aggregated for the purposes of conducting an investigation into the services provided to them and their family. A formal notification of the Manitoba Advocate's intent to conduct a deeper investigation was sent to the Minister of Families. On March 15, 2018, however, *The Advocate for Children and Youth Act* (ACYA) was proclaimed and the scope of MACY's work was broadened under the Advocate's new mandate. Additional notifications were forwarded about the investigation to

² See Appendix C for further information about *The Advocate for Children and Youth Act* (ACYA). For information on the notification process and reports by the Chief Medical Examiner to the Manitoba Advocate for Children and Youth, see *The Fatality Inquiries Act*, particularly S.10(1-2).

the Minister of Health, Seniors and Active Living, the Minister of Justice, and the Minister of Education in those cases where the youth received mental health services, addictions services, youth justice services, individual educational programming, or victim support services in such a way that fell under the purview of the expanded legislation, referred to as "designated services."

The services reviewed for this investigation include those provided by:

- The child and family services (CFS) agencies and CFS designated intake agencies (DIAs), which included CFS agencies overseen by each of the four CFS authorities in Manitoba, which receive their mandates through Manitoba Families;
- Addiction services across the province, both residential and community-based, provided by or funded by Manitoba Health, Seniors and Active Living;
- Mental health services, both inpatient treatment and community services, provided by or funded by Manitoba Health, Seniors and Active Living;
- Schools across the province under the authorities of provincial school divisions, which receive their mandates from Manitoba Education;
- First Nations schools overseen by the boards of directors for the relevant First Nations education authorities;
- Manitoba Justice records from both youth custody facilities and probation services across the province; and
- Victim support services records from Manitoba Justice.

Additionally, supplemental files reviewed included The Reports of the Medical Examiner and Autopsies, the records of various Manitoba police services and RCMP from, records of various health centres and facilities across the province, Child Protection Centre records, nursing station records provided by the First Nations and Inuit Health Branch (FNIHB), and private practice therapy records.

When reviewing records from those services above for the purposes of an investigation, particular attention was paid to those circumstances and factors that corresponded to suicide risk factors previously examined by the Manitoba Advocate and discussed in the preface section in this report. In addition to those analogous factors, themes that had not previously been identified were also noted.

Further to the 131 designated services files reviewed, interviews were conducted with several service providers in the designated service area of mental health including:

• Representatives from the Manitoba Adolescent Treatment Centre (MATC), including Rural and Northern Telehealth Services;

- Child and Adolescent Psychiatry at Health Sciences Centre;
- Child Health at Heath Sciences Centre;
- Children's Emergency Children's Hospital at Health Sciences Centre;
- Two additional community mental health organizations involved in the provision of various mental health services in Winnipeg; and
- The Northern Health Region.

These interviews served to increase understanding of the mental health system in Manitoba and how a child or youth would move through that system when they were accessing services. Further, our office gathered representatives' professional impressions about the functioning of the current system and its ability to meet the needs of children and youth in Manitoba.

Our office also held two comprehensive focus groups with MACY's Youth Ambassador Advisory Squad! (YAAS!) to discuss youth suicide and service delivery by designated services in Manitoba.³ YAAS!, made up of a number of Youth Ambassadors, plays a pivotal role in the work of MACY by providing a deeper understanding of the issues facing youth in Manitoba and feedback on how government services could be improved to better support them. The importance of including the voices of youth in a report discussing challenges that have impacted their lives cannot be understated. Youth are the experts in their own lives and YAAS! members voiced clearly what they feel is needed to support and foster good mental health. Their input, advice, and feedback is integrated throughout this report with the intent to create meaningful change and improve the effectiveness and responsiveness of services provided to children and youth in Manitoba.

Through comprehensive file reviews, identification and analysis of risk factors for suicide, and interviews with service providers, missed opportunities for intervention or gaps in the services provided to the 22 female youth and their families, were identified by the Manitoba Advocate for the purposes of this report. All identifying information in this report with respect to individuals, including the child/youth/young adult and their families, service providers, and places has been modified or removed to protect confidentiality and privacy. This report contains the Manitoba Advocate's recommendations for systemic improvements that may prevent the deaths of other youth in Manitoba who face similar circumstances. To see earlier recommendations that focus on Winnipeg services, please see the recently released report *The Slow*

³Designated services are defined in *The Advocate for Children and Youth Act* as including: child and family services, adoption, disabilities, education, mental health, addictions, youth justice, and victim supports (including domestic violence and sexual exploitation).

Disappearance of Matthew: A Family's Fight for Youth Mental Health Care in the Wake of Bullying and Mental Illness (Manitoba Advocate, 2020).⁴

When the draft of this report was completed in February 2020, agencies, authorities and government departments that provided information for this investigation were given a copy to review and were invited to attend an in-person briefing hosted by the Manitoba Advocate to discuss the investigations and findings. In several cases, organizations and government departments were provided both a draft copy of the report and an in-person briefing.⁵ The purpose of the domain meetings are two-fold: to verify the accuracy of the information presented in this report, and for the Manitoba Advocate to receive and consider any service or policy updates or feedback on the report. In acknowledgement of the essential voice of Indigenous political leaders and governance systems, the Manitoba Advocate extended invitations to Manitoba Keewatinowi Okimakanak, the Assembly of Manitoba Chiefs, the Southern Chiefs Organization Inc., and to the Manitoba Metis Federation to review this report and its conclusions. Prior to the release of the report, briefings were held with Indigenous government representatives.

It is important to note that there are limitations to this special report. The accuracy of our evidence relies on the completeness and accuracy of administrative records and the veracity of service providers in the additional information collected during interviews. Furthermore, especially when examining issues of mental health, mental illness, and suicide, formal training and understanding by service providers will play a role in their abilities to identify risk and protective factors, understand the complexity of presenting issues, and develop action plans and interventions that respond in meaningful ways. While in many cases, data were verified and cross-checked with multiple sources, this was not always possible. Unfortunately, however, in some cases, there was a lack of documentation all together.

After the conclusion of an investigation, or the release of a special report, our work continues. Under *The Advocate for Children and Youth Act* (ACYA), the Manitoba Advocate is empowered to monitor and report publically on the levels of compliance with recommendations made under the ACYA. Our office is committed to improving public awareness and opportunities for public education. To that end, the Advocate has initiated processes whereby systems, which receive recommendations for change, will be required to report their progress to the Advocate every six

⁴Find the report online at our website: <u>https://manitobaadvocate.ca/wp-content/uploads/MACY-Special-Report-The-Slow-Disappearance-of-Matthew-Feb2020.pdf</u>

⁵These in-person discussions and briefings are known as "domain meetings."

months. Those updates will be analysed by our office and this analysis will be shared publically so that Manitobans can understand and follow improvements in publically funded, child-serving systems.⁶

BACKGROUND

When investigating the suicide deaths of the 22 youth whose stories informed this report, we looked to the systems the girls had contact with and the services they received prior to their deaths, paying careful attention to mental health and addictions services. In our province, the Department of Manitoba Health, Seniors and Active Living is largely responsible for mental health and addictions services and nearly every youth in this report had contact with that system. Over the course of our investigation, it became alarmingly apparent that basic availability and barriers to accessing these services had profound impacts on the lives of these youth. Sixteen of the 22 girls resided in rural communities for either the entirety of their young lives, or a part of them. Given that, the intention of the current report is to explore the unique experiences of children, youth, young adults, and families who reside outside of major urban centres, with a particular focus on the experiences of youth from rural and remote communities.

As noted, the Government of Manitoba commissioned a review of the mental health and addictions systems in our province with the intent to improve access to, and coordination of, mental health and substance use/addiction services for Manitobans. The Virgo Report (Virgo Planning, 2018) was studied in depth by our office to inform this report. The Virgo Report engaged stakeholder groups and system users in extensive questionnaires about the services available, the functioning of the systems themselves, the needs of Manitobans, and the capacity of the current health infrastructure to meet those needs. The Virgo Report includes multiple recommendations framed by six strategic priorities to create a strategic plan that will guide the implementation of an accessible and coordinated system of mental health and addictions services in Manitoba. The Virgo Report is comprehensive, and many of the findings and recommendations in this report are informed by those in the Virgo Report.

Similar to the findings of our 22 child death investigations, the Virgo Report repeatedly noted that the availability of, and accessibility to, services in the mental health and addictions systems vary greatly across our province by region. Rural and remote communities throughout Manitoba, for example, experience limited access to services and supports due to their location and the availability of service providers. Of course, these rural

⁶To visit our Recommendations Tracking database please use the following link: <u>https://manitobaadvocate.ca/recommendation-tracking/</u>

and remote locations, where services are limited or non-existent are also the locations populated by Indigenous Peoples. This leads to unequal access to provincial services, which is a children's rights issue. Twenty of the 22 youth in this report were either First Nations or Metis.

Recent national reports, such as *Honouring the Truth, Reconciling for the Future and Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls* (2019; also known as "the National Inquiry"), brought attention to the historical and present injustices perpetrated against Indigenous Peoples through hundreds of years of forced colonization and assimilation practices. The forced removal of Indigenous Peoples from their lands by settlers and targeted attempts to separate people from their cultures, languages, families, and communities has resulted in acute reverberations that span generations today.

And yet, Indigenous families are rebuilding, reclaiming, and returning to culture, to their traditional practices, which have incredible healing and protective effects on children, youth, young adults, families, and communities at large. Meaningful investments to support these waves of reclamation and revitalization at the community level will benefit all Manitobans. As one youth on MACY's Youth Ambassador Advisory Squad (YAAS!) explained, investments have to not only meet the needs of individual children and youth, but should also seek to foster healthy families and communities. Parents and extended families may also struggle with their mental health and addictions, and improving the safety and health of their children includes "keeping parents alive" and healthy (YAAS! member, Interview, January 22, 2020). System experts and others interviewed for the purposes of this report echoed the need to engage families and communities as a whole in promoting mental wellness for children and youth.

Unfortunately, poor service access, a lack of coordination, and inconsistent service quality were themes identified in the 22 investigations completed for the purposes of this report. The fact is that the quality and effectiveness of health services depends on where a child lives in Manitoba. The current gaps and barriers within the mental health and addictions systems are further complicated by the jurisdictional divide between the various services funded by the federal or provincial governments. The Virgo Report noted jurisdictional issues as a "fundamental challenge to be addressed going forward as it underlies significant issues related to access and coordination" (2018, p. 236). In recognizing this as an important step forward, multiple recommendations were made in the Virgo Report to address these barriers including recommendation 5.4. This recommendation from the Virgo Report was highlighted by the Manitoba Advocate in the public special report, *Documenting the Decline: The Dangerous Space between Good Intention and Meaningful Interventions* (2018b). The recommendation reads:

Establish a concerted cross-sectoral process to reduce perceived and real jurisdictional boundaries that challenge access to, and coordination of, services. This process of developing a Strategy, as well as any new opportunities and resources for working together

(e.g., through Jordan's Principle), should be viewed as an accelerator of a new period of trust and collaboration based on shared beliefs and strengths among all partners and should include an interest in wellness, hope and family/family health (2018, p. 237).

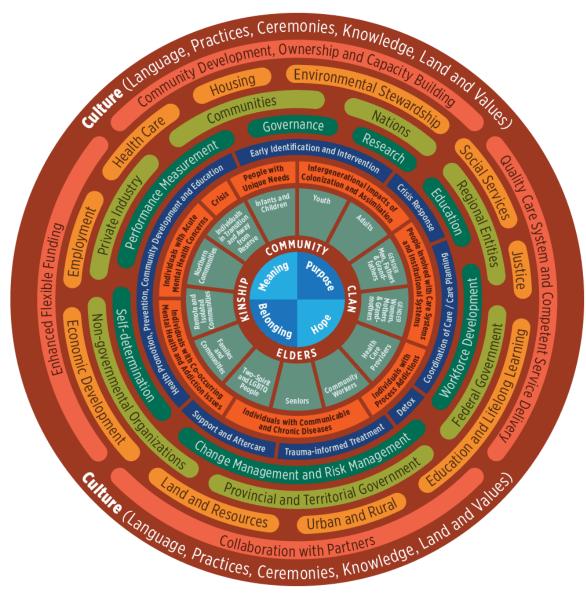


Stock image

"Stop Giving Me a Number and Start Giving Me a Person"

Manitoba Advocate for Children and Youth (2020)

There have not only been calls to improve service quality, access, and coordination at the provincial level, but also the federal level. The First Nations Mental Wellness Continuum Framework (Health Canada, 2015), was developed in collaboration between First Nations partners and Health Canada's First Nations and Inuit Health Branch, and released in 2015. It was designed to "strengthen federal mental wellness programming and support appropriate integration between federal, provincial, and territorial programs" with an all-encompassing goal to improve mental wellness outcomes for Indigenous Peoples (Health Canada, 2015, p. 1). The model of the framework consists of 10 levels, made up of rings around an inner circle of four directions, or key wellness outcomes purpose, hope, meaning, and belonging which act as the building blocks for mental wellness and support culture as a model for intervention (Health Canada, 2015).⁷ Moving outwards from that inner circle, other components include community, the unique populations served, specific needs of those



⁷ See: <u>https://thunderbirdpf.org/first-nations-mental-wellness-continuum-framework/</u>

populations, a continuum of essential services, supporting elements, partners in implementation, indigenous social determinants of health, themes for mental wellness, and culture as a foundation. The Virgo Report also supports this framework and recommends that it guide the implementation of the recommendations therein.

Improving the accessibility and quality of services for Indigenous Peoples was also an area for change in the National Inquiry (2019). Its *Calls for Justice* 3.1 to 3.7 pertain particularly to health and wellness and we support each important *Call for Justice*, but note the particular importance of 3.4 to this report; it states:

We call upon all governments to ensure that all Indigenous communities receive immediate and necessary resources, including funding and support, for the establishment of sustainable, permanent, no-barrier, preventative, accessible, holistic, wraparound services, including mobile trauma and addictions recovery teams. We further direct that trauma and addictions treatment programs be paired with other essential services such as mental health services and sexual exploitation and trafficking services as they relate to each individual case of First Nations, Inuit, and Métis women, girls, and 2SLGBTQQIA people (2019, p. 180).

This report today stands in a growing line of similar and previous reports such as the National Inquiry (2019), the Virgo Report (Virgo Planning, 2018), and the *First Nations Mental Wellness Continuum Framework* (Health Canada, 2015). These comprehensive examinations of public services and the experiences of citizens ought to be sufficient catalysts to compel decisive action and innovation by the federal and provincial governments. Service inequalities must be addressed for First Nations and Metis citizens in Manitoba, but most especially for children, youth, and their families in our province who reside in rural and isolated communities.

Leah: Referrals with No Follow-up

Leah lived in both a rural community and an urban area in Manitoba during her life. She was born into a large sibling group and was friendly and always willing to learn new things. At the time of her death at age 15, she was residing with an extended family member.

Child and family services (CFS) had minimal involvement with Leah's family in her early years. When Leah was 13 years old she was referred to a residential addictions treatment centre for youth. Leah had been consuming alcohol and using drugs, which was impacting her life. Leah resided at the treatment centre for three months where she engaged in individual and group counselling and cultural activities and ceremonies. Recommendations when Leah left the program noted Leah's need for her family, her addictions counsellor, and other community resources to

support her in maintaining sobriety and attending school. Leah was provided items for self-care and an after care plan that included crisis telephone numbers. The expectation was placed on Leah and her family to initiate contact with necessary resources after she left treatment.

Leah did well for a short time after returning from treatment, but she experienced bullying and she relapsed in her sobriety. In the following year, Leah was diagnosed with Fetal Alcohol Spectrum Disorder (FASD) as well as Attention Deficit Hyperactivity Disorder (ADHD) and was prescribed medication. She also began to express suicidal ideation and after a suicide attempt when she was 14, Leah was held at a hospital under *The Mental Health Act*. She underwent a psychiatric evaluation and was assessed to be dealing with psychosocial stressors in maladaptive ways, had poor coping mechanisms, and was exhibiting characteristic traits of adolescent borderline personality disorder. When Leah was medically cleared at hospital, she refused to return to her home and CFS was contacted. Leah was subsequently referred and admitted to a crisis stabilization unit for eight days.

While admitted, Leah participated in one-on-one counselling, group therapy sessions, completed school work, and was supported by psychiatric nurses, social workers, and a psychiatrist. She refused to take her prescribed medication, informing the staff that she chose to self-medicate with cannabis instead. Leah was assessed to have "poor insight and judgement" surrounding drugs, alcohol, and decision-making. She had not been attending school for over two months due to bullying. While admitted, she disclosed sexual abuse by a family member but was unable to provide further information during follow-up interviews with police.

During the latter portion of her admission, she no longer expressed suicidal ideation or a plan and she was deemed ready for discharge. Her discharge plan included counselling, increased supervision by her caregivers, locking up medications in any home where she would reside, and referring her for substance misuse counselling. She and her family were directed to contact crisis services if needed. Leah was discharged to her mother's care but it was arranged privately that she would reside with an extended family member. The CFS agency involved continued to have an open file for Leah's family but there was no evidence that the CFS agency had contact with the family after Leah was discharged from the crisis stabilization unit. We also found no evidence that Leah was referred to the resources recommended in her discharge plan. As is too frequently the case, Leah and her family were left to initiate and navigate aftercare resources on their own. After her discharge, Leah's use of substances increased and then spiralled out of control and she became involved in criminal activity. Leah was often transient, staying with various family members or a boyfriend who was suspected to be gang-involved; her family was often unaware of her whereabouts.

In the days before her death, Leah expressed suicidal ideation and went missing from the home of the family member where she was staying. After two days of being missing from her home, her body was located and her manner of death was deemed suicide. Toxicology reports showed that Leah had amphetamine and methamphetamine in her system at the time of her death.

Gabriella: An Honour Roll Student

Gabriella resided in an urban community in Manitoba. She was born into a large sibling group, and at the time of her death at age 17, she was in the care of CFS. Gabriella was very intelligent, hardworking, and was often on the honour roll at her school.

Gabriella's family's involvement with CFS began prior to her birth due to parental alcohol and substance misuse, intimate partner violence, and physical abuse of the children. Gabriella's parents separated in her early years and her father became the primary caregiver of her and her older siblings. Gabriella was apprehended three times by CFS from her father's care between the ages of six and 10, due to parental alcohol misuse and allegations of child abuse. Gabriella and her siblings were returned on two occasions but continued to disclose to their CFS worker that their father was too rough and had an alcohol misuse problem. When Gabriella was 10 years old, her father seriously physically assaulted her while he was intoxicated. Gabriella was removed from her father's care for the last time and he was charged and convicted of assault causing bodily harm. An abuse investigation by CFS deemed the abuse substantiated, and he was placed on the provincial child abuse registry.

Gabriella remained in the care of CFS and when she was 13 years old, the CFS agency involved obtained a permanent order of guardianship for Gabriella. During that time, Gabriella had begun to self-harm and was referred to a therapist, who she would see several times a week. While therapy continued as Gabriella aged, further stressors arose. When Gabriella was 16, she disclosed that a family member had sexually abused her in her pre-teen years. Gabriella's disclosure was referred for a further abuse investigation, but she indicated she did not want to be interviewed and the CFS investigation was concluded as inconclusive. Just months later, Gabriella was admitted to an acute psychiatric inpatient unit following a suicide attempt. She was admitted for eight days, during which she received medications intended to treat depression. Gabriella's suicide risk level was deemed low as she was no longer expressing suicidal ideation by the end of her admission. As such, she was discharged with a plan that she should follow-up with her therapist, continue to take her medications for treatment of major depressive disorder, follow-up with her family doctor as needed, contact crisis resources as needed, and a referral was made to an acute assessment service to check Gabriella's mood and medication. An assessment did occur one and a half months later where Gabriella shared that she sometimes felt

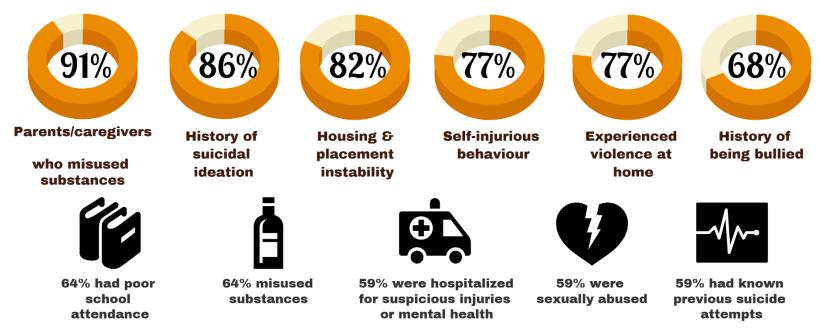
suicidal ideation but was able to cope on her own. She was deemed to have "significant supports and engagement in extracurricular activities," which promoted Gabriella's stable mood and ability to cope. Her medications were to remain the same, crisis numbers were provided, and follow-up was to occur for the next 12 months.

When Gabriella was 17, she was moved by CFS to an independent living program. One week later, she was treated at an emergency department after overdosing on over-the-counter medication. She was released when she indicated she was not suicidal and she was given a discharge plan that she should follow-up with her family physician. Despite Gabriella's struggles with her mental health, she had many successes in her life, including high academic achievements, completing a driver's education program and getting her learner's licence, and securing part time employment. One month after moving to her new placement, however, she disclosed that she had been provided methamphetamine and then sexually exploited by a family member. Gabriella was referred to a program that worked to prevent the sexual exploitation of children and youth and for therapy to treat post-traumatic stress.

After Gabriella was sexually exploited she struggled with substance misuse. She was also seriously assaulted by her boyfriend, which resulted in physical injuries. She was assessed at an emergency department and treated for a mild concussion; her mental wellbeing was not documented to have been assessed at that time, despite a history of recent suicide attempts. Gabriella obtained a peace bond to prevent her ex-boyfriend from having contact with her. She struggled to cope with her relationship ending and her school attendance began to decline.

One month later, Gabriella was assessed again by the acute mental health assessment service. She expressed that she missed her boyfriend and was considering resuming her relationship with him. She was struggling with her school attendance, was no longer involved in some of the extracurricular activities she had previously been involved with, and was experiencing sustained periods of sadness. It was recommended by the assessing psychiatrist that Gabriella increase her exercise to 60 minutes per day, stop using cannabis, attend school regularly, and pursue extracurricular activities that made her feel better. Self-esteem was discussed as were Gabriella's "choices" regarding her friends and exboyfriend. The discharge plan given to Gabriella indicated that her community-based therapist should continue to reinforce this plan. A mental health treatment service was offered but declined by Gabriella. A list of crisis numbers were again provided with the instruction that Gabriella should reach out to them as needed. One day later, Gabriella died by suicide. A toxicology report found that she had prescription medication in her system well above therapeutic levels at the time of her death.

Risk Factors for Suicide Of the 22 youth profiled in this report:



Other risk factors included: Histories of physical abuse, alcohol/drug use at the time of death, suicide attempts by friends/family members, suicide deaths by friends/family members, school behaviour problems, criminal justice involvement, sexual exploitation, and recent conflict with a close friend or partner.

These girls experienced an average of 6 risk factors

100% experienced early childhood trauma



THE COMPLEXITY OF SUICIDE

As the profile of suicide rises, there seems to be an increasing amount of information available about suicide risk factors and warning signs. It is important to note that while suicide risk factors are an essential part of prevention and intervention planning, they are not directly predictive of whether an individual will die by suicide at a specific moment. Risk factors are necessary to consider in the context of assessing risk and providing supports to youth, but no plan or person can ever eliminate all risk an individual may be experiencing in their life.

A web search will result in many pages of information about suicide, risk factors, and warning signs; however, information from any source should be read with caution, as there is a considerable amount of outdated and inaccurate information available. Listed below are some helpful and accurate websites to learn more about suicide, although this list is not exhaustive:

Reason To Live: <u>http://reasontolive.ca/</u> Everyone Matters Manitoba: <u>http://everyonemattersmanitoba.ca/</u> Canadian Mental Health Association: <u>https://cmha.ca/</u> Centre for Suicide Prevention: <u>https://www.suicideinfo.ca/</u> Mental Health Commission of Canada: <u>https://www.mentalhealthcommission.ca</u> Canadian Association of Suicide Prevention: <u>https://suicideprevention.ca/</u> Manitoba Advocate for Children and Youth: https://manitobaadvocate.ca/

The issues connected with suicide are complex, varied, and are impacted by myriad factors unique to the individual. Some of the most important ways that people can be protected from suicide are through supportive and meaningful relationships in their lives. When people understand and experience connectedness to others, this can serve to increase their self-worth and hope for their own future. Each of us have a role to play in building a stronger community web that offers support, and which can identify when people need more targeted assistance to face the challenges they may be experiencing. At all times, it is important to reinforce the message that we all experience varying degrees of challenges; help is available and there is always hope.

An Analysis of Suicide Risk Factors

Of the risk factors for suicide discussed earlier, many were prevalent when we looked at the lives of the 22 youth whose stories underpin this report. Research has long shown that certain experiences across the lifespan can increase risk for a youth to engage in suicidal behaviours or die by suicide (Lwin, Head, Wedeles, & Nikolova, 2015). Traumatic events can have far-reaching and long-lasting impacts on a child's developing brain. Indeed, research has shown that repeated exposure to trauma during early childhood can actually change the structure of the brain and how it functions, which can impact or delay a child's normal development (Bellis & Zisk, 2014). These delays can impact memory, impulse control, coping skills, and cognition, difficulties in school and with regulating emotions, and complicate a child's ability to develop healthy relationships (The National Child Traumatic Stress Network, 2020). All of the youth in this report who died by suicide experienced chaotic childhoods that were marked by varying degrees of instability. Many of these girls experienced physical and sexual abuse, witnessed or were exposed to violence, were exposed to parent/caregiver substance misuse, experienced multiple changes in placement, and were exposed to family members or people close to them who experienced suicidal ideation, who attempted suicide, or who died by suicide. In addition, many of the 22 girls had poor school attendance that began in their early years, exhibited school behaviour problems, and were bullied. Despite the long-term service involvement that many of these youth had from early childhood, they received little support and effective interventions were not implemented to mitigate these pervasive risk factors.

In the absence of intervention, exposure to childhood trauma can increase the risk for depression, violent behaviours, substance misuse, suicidal behaviours, suicide, and more during adolescence (National Child Traumatic Stress Network, 2020). As was the case with these 22 youth, many were known to be using alcohol or other substances, engaging in self-harming behaviour, had expressed suicidal ideation or attempted suicide, had been hospitalized for the same, were involved with the justice system, engaged in unhealthy relationships, or were being sexually exploited (Table 1). Individually, these factors can increase a youth's risk for suicidal behaviour or death by suicide; however, when combined, as they were for many youth in this report, risk increases even further.

Table 1- Frequency of documented risk factors for each of the 22 girls.

RISK FACTOR	TIMES DOCUMENTED	PERCENTAGE
Parent/caregiver substance misuse	20/22	91%
History of suicidal ideation	19/22	86%
Placement instability	18/22	82%
Self-injurious behaviour	17/22	77%
Exposure to violence in the home	17/22	77%
History of being bullied	15/22	68%
Poor school attendance	14/22	64%
Youth substance use	14/22	64%
History of hospitalization for suspicious injuries	13/22	59%
or mental health admissions		
History of sexual abuse	13/22	59%
Known previous suicide attempt(s)	13/22	59%
History of physical abuse	11/22	50%
Alcohol and/or drugs at time of death	10/22	45%
Suicide attempts/ideation by family/friends	10/22	45%
Suicide death by family/friends	9/22	41%
School-behaviour problems	9/22	41%
Criminal justice involvement	7/22	32%
Sexual exploitation*	6/22	27%
Recent conflict (close friend or partner)	2/22	9%

***NOTE:** Sexual exploitation was greatly underreported in the file documentation. Our investigators noted multiple occasions where documented situations or events described risk factors for sexual exploitation, but these situations were not understood or investigated by service providers to be possible sexual exploitation of the youth. Examples included extended or repeated periods of the youth going missing, their documented associations with certain adults, unexplained access to sums of money, and more.

The risk factors identified during *Phase One* (Manitoba Advocate, 2015) continue to be factors for youth who die by suicide (Tables 2 and 3). Of particular note, housing and placement instability has remained a top theme among youth in all previous MACY suicide reports. **Table 2 - Comparison of the top themes emerging from Phase One, Phase Two, and the current (Phase Four) report.**

TOP THEMES FROM PHASES ONE, TWO, AND FOUR			
PHASE ONE: Suicide Group	PHASE TWO: Control Group	PHASE FOUR: Female Aggregate	
Poor school attendance	Poor school attendance	Substance misuse by parent or caregiver	
 Criminal justice involvement 	 Criminal justice involvement 	 Previous suicidal ideation 	
Exposure to suicide	• Exposure to suicidality (attempts or	Housing & placement instability	
 Substance misuse: youth and parent/caregiver 	deaths by family members or friends)	History of self-injurious behaviour	
 Housing & placement instability 	 Substance misuse – youth and 	• Exposure to violence in the home	
 Self-harm, suicidal ideation & prior suicide attempts 	parent/caregiver	History of being bullied	
Physical abuse	 Housing & placement instability 	Poor school attendance	
 History of hospitalization for suspicious injuries or 	• Exposure to violence in the home	Youth substance use	
mental health	Previous suicide ideation	• History of hospitalization for suspicious	
 Alcohol or drug use at time of death 	Physical abuse	injuries or mental health	

Table 3 - Comparison of frequency of key risk factors documented in service files from Phase One, Phase Two, and current report.

	PHASE 1 (50 youth who died by suicide)	PHASE 2 (Control group of 100 youth)	PHASE 4 (22 female youth suicides)
Parent/caregiver substance misuse	72%	64%	91%
History of suicidal ideation	64%	26%	86%
Placement instability	78%	79%	82%
Self-injurious behaviour	44%	16%	77%
Exposure to violence in the home	30%	45%	77%
History of being bullied	22%	3%	68%
Youth substance use	74%	41%	64%
Poor school attendance	62%	33%	64%

Social Determinants of Health and Risk Factors for Suicide

Risk factors for suicide are important to understand as they can provide guidance on how to intervene to prevent death by suicide and inform good planning and policy. In addition, "the conditions in which people are born, grow, live, and age" (World Health, 2020, para. 1), also known as social determinants of health, interact to impact overall health and wellbeing. The Public Health Agency of Canada (2019) describes 12 social determinants of health:

Income and social status, employment and working conditions, education and literacy, childhood experiences, physical environments, social supports and coping skills, health behaviours, access to health services, biology and genetic information, gender, culture, and race/racism (para. 2).

There has been further recognition, however, that experiences like discrimination, racism, and historical trauma also have an impact on one's overall health status (Health Canada, 2015; Public Health Agency of Canada, 2019). The World Health Organization (2007) notes that the impacts of colonization have led to poorer health outcomes for Indigenous Peoples. In fact, the impacts of colonization can have such a profound impact, that Health Canada (2015) reported "the rates of suicidal ideations among First Nations youth are higher when one or more parent and/or grandparent attended Indian Residential School" (p. 29). In recognizing this, The Assembly of First Nations (2013), as reported in Health Canada's, *First Nations Mental Wellness Continuum Framework* (2015), proposed an enhanced set of social determinants of health. These reflect unique aspects of Indigenous culture and identity, while also taking into account the lived experiences of individuals, families, and communities, and how these factors interact in different ways to have an impact on overall health. They propose the following social determinants:

Community readiness, economic development, employment, environmental stewardship, gender, historical conditions and colonialism, housing, land and resources, language, heritage and strong cultural identity, legal and political equality, lifelong learning, on and off reserve, racism and discrimination, self-determination and non-dominance, social services and supports, and urban and rural (p. 29).

These determinants are particularly important in our province's context as the Virgo Report (2018) estimated that 18% of Manitoba's overall population are Indigenous. Yet, when looking at both lists, great disparities exist in many health determinant areas for Indigenous Peoples. For example, a recent provincial study released by Katz et al. (2019) found that:

- the average household income of 89% of First Nations peoples in Manitoba is less than \$59, 575;
- 41% of First Nations Peoples live in crowded housing;

- 59% of housing requires unique repairs;
- 45% of First Nations families do not have access to safe drinking water in their home; and
- 66% do not have food security.

Access to services and supports is also important to overall health. Accessibility can be impacted by physical barriers, such as geographic distance and access to transportation, but also by more complex structural and systemic barriers, such as ingrained systemic racism and discrimination. Barriers in both areas were noted in the Virgo Report and presented as themes in the stories of the 22 youth that informed this report. In their interviews with stakeholder groups, the authors of the Virgo Report noted that "Indigenous Peoples…noted experiences of racism and discrimination as a significant barrier to accessing mental health services" (2018, p. 111). Similarly, a Manitoba study found evidence that "First Nations people are not accessing specialist or even primary healthcare services close to home…This finding points to a gap in the provision of culturally safe and responsive primary care services close to First Nation communities" (Katz et al., 2019, p. 175).

Social determinants of health were repeatedly mentioned in the Virgo Report as ongoing challenges for Indigenous Peoples to access resources that promote positive mental health and wellness and were described as "foundational" to mental health (Virgo Planning, 2018, p. 94). Unfortunately, disparities in the social determinants of health have persisted for generations to create circumstances in Manitoba that continue to contribute to poorer outcomes for Indigenous Peoples. When compared to its provincial and territorial counterparts, Manitoba has:

- 76% of First Nations children living in poverty, the highest rate among provinces;
- the highest number of children in care, 90% of who are Indigenous;
- the highest rate of youth incarceration, with 90% of those youth being Indigenous;
- the highest homicide rate, of which the majority of victims are also Indigenous; and
- the second highest rate of violence against women and girls in the north of all northern regions in Canada (Canadian Centre for Policy Alternatives, 2016, Virgo Planning, 2018; Malone, 2019; Jones, 2019; Gibson, 2019).

With these stark numbers, it is not a surprise that that the rate of suicide for adult First Nations Peoples in Manitoba is **five times** the rate for all other Manitobans (Katz et al., 2019). The prevalence of drug and substance use disorder is **three times** as high for adults (Katz et al., 2019). Both increased in prevalence in relation to lower income. That study was adult specific, however, and as previously noted in this report, death by suicide remains the leading manner of death for youth in Manitoba. Again, 20 of the 22 youth included in this current investigation identified as First Nations or Metis.

Social determinants of health provide context for many of the risk factors for death by suicide used in this report. When our office spoke with service providers from child and family services agencies and authorities all over Manitoba, many reported barriers and inequities in accessing mental health and addiction services for the children, youth, and families they serve. They also spoke at length about the health of families and communities, and the role governments must play to foster health and wellness in the environments where children grow and develop.

The top themes of this report (Tables 2 and 3), which are detailed in the following section, are informed by the 20 risk factors we examined. These provided a basis for the seven recommendations made by the Manitoba Advocate to improve services and prevent further suicide deaths of youth in Manitoba. As mentioned above, these recommendations are also informed by those in the Virgo Report (2018), Health Canada's *First Nations Wellness Continuum Framework* (2015), in addition to, the *Calls for Justice* made in the National Inquiry (2019). Moving forward, all three documents supported the necessity of inter-governmental partnership and collaboration at all levels to improve the delivery of mental health and addiction services. Indeed, Health Canada (2015) stated, "it will be imperative that federal and provincial/territorial governments work together to address these inadequacies" (p. 45).

HOW CAN WE PREVENT YOUTH SUICIDE IN MANITOBA?

A Tiered Model, Where Services Match Needs

FINDING: Manitoba children and youth urgently need a continuum of mental health and addictions services to be developed and delivered through a tiered model that is fulsome, not interrupted by barriers to accessing service, and which includes tailored support for children and youth as they transition from one tier to another along the continuum.

When the Virgo Report was released, it confirmed what many Manitobans have long felt: that youth mental health and addictions services in Manitoba are underfunded and do not correspond to the high need for services (Virgo Planning, 2018). In fact, one study noted that in Manitoba, diagnoses of mental health disorders in children are higher than those of some physical illnesses, such as asthma and diabetes, with 14%, or 1 in 7, of Manitoba's children having been diagnosed with at least one mental health disorder (Chartier et al., 2016). The same study also found that rates of suicide for youth age 13 to 19 in Manitoba are disproportionately high and, at a rate of 74 per 100,000 youth, is double the national average (Chartier et al., 2016). Despite the staggering levels of need in Manitoba, less than one third of children in the above study received the treatment they needed (Chartier et al., 2016).

As the Virgo Report found, the current mental health and addictions services in our province have many gaps and cracks through which children and youth fall. In fact, based on the responses of a quantitative data survey, the Virgo Report (Virgo Planning, 2018) identified 15 challenges, some with multiple sub-themes, in the delivery of mental health services and supports, as noted by Manitobans. An additional 24 challenges were identified in the delivery of mental health services and supports to Indigenous populations (Section 6.2.1.1.). Similarly, 15 challenges in the delivery of substance use/addictions services and supports were noted, with an additional 21 challenges identified in delivery of substance use/addiction services and supports to Indigenous populations (Section 6.2.1.2.2.).

The Virgo Report, proposed six strategic priorities to increase access to, and coordination of, services in the mental health and addictions systems in Manitoba. The first strategic priority recommends using a population health planning approach designed to meet the varying needs of Manitobans, spanning from universal prevention efforts to individualized treatments for the most complex and severe challenges. Using this approach, needs are organized conceptually in "tiers" (Virgo Planning, 2018, p. 48). This approach was also supported and discussed in the

national mental health strategy, *Changing Direction, Changing Lives: A Mental Health Strategy for Canada* (Mental Health Commission of Canada, 2012). In concert with the second strategic priority listed in the Virgo Report, "a comprehensive continuum of evidence informed services and support," this approach may serve as a solution to bridge a portion of the current systemic gaps and act to better meet the varying needs of Manitoba's children and youth (Virgo Planning, 2018, p. xix).

The Virgo Report states that a continuum of care "encourages a stepped [tiered model] approach...identifies gaps...focuses attention on screening and assessment and matching people to the right level of treatment and support and reducing wait times" (Virgo Planning, 2018, p. 48). A tiered model is made up of services and supports that meet varying levels of needs in a population (Figure 2). Supports and interventions are organized in a step-wise manner with broad, population-level activities at the widest tier, Tier 1, which support prevention and health promotion. As an individual's needs increase, they may move upwards through the tiers, with the highly specialized and intensive treatments offered from the topmost tiers, Tiers 4 and 5 Early screening and interventions directed toward mild to moderate mental health and addictions challenges then fall in the middle of the continuum (Tiers 2 and3). Figure 2 below depicts the continuum of mental health and addictions services using a tier-based approach proposed by the Mental Health Commission of Canada (2015).

Figure 2 – Tiered approach to a continuum of mental health and addictions. Source: Mental Health Commission of Canada

Tier 5: Highly specialized inpatient/residential settings

<u>Tier 4</u>: Specialist acute inpatient, comprehensive hospital, and community-based day and mobile treatment teams

Tier 3: Mental health and addiction services system response: assessment, treatment,

planning, crisis management, and system navigation interventions

<u>Tier 2</u>: Primary response from GP, community services, etc, and integrated, accessible, primary and community care (first responder)

Tier 1: Universal public/community response: health promotion, prevention, and harm reduction

There Are Still Too Many Gaps and Barriers

While a comprehensive, coordinated, and integrated continuum of care organized using a tiered model of mental health and addictions services for children and youth is ideal, there are multiple gaps and barriers along the existing continuum of care in Manitoba that must be addressed. The Manitoba Advocate has spoken candidly about multiple flaws within the current system in previous public reports and in statements of concern to the public.⁸ Most recently, the Manitoba Advocate released a public special report on the suicide death of Matthew,⁹ whose life story illuminated significant deficits inside the Winnipeg sector of mental health services, but these cracks in the system are felt even more acutely for children and youth who live and seek mental health and addictions care outside of our province's capital city.

Given the high incidences of mental health diagnoses of children and youth, deaths by suicide of youth, and the rising accessibility and use of opioids and methamphetamine in Manitoba, this is a critical time to address the glaring gaps and commit to removing all barriers to mental health and addiction services, most especially for children and youth across Manitoba.

This current investigation found that many of the Virgo Report's criticisms of Manitoba's youth mental health and addictions system remain true today and are certainly reflected in the stories of the 22 girls which informed this report. These include a lack of access to locally available services, a lack of follow-up support after crisis, service providers not communicating and collaborating to carry out plans, a lack of access to culturally appropriate services, and services that do not match the needs of youth. Similar to the Virgo Report (2018), gaps noted by those involved in the creation of Health Canada's *First Nations Mental Wellness Continuum Framework* (2015) included a lack of access to children and youth mental wellness programming, locally available services for those who reside in First Nations communities, provincially delivered services that are not culturally competent or safe, and that services are delivered by community workers who receive little or no training, supervision, or support. It is of vital importance that these and other gaps be eliminated to create a child-*focused* and child-*centred* system. It is an unacceptable reality that at a time when suicide remains the leading manner of death for youth ages 11-17 in our province, the provincial and

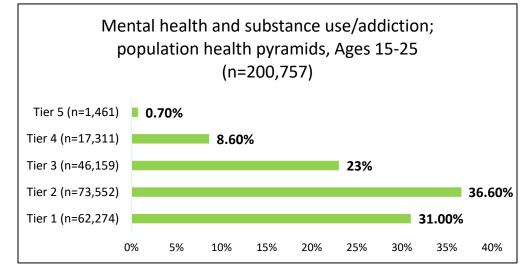
⁸For example, see The Manitoba Advocate's Statement of Concern entitled *A Call to Action: A Mental Health and Addictions System to Meet the Needs of Children and Youth* released in September 2018 and found at: <u>https://manitobaadvocate.ca/wp-content/uploads/Advocates-Statement-of-Concern-MH-Addictions.pdf</u>

⁹To read Matthew's story, please follow this link: <u>https://manitobaadvocate.ca/wp-content/uploads/MACY-Special-Report-The-Slow-Disappearance-of-Matthew-Feb2020.pdf</u>

federal systems chiefly responsible for responding to the mental health needs of youth are massively underfunded, often inaccessible, and inefficient. We heard that message clearly from system experts, from senior government personnel, from families, and – *loudly* – from youth themselves.

The quality of the youth mental health and addiction system is important. The way the system operates and responds to youth as they move

Figure 3 - Mental health and substance use/addiction; population health pyramids. Source: Virgo Planning, 2018b, p. 88)



between the five tiers has a direct impact on the lives and life outcomes of the hundreds of thousands of children and youth who have a right to quality public mental health care. Figure 3, taken from the Virgo Report, estimates the numbers of youth and young adults ages 15 to 25 in Manitoba who require mental health and addiction services from the various tiers of the provincial system (Virgo Planning, 2018b, p. 88). It is important to note, children and youth under the age of 15 are missing from this Virgo Report figure and in a number of other key areas of the report's analysis, as "there is no available population health data for children and youth that allow for an estimation of need using the population-health pyramid approach" (p. 183). While there are estimations

of need for children and youth under the age of 17 in the Virgo Report, these values were found using alternative sources of information from which to base estimates. The Virgo Report notes that there are limitations to these methods including an overall underrepresentation of need, especially for Indigenous children and youth, whose complex needs are not reflected in the sources used to project those estimates.

Another valuable aspect of the Virgo Report was its analysis and discussion of the coverage of services, and therefore, the gaps in coverage. For example, in Figure 4 below, when looking at the estimated numbers of youth and young adults who require, and have a right to, substance use/addiction services, the Virgo Report indicated that 138,483 Manitoba youth and young adults need Tiers 2-5 services, while only 5,701 are able to access those services, reflecting that the system is only providing services to 4.1% of the youth and young adults who need them (Virgo

Planning, 2018b, p. 95). A similar chart for the mental health system was not included in the Virgo Report, but we understand from meetings with key stakeholder groups, that work is underway.

Tier	Percentage in need	Estimated number of individual in- need	*	In-need:	Current	Coverage:
5	0.7	1,461		64,931	services: 5,701	8.8%
4	8.6	17,311				
3	23.0	46,159] []	
2	36.6	73,552	**	In-need: 138,483	Current services:	Coverage: 4.1%
1	31.0	62,274			5,701	
*Tiers 3-5	32.3	64,931			,	
**Tiers 2-5	68.9	138,483				

Figure 4 - Estimated coverage of substance use/addiction services for Manitoba, aged 15-25. Source: Virgo Planning, 2018b, p. 95.

The story of one youth, Madison, who died by suicide at age 15, illustrates all of the key findings above as well as the gaps and barriers that a young person in Manitoba may face when attempting to access mental health support.

Madison: Repeatedly Returned to an Unsafe Home

Madison resided in both a small city and a rural community in Manitoba during her life. She had a large sibling group and spent much of her life in the care of CFS. She was a permanent ward of a CFS agency at the time of her death. Madison was described as compassionate by those that knew her.

Madison's family's involvement with CFS began shortly following her birth due to her mother and father's alcohol and substance misuse and allegations of child neglect. For these reasons, Madison entered into the care of CFS four times between her birth and age four. Despite coming

into care for safety concerns, the case decisions the agency made for Madison continued to expose her to child protection concerns. Madison was removed from a foster home she was placed in at age five due to allegations of physical abuse. In the following year, the CFS agency involved arranged for Madison to participate in a psychological assessment. Her overall cognitive ability was assessed to be in the low to average range and it was recommended that Madison receive counselling to address her sadness, anger, and frustration. During the investigation, our office found no evidence that counselling was provided to Madison as recommended.

Madison became a permanent ward of the CFS agency when she was eight years old. At that time, she began to express that she was lonely and she longed for a connection to her biological family. Reports about child protection concerns in her foster home arose including alcohol misuse by the caregiver, the poor condition of the home, and physical abuse of the children who lived there. Due to these concerns, one CFS agency removed the children under their care that were placed in the foster home; however, Madison's CFS agency did not remove her from the same foster home. Madison's foster home came under investigation on two further occasions and she was removed and returned to the home by the CFS agency four times over the next five years. Madison repeatedly asked to be moved to an alternate placement and indicated she felt unsafe in that foster home. When the agency did not respond to her disclosures, Madison ran away from the foster home and refused to return.

In a second psychological assessment at age 12, Madison stated she needed to live with her mother, whom she had not seen in two years. Madison was being bullied in school and the psychologist once again recommended that the CFS agency organize counselling for Madison to address her trauma-related anger, self-esteem, and issues regarding her family of origin. Madison was eventually placed with two separate family members but these placements were short-lived due to alcohol misuse by her caregivers. She was subsequently returned by the CFS agency to the foster home she repeatedly had asked to leave. Once again, we found no evidence that Madison was referred to a counsellor.

At age 13, Madison began to express suicidal ideation and self-harm. A suicide note was found in her belongings. She was assessed by a mobile crisis service and disclosed sexual abuse that had happened to her at age five in a foster home where she had previously been placed. She indicated she had disclosed the abuse to a previous foster parent, but that individual had not believed her and had not reported her disclosure. The mobile crisis service reported Madison's disclosure to CFS, completed a safety plan which Madison signed, and referred her to see a mental health worker. The mobile crisis service committed to following up with Madison within 48 to 72 hours and told her they would remain involved until a mental health worker was assigned; Difficulty connecting with Madison's CFS worker and foster parents, however, impeded their ability to schedule appointments and provide consistent support. Following Madison's disclosure, charges of sexual assault, sexual exploitation, sexual

touching, and sexual interference were laid against two individuals. Madison met with a mental health worker once but her file was closed when the mental health service was unable to successfully engage her in the plan.

The same pattern of service providers intervening during times of crisis, with no sustained follow-through repeated for Madison in the following two years. Madison was transferred on two occasions, hours from her home, to receive a mental health assessment and was assessed at a regional hospital emergency room four times for suicidal ideation, suicide attempts, and extreme intoxication. She was struggling to cope with several stressors, including the death of a sibling and a friend, unresolved trauma associated with sexual abuse, trauma-related anger, and bullying at both school and in the foster home she had repeatedly asked to leave. She was referred to the community mental health program two further times but that service was unsuccessful in engaging her participation. When in hospitals, medical staff would discharge her when she would agree to safety plans and when she would deny ideation at the time of an assessment, with the same recommendations always made to follow-up with the community mental health program.

In the last six months of her life, Madison fell deeper into crisis She was failing many of her classes at school due to multiple absences and was using substances. On one occasion, she was located outside in her community by police, unconscious due to intoxication and hypothermic, having no recollection of the night prior. Madison continued to express suicidal ideation with a plan but psychiatric admissions were deemed unnecessary by health personnel. On her final discharge from hospital, the discharge plan recommended that Madison receive a psychiatric consult, connect with a mental health nurse, and contact local crisis resources or her other supports, if she were to feel suicidal again. Evidence shows that the mental health worker attempted six times to connect with the CFS agency to arrange supports for Madison, as there was confusion about whether her placement would be located in a First Nations community or in an area where she would be able to access the community mental health program. Services, however, were never arranged and Madison died one month later.

Madison's early-childhood trauma was not recognized by the CFS agency involved, nor did the agency act protectively towards Madison, despite the agency's legal and ethical responsibility for her care, protection, and development. Madison was not connected to meaningful interventions early in her life and by her adolescence, she was experiencing ongoing and repeated crises. As with many of the 22 girls highlighted in this report, Madison was able to access mental health services in times of crisis but was not supported to follow-up with community resources afterward, resulting in those resources ending their involvement. As is too often the case, mental health and crisis resources in Manitoba step back from active involvement when youth are not patients inside a hospital setting. During discharge from hospital, youth typically receive a list

of recommendations and phone numbers and the onus is placed on them to initiate and organize their own care, which is an unreasonable burden to place on children and youth.

A lack of communication by the CFS agency with Madison's mental health worker also impacted the support Madison was able to receive. Even when Madison travelled hours from her home to receive two mental health assessments in an urban centre in Manitoba, the outcome did not change for her. Further, support was delayed or ended because of barriers when Madison would intermittently reside in placements in federally-funded jurisdictions. When she resided in those areas, she was unable to access provincially-funded resources to which she had previously been connected. It is important to note that all service providers who interacted with Madison omitted addictions supports in their care plans. By missing this crucial contributing factor, plans that were to help Madison had a perpetual gap. For Madison, these gaps and barriers in mental health resources had a catastrophic effect.

Steps in the Right Direction: Recent Provincial Investments

The government of Manitoba has begun to respond to the Virgo Report, and some positive mental health and addictions funding announcements have been made to start addressing the gaps and barriers that Manitoba children and youth face. In 2019, the province held six public events to announce a number of enhancements to mental health services for children and youth.

Program Name	Description	Investment					
Announced January 15, 2019							
Strongest Families Institute (SFI)	Provides evidence-based programs for children, youth, and families dealing with mild to	\$500,000					
	moderate mental illness and other health issues. Distance coaching approach to services. No wait						
	list policy.						
Announced October 7, 2019							
NorWest Youth Hub	Funding will be used to increase mental health and addictions counselling, as well as Indigenous	\$823,000					
	cultural supports.						
Project 11	Provides lessons and activities designed to increase mental health awareness and positive coping	\$621,000					
	strategies.						
Thrival Kits™	Expand the distribution of Thrival Kits [™] – a mental health wellness promotion project for	\$1.5 million					
	elementary schools.						
Announced October 17, 2019							

"Stop Giving Me a Number and Start Giving Me a Person"

Manitoba Advocate for Children and Youth (2020)

The Métis CART Pilot Project	The project will see teams that include a caseworker, family mentor, and addictions and mental	\$1.9 million
	health workers for families with parental substance use and child abuse or neglect problems.	
	Announced November 6, 2019	
Community Schools Program	Funding from the program will be given to build five new schools (two of the five schools are in	\$1.6 million
	Winnipeg).	
Community Helpers	Provide mental health and addiction services to families and caregivers, reducing the risk of Child	\$525,000
	and Family Services apprehension or placement breakdown.	
	Announced November 12, 2019	
Project Neecheewam	Improve access to Indigenous-led healing, care, and treatment services to sexually exploited	\$3.8 million
	youth.	
MATC and StreetReach	Funding so MATC (Manitoba Adolescent Treatment Centre) can work collaboratively with	\$1.12 million
	StreetReach to provide care for youth who have multi-systems needs that require "integrated	
	access to mental health, substance use and addictions services."	
	Announced November 18, 2019	
HSC's child and adolescent mental	Expand resources already available at HSC. Includes increasing availability of child and adolescent	\$4.2 million
health services	psychiatric nurses for assessment in emergency departments, group treatment (anxiety	
	disorders), group treatment (ongoing care after 12-week crisis treatments), access to individual	
	treatment, and urgent consultation to rural/ remote health facilities.	

These are good investments in the lives of children, youth, young adults, and families. Still, gaps and barriers persist in provincial service delivery and as the mental health needs of citizens increase, the above-noted investments represent the starting point of a plan needed to bring our provincial systems into a robust and responsive modern reality. These system gaps are felt most acutely by those children and youth who reside outside of Winnipeg, and who are unable to access and benefit from many of these newly announced initiatives. Children and youth in Manitoba's north, are able to access even fewer. As the Manitoba Advocate has a legal responsibility to monitor the child and youth mental health and addiction system in our province, these new investments become part of that monitoring, most specifically, their benefit in the lives of children, youth and young adults.

As the Canadian Centre for Policy Alternatives (2019) noted, "mental health spending in Manitoba remains below the standard set by international and national research which says it should be 9 per cent of total health spending. In 2019/20 Manitoba budgeted...5% of the health budget" for mental health services (p. 9). The difference between 9% and 5% of total health spending amounts to \$213 million that was not

allocated to improving the lives and mental health and wellness of Manitobans in the 2019/2020 fiscal year (Government of Manitoba, 2019). The Virgo Report (2018) also noted that "children's services were seen as particularly disadvantaged in terms of funding relative to adult services" (p. 136). And further, And further, in a discussion noting the disparity between needs and system capacity, the Virgo Report highlighted how chronic underfunding of child and youth mental health in Manitoba has real and serious effects, especially on young people in our province:

A common theme cutting across, and indeed driving, much of the previous work is the disparity between the nature and scope of Manitobans' needs and the capacity of the system to respond. This disparity, and the results of analyses of system bottlenecks and transition "hot spots" has drawn significant attention to the prevailing concerns with access and coordination of services, and potential solutions...The focus of the present review on access and coordination of services has been well placed with consistently expressed concerns regarding difficulties to access services and confusion around system navigation...A similar theme emerged for the relative investment in adult versus children and youth services; the latter being viewed in some reporting as the "poor cousin of the poor cousin" (Virgo Planning, 2018, p. 27).

Although since the release of the Virgo Report, progress is starting to be made, mental health and addictions services for Manitoba's children and youth still need further attention, innovation, and funding to bridge gaps across the current continuum and to ensure that services are available, equitably, to all children and youth.

A barrier to that progress in previous years in Manitoba has been pilot projects, or the Government's use of time-limited, single use funding. The Virgo Report described the Manitoba government as being in "demonstration mode" or "pilot testing" mode, with no perceived follow through even when program evaluations have shown success. As the Virgo Report (Virgo Planning, 2018) authors reported:

Another commonly expressed theme concerned the challenges experienced **scaling up projects after successful evaluation or pilot projects.** The province was also seen as always being in "*demonstration*" or "*pilot testing*" mode, and then being in the position of needing to ask for money to scale up successful projects and then waiting (and waiting)...Also frequently voiced was the lack of funding and missed opportunities for prevention, health promotion, and early identification (p. 138; bolding and emphasis in original).

It would be helpful if announcements, including new investments that are pilot projects, were released with a clear and publicly communicated work plan so as not to leave the government's vision a mystery, not understood by the taxpayers who are ultimately funding it. What is needed is for the government, specifically the provincial department of Health, Seniors and Active Living to articulate its vision clearly, with a work plan

and timelines regarding how funding and program commitments will transform the "poor cousin" of child and youth mental health, to a family member who understands they are a valued and important priority.

In recognizing this need, the most recent report released by the Manitoba Advocate, *The Slow Disappearance of Matthew: A Family's Fight for Youth Mental Health Care in the Wake of Bullying and Mental Illness* (Manitoba Advocate, 2020), made the following recommendation:

RECOMMENDATION SEVEN: A transparent framework for child and youth mental health and addictions health system transformation The Manitoba Advocate for Children and Youth recommends that in a commitment to transparency and accountability, Manitoba Health, Seniors and Active Living publicly release its framework and plan for transforming the youth mental health and addictions system in Manitoba so recent and anticipated investments and announcements can be understood by Manitobans not as one-off announcements, but as part of an overall tiered strategy for improving access, coordination, content, and capacity of the child and youth health care system in the province (p. 77).

Matthew's report was not the first report released by the Manitoba Advocate to make this recommendation. In fact, two previous reports have made similar recommendations, *Documenting the Decline: The Dangerous Space between Good Intentions and Meaningful Interventions* (Manitoba Advocate, 2018b) and *A Place Where it Feels like Home: The Story of Tina Fontaine* (Manitoba Advocate, 2019). Both reports called upon various government departments to respond to the lack of services and supports available to children and youth in Manitoba and to publically release a clear implementation plan to address the child and youth-specific recommendations (2018b) calls upon the Department of Health, Seniors and Active Living to conduct a service inventory of what services and supports are currently available and to evaluate existing gaps within the systems, including recommendations as to how existing services could be repurposed. The Department of Heath, Seniors and Active Living has yet to provide a meaningful response to the Manitoba Advocate's recommendation in the last two years. Not only has this department not publically released its framework, as was called for in 2019, it has provided no evidence of a service inventory or an evaluation of systemic gaps.

A publically communicated and strategic plan for the transformation of the youth mental health and addictions systems is important for the wellbeing of children and youth. A framework and strategic plan, however, must be built on a strong foundation, fortified by assessments of the services currently available and a robust understanding of the needs of children and youth in Manitoba. Analyzing the gaps in these two areas must inform an overall plan. As the Virgo Report recommends, Manitoba needs to stop merely plugging holes by filling gaps in the system

haphazardly as funding arises, but step back and look at the whole picture. As such, we are reiterating the recommendations the Manitoba Advocate has previously made in the special reports noted above.

RECOMMENDATION ONE: CONDUCT A GAP ANALYSIS

RECOMMENDATION ONE: The Manitoba Advocate for Children and Youth recommends that the Department of Health, Seniors and Active Living conduct a gap analysis of the youth mental health and addictions system, based on the tiered model proposed in the Virgo Report. The gap analysis ought to speak to the overall transformation framework and strategic plan for child and youth mental health and addictions services. Further, the Manitoba Advocate recommends the gap analysis, framework, and strategic plan is released publicly to Manitobans.

OUTCOMES:

- Conduct a jurisdictional scan to complete a full service inventory of youth mental health and addictions services and supports available at each of the five tiers, ranging from prevention initiatives to those designed to meet the highest needs.
- Conduct a gap analysis using the inventory of services and a needs-based assessment of children and youth in Manitoba, taking into consideration what current services in the inventory can be modified or adapted (i.e., increase capacity, needs modification to enhance functioning, or based on new evidence or evaluation, etc.) to better meet needs of children and youth.
- Provide to the public the short-term (1 year) and long-term (3-5 year) vision and strategic plan for program development and investment to guide system enhancement.

IMPACT FOR CHILDREN AND YOUTH:

A strong assessment and analysis is required for any strategic plan. Manitoban children and youth will be better served if a provincial strategic plan for transforming mental health and addictions services is informed by an accurate assessment of the services available as well as the current needs across the province.

Once a comprehensive, tailored, and effective framework and strategic plan is developed, it must be followed by actions and commitments for children, youth, young adults, and families to see meaningful change. As noted in the Virgo Report, action is required and "careful attention is

needed to enhance these services and supports across all tiers of severity and complexity" (2018, p. 221). The need for change drives the second recommendation of this report.

RECOMMEDNATION TWO: DEMONSTRATE EQUITABLE ACCESS TO SERVICES

RECOMMENDATION TWO: The Manitoba Advocate for Children and Youth recommends that the Department of Health, Seniors and Active Living demonstrates its framework and strategic plan for transformation of the youth mental health and addictions systems in Manitoba ensures equitable access to services across all areas of Manitoba, which are tailored to the unique needs of children and youth in our province.

OUTCOMES:

- Look to previously published provincial reports, such as the Virgo Report (2018), as well as best-practice nationally and internationally, to guide the implementation of a framework for a functioning continuum of services and supports that serve to meet the mental health and addictions needs of children and youth in Manitoba whose needs fall in each of the five tiers.
- Implement culturally-informed and safe services and supports, modified or new, incorporating feedback from important stakeholders, including children, youth, and families, service providers, and Indigenous leadership and Elders, which serve to meet the mental health and addictions needs of children and youth in Manitoba who fall in each of the five tiers.

IMPACT FOR CHILDREN AND YOUTH:

With system enhancement across all five tiers, children and youth in Manitoba will have equitable access to services and supports at to meet their needs and enhance their overall health and wellbeing. Investments across all five tiers are investments supporting the health and wellbeing of all Manitobans for the present and future.

Early Trauma Requires Targeted Intervention

FINDING: Manitoba children and youth need improved early recognition of trauma by service providers and timely intervention to combat the effects of childhood trauma, which increases the risk for co-occurring substance misuse and mental health challenges, including the risk for suicide in children, youth, and young adults.

Despite the extensive service involvement many of the 22 female youth had with designated services, often from an early age, there was little assessment of suicide risk factors or recognition of the pervasive, negative impacts trauma might have across the lifespan.¹⁰ As a result of this lack of assessment, support plans and interventions were not implemented to mitigate suicide risk factors. This is a pattern that MACY staff often witness in the lives of the youth we advocate for, and these are also issues discussed in other special reports from our office, including *In Need of Protection: Angel's Story* (Manitoba Advocate, 2018c), which examines Adverse Childhood Experiences (ACEs), and *A Place Where it Feels Like Home: The Story of Tina Fontaine* (Manitoba Advocate, 2019).

The absence of early intervention and effective trauma treatment in childhood is concerning given the impact it can have. Research has shown a causal link between early childhood trauma and negative outcomes with respect to the mental health and development of children from childhood to adolescence, and further, across the lifespan (Gerson & Rappaport, 2013). It is well established that experiencing trauma increases the risk for alcohol and substance misuse, anxiety, depression, and suicide attempts (Rosenberg, 2011). Further, the effects of trauma during childhood are cumulative and "the greater the trauma, the greater the risk" (Rosenberg, 2011, p. 428). Many of the 22 youth in this report experienced multiple traumas that occurred concurrently during their early childhood years which led to pervasive consequences that impacted their health and wellbeing in their adolescence.

While each of the 22 youth experienced childhood trauma, only three of the youth received some form of targeted intervention in their early and middle childhood years. For those who did receive some form of intervention or treatment following early childhood trauma, the

¹⁰According to Section 1 of *The Advocate for Children and Youth Act*, "designated services" are inclusive of: child and family services, adoption, disabilities, education, mental health, addictions, youth justice, and victim supports (including domestic violence and sexual exploitation).

corresponding intervention was not always sufficient to address the presenting needs or these youth faced barriers to accessing services, such as long waitlists. This was the case for one youth, Hannah, who died by suicide at age 16.

Hannah: "Constant Emotional Pain"

Hannah's family had a substantial history with CFS prior to her birth, which continued throughout Hannah's life. Between her birth and age 10, Hannah was cared for by her mother, father, or alternate family members. The environments where Hannah grew up were often chaotic, and CFS was involved due to numerous factors, including parental addictions, child abuse and neglect, protection concerns regarding the addictions of other family members residing in the home, suicidality of family members in the home, violence, and criminal behaviour of family members in the home.

At the age of 10, Hannah experienced a traumatic event and was to begin attending sessions with a mental health therapist in her community. Hannah, however, missed scheduled appointments and the therapist was unable to reach her parent to reschedule the sessions. Months later, Hannah was apprehended due to parental alcohol misuse and neglect. Hannah was placed separately from her siblings in her community.

After entering into the care of CFS, Hannah's life remained chaotic and she experienced little stability. In the five years Hannah was in care of CFS, the CFS agency moved her more than 20 different times. She eventually became a permanent ward of CFS at the age of 12. After that point, she began to self-harm and express suicidal ideation. She was referred to the community mental health program, but was placed on a wait list for services. Hannah was later assessed by a psychologist and diagnosed with adjustment disorder and depression, stemming from a number of circumstances: separation from her family, neglect associated with her parents' alcohol misuse, and the recent death by suicide of a close adult family member. Hannah also cited bullying by peers as a stressor. It was recommended she be connected to a mental health therapist, but she remained on a wait list for community mental health support.

By age 13, Hannah's school attendance was poor, she had begun using substances, alcohol, and solvents, and was frequently missing from her CFS placements. During an assessment with a mobile crisis service after she had expressed suicidal ideation, Hannah indicated she was in "constant emotional pain." When she denied suicidal ideation or a plan at that time and a signed a written safety plan, she was deemed low to medium risk. She was again referred to the community mental health program and assigned a mental health worker. Due to the mental health worker being unable to reach Hannah's CFS worker to plan for appointments, however, Hannah did not meet with her assigned mental health

worker for four months. Hannah eventually attended two sessions with her mental health worker where she disclosed symptoms of depression and anxiety. She denied suicidal ideation or further suicide attempts.

Three months later, at age 14, Hannah attempted suicide twice in 24 hours. On both occasions, she received a mental health assessment at the local hospital's emergency department. On the first occasion, she agreed to keep herself safe (contracted for safety), signed a written safety plan, and was assessed as low risk. She was discharged from hospital with a plan to meet with a psychiatrist for medication, attend regular sessions with her mental health worker, have increased contact with her family, and to engage in traditional ceremonies, which she indicated she wanted to do. Hours later, Hannah began consuming alcohol and attempted suicide again. She indicated at the local hospital that she was overwhelmed by thoughts of her family member's death by suicide and was missing her family. She expressed a plan to die by suicide and believed she could no longer keep herself safe. She was flown to a second emergency department to receive further assessment and treatment. This process took another 24 hours, after which Hannah was assessed as low risk for further attempts as she indicated she was no longer experiencing suicidal ideation. She was discharged from hospital without being admitted. One month later, she overdosed on prescription medication but later denied it had been a suicide attempt. Hannah met with her mental health worker on one further occasion where she denied the need to meet with a psychiatrist for medication. She indicated her mood had improved and she recognized that alcohol use affected her sadness, impulse control, and judgement, and she had made a decision to abstain from using alcohol. That was the last time Hannah met with a mental health professional as she returned to her home community and was not referred to a similar resource.

In the last year of Hannah's life, she was placed with her family. Concerns regarding Hannah's suicidal ideation and alcohol and substance misuse continued, and new concerns of criminal behaviour emerged. At age 16, Hannah had witnessed three assaults and one homicide, she had been stabbed twice, and had been charged in the assault of a peer. While the CFS agency involved recognized that Hannah needed mental health support and therapy, follow through in securing those services for Hannah did not occur and at age 16, Hannah died by suicide in her community. She had alcohol and other substances in her system at the time of her death.

As was the case for Hannah, and for many youth whose stories are included in this report, interventions were implemented through a crisisoriented model of service during adolescence, and were directed toward addressing a risk or behavioural incident, not the root cause: the impact of trauma on a child's health and development. In other stories shared in this report, interventions as a whole were absent. This service delivery model left the youth in this report at a disadvantage as they grew through their childhood years and into the new and confusing period

of adolescence. One service provider interviewed by our office noted early intervention supports as a significant gap in the current mental health and addiction system:

...we're waiting until people get really unwell and then we're waiting for service in emergency. Early interventions are best-practice but even those that are there, like CBT [cognitive behavioural therapy] groups, people are waiting for years to get into them. Schools don't have enough services or resources either (Service Provider, Interview, November 19, 2019).

The stories of these 22 youth demonstrate a pressing need for the improved early recognition of, and intervention for, trauma for Manitoba's children and youth. Further, all Manitoba children and youth need access to trauma-informed early interventions that appropriately correspond to their needs. For some children, like those in this report that present with a number of risk factors for suicide, necessary service responses mean targeted interventions for mild to moderate mental health challenges. For others, universal health and wellness promotion and prevention efforts can be beneficial.

There Are So Many Benefits to Investing in Children

Multiple reports, including the Virgo Report (Virgo Planning, 2018), *First Nations Mental Wellness Continuum Framework* (Health Canada, 2015), and *Changing Directions, Changing Lives: The Mental Health Strategy for Canada* (Mental Health Commission of Canada, 2012), have highlighted the importance of directing planning and policy to universal mental wellness promotion and early intervention efforts. The Virgo Report (2018) states, "investing in children's mental health services was also identified as an effective strategy for the prevention of problems and illnesses in youth and older adulthood" (p. 112). In addition, these efforts can prevent "…more significant, distressing, costly, and complex concerns in the future" (p. 112).

Current illness prevention and mental health promotion efforts vary in Manitoba with respect to their delivery and availability. It is inherently important that programming be delivered widely and early since 70% of young adults indicate they started to experience symptoms of mental illness in childhood (Mental Health Commission of Canada, 2016). Further, Health Canada (2015) states "that the years from conception to age six have the most important influence of any time in the life cycle and are critical in terms of brain development, mental health, parent/child relationships, and health outcomes for the child, the family, and the community" (p. 16). Early intervention is therefore imperative to provide support and mentoring to parents so healthy childhood development can be supported.

During the course of this investigation, we took the opportunity to consult with the Youth Ambassador Advisory Squad (YAAS!), which provides advice and consultation to the office of the Manitoba Advocate. When we asked the youth what was missing from the system, they spoke about the lack of early intervention, prevention, and trauma care in the early years. YAAS! suggests that money needs to be dedicated to the early intervention efforts to support parents, educators, and other professionals to begin teaching mental health literacy, coping skills early in a child's life, and to have open conversations with children about what they feel and need. This suggestion fits on Tier 1 of the tiered model, aimed at the general population of the province and focused on "population-based health promotion and prevention" (Virgo Planning, 2018, p. 12). Further, health promotion, prevention, community development and education, are also included in the continuum of essential services supported by Health Canada's (2015) *First Nations Mental Wellness Continuum* Framework.

One area where Manitoba has selected to deliver this programming is in schools. Because all children in Manitoba must attend school by law, directing efforts to this venue will ensure that these programs will reach a larger audience. As mentioned above, the provincial government has announced recent investments into Project 11 and Thrival Kits[™], which are made-in-Manitoba projects that are delivering mental health promotion activities inside Manitoba schools. These early intervention initiatives exist on one side of the mental health service continuum, and are important in building community-wide capacity.

In addition to universal prevention and mental health promotion efforts, service providers must be well versed in the effects of early childhood trauma. Understanding Adverse Childhood Experiences (ACEs) and the impacts they can have, was discussed at length in the Manitoba Advocate's report *In Need of Protection: Angel's Story* (2018c). In recognizing the numerous ACEs Angel had experienced in her early childhood, and the lack of intervention she received, our office found that there was a concerning lack of awareness and training on ACEs for service providers. As a result of that lack of knowledge, Angel was left to self-manage the compounding trauma in her life, her risk levels continued to escalate, and service providers did not intervene to protect her.

Like in Angel's story, multiple opportunities were missed for the 22 youth in this present study. Interventions by service providers occurred in response to crisis events such as periods of hospitalization, mental health breakdowns, and incidents of self-harm and suicide attempts. Early intervention and rapid responses to childhood trauma must be understood as important and this understanding by governments is demonstrated by prioritized funding. As the authors of the Virgo Report recommended:

52

Consistent with the recommendation of the Peachey report, allocate 8% of SUA/MH [Substance use/addictions and mental health] resources for prevention, recognising the close relationship between responding early intervention services to emerging SUA/MH challenges and the need for subsequent services in the future (Virgo Planning, 2018, p. 218).

We know that risk factors for suicide have been found to have strong associations with childhood trauma. One study by Choi et al. (2017) found that childhood trauma and mental health and substance use disorders were prevalent at a much higher rate in a population of individuals that had attempted suicide versus a population that had not. The story of one child, Andrea, whose suicide death we investigated for this report, highlights the importance of investing in children's mental health and wellness early. Andrea died by suicide when she was just 11 years old and had recently finished her Grade 6 school year. Andrea was exposed to a number of risk factors for suicide, yet received no documented support despite evidence of mental health challenges as early as age 7.

Andrea: Clear Warning Signs, No Help

Andrea spent her life in a small community. She had a large sibling group and she was particularly close to her mother.

Andrea's parents struggled for many years, and their relationship was characterized by substance misuse and severe intimate partner violence, including a number of incidents that resulted in her mother's hospitalization and her father's incarceration. These incidents were often witnessed by the children.

Andrea was first apprehended by CFS when she was 1 year old, but she returned to her mother's care a few days later. Her father was incarcerated following an assault at the time but her parents resumed their relationship upon his release. This pattern of the children being apprehended then returned to their parents' care shortly after continued throughout Andrea's childhood. No lasting interventions were provided to the family and the children witnessed ongoing violence and lived in the perpetually unstable and unsafe environment. Her parents continued to struggle with substance misuse and despite documentation that her parents were remorseful following violent incidents and apprehensions, no services were provided that helped the parents make meaningful or lasting changes for their family.

Andrea was apprehended once again when she was 6 years old, as her toddler sibling had been left home alone in the care of a third sibling who was younger than 10. When CFS workers attended the home, they found evidence of child neglect and other protection concerns.

Andrea spent approximately 15 months in CFS care and was placed separately from her siblings. She struggled in all areas at school, there were known issues with being bullied by peers and documentation suggested that she may have had an undiagnosed learning disability. These concerns regarding her development were not addressed by service providers.

When she was 7 years old, Andrea was found with a piece of fishing line around her neck. She was transported to the local nursing station, where she spoke with a nurse and CFS workers, before being returned to her CFS placement with instructions for her caregiver to keep a close eye on her. There was no documentation of Andrea being offered further mental health support or follow-up.

While she was in care, Andrea missed her mother and would often run away from her CFS placement in order to visit her parents in the community. After this, the CFS agency returned her to her mother's care, as her mother was able to maintain sobriety for a period of time and was engaging in required CFS agency programming.

When she was 8 years old, Andrea and a number of her peers engaged in an incident of self-harm together. Andrea disclosed that her mother was consuming alcohol again and was having "drinking parties" at the home. Andrea shared that she did not sleep well and she felt scared in her home. When asked if she would self-harm again, she responded "I don't know." Despite these disclosures, Andrea was returned to her mother's home and no further support or follow-up was offered.

Andrea's mother was hospitalized when Andrea was 10 years old, and died when Andrea was 11 years old. A few months after her mother's death, Andrea died by suicide in her family home.

Like so many others in this report, Andrea repeatedly asked for help and received no meaningful response from the adults in her life. There was ample evidence that Andrea was struggling at home, at school, and in her community but she was left to find her way alone despite her incredibly young age. The service providers did not demonstrate they understood what pain or trauma were underlying her behaviours and thus, interventions that could have made a difference in Andrea's life were not sought.

Children who have experienced trauma have varied responses, and while some may display obvious struggles like Andrea, others may struggle more internally. As the report, *The Changing Face of Youth Suicide in Manitoba and the Narrow Window for Intervention: Phase Two report* (Manitoba Advocate, 2016) states:

Some children may present with behavioural challenges or speak openly about their struggles, while other children may not present with any challenges. 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 (p. 14).

Service providers have a central role in the identification of early childhood trauma and a responsibility to seek trauma-informed interventions and healing-centred engagement for children who need them. The service delivery shift that began with trauma-informed care continues to advance, building upon feedback from young people (Ginwright, 2018). Trauma-informed care began with a change in how service providers interacted with those they supported, moving from questioning "what is wrong with them" to "what has happened to them" (Rosenberg, 2011, p. 248). Services delivered through a trauma-informed lens are built on engagement, participation, empowerment, and recovery and must be delivered by providers who are culturally competent (Rosenberg, 2011). *Healing-centred engagement* shifts our lens once again, moving one step further from a deficit-based model of care and changing the question from "what has happened to you" to "what is right with you" (Ginwright, 2018). Healing-centred engagement to healing, moves past the assumption that one is defined by their trauma.

From Trauma-Informed Care to Healing-Centred Engagement

Healing-centred engagement is a shift in service delivery that all providers should become well versed in across services and systems. Healingcentred engagement seeks to address the gaps in trauma-informed care, including the assumption that trauma is an experience that is individual instead of collective, that trauma-informed care does not address the root causes of trauma, and that trauma-informed care concentrates on the treatment of the trauma as opposed to promoting wellbeing (Ginwright, 2018). More appropriately, healing-centred engagement seeks to foster wellbeing in a holistic sense that incorporates "culture, spirituality, civic action and collective healing" (Ginwright, 2018, para. 10) and "...views those exposed to trauma as agents of creation of their own well-being rather than victims of traumatic events" (Ginwright, 2018, para. 12).

- Dr. Shawn Ginwright (2018) proposes that there are four elements of healing-centred engagement:
 - 1. Engaging individuals in their own healing by fostering an understanding of the circumstances that created their trauma and helping them to advocate or take action to challenge those circumstances;
 - 2. Encouraging holistic healing by helping young people to engage in their culture and cultivate identity and belonging through that engagement;
 - 3. Moving past simply treating the symptoms of trauma to building upon strengths or "assets" to assist in creating long-term health and wellbeing; and
 - 4. Encouraging service providers to consider their own health and wellbeing and encouraging them to receive the support they need to be effective helpers for young people.

Healing-centred engagement acknowledges an important and necessary component of wellness: holism. The *First Nations Mental Wellness Continuum Framework* (Health Canada, 2015) also promotes similar components to healing-centred engagement. It states "holistic approaches that centre on First Nations identity development, especially approaches that link culture to identity and focus on resilience rather than deficits, have been found to have positive effect" (p. 32). Members of MACY's Youth Ambassador Advisory Squad (YAAS!) also spoke with us about the importance of holistic care that incorporated Indigenous ways of knowing and took into consideration the impacts of colonization in their own lives.

Many of the 22 girls in this report relayed feelings of hopelessness throughout their lives but especially during those times when they were accessing services following suicidal ideation or a suicide attempt. Ginwright (2018) makes a powerful statement that resonates through the stories of all 22 girls in this report. He states:

Daily survival and ongoing crisis management in young people's lives can make it difficult for them to see beyond the present...The greatest causality of trauma is not only depression and emotional scares, but also the loss of the ability to dream and imagine another way of living (para. 19-20).

If we want to create different circumstances for children and youth in Manitoba, systems must seek to engage youth in their own healing by fostering their understandings of trauma, promoting a sense of mastery over the circumstances they have experienced, creating connections to

culture, belonging, and identity, building upon strengths to promote wellbeing, and ensuring children and youth are supported by healthy service providers who understand their responsibility to actively engage youth in the process.

This has not been the first special public report by the Manitoba Advocate where early childhood trauma has been a prominent theme. As such, recommendations have been made to provincial government departments in the past, such as **Recommendation One** made in the special report, *In Need of Protection: Angel's Story* (Manitoba Advocate, 2018c):

The Manitoba Advocate for Children and Youth recommends that Manitoba Education and Training, Manitoba Families, Manitoba Justice, and Manitoba Health, Seniors and Active Living engage with experts in childhood trauma and Adverse Childhood Experiences (ACEs) in order to develop a trauma prevention and response plan of action to (a) educate service providers and the public on ACEs, and (b) create appropriate, accessible immediate and long-term evidence-informed interventions to address the trauma crisis that is going on in Manitoba (p. 60).

In response to this recommendation made more than 16 months ago at the time of writing, the Government of Manitoba, through its Manitoba Advocate for Children and Youth-Recommendations Action Planning (MACY-RAP) committee has yet to provide a meaningful response that meets the intent of that original recommendation from 2018. As a result and with the government's lack of action on early trauma, some children in our province continue to carry immense pain from one day to their next with little or no support, intervention, engagement, or healing. Children deserve better and the government must begin responding in meaningful ways that demonstrates its understanding of the short- and long-term costs of inaction. Today, the Manitoba Advocate is re-issuing a recommendation on early trauma education for service providers.

RECOMMENDATION THREE: TRAIN WORKERS ON TRAUMA AND ITS EFFECTS

RECOMMENDATION THREE: The Manitoba Advocate for Children and Youth recommends that the Government of Manitoba provide early childhood trauma education and training about trauma and its effects to service providers across all government departments delivering services to children and youth.

OUTCOMES:

- Operating from a child's rights perspective, develop a curriculum for education and training concerning early childhood trauma and its effects that includes provincially relevant information, such as the history of colonization and its impact on Indigenous Peoples.
- Develop a sustainable strategy by which to deliver, evaluate, and revise the curriculum as required based on impact evaluations.

IMPACT FOR CHILDREN AND YOUTH:

Education and training will increase the knowledge of service providers to understand early childhood trauma and its effects on a child's overall health and development. This knowledge will increase the capacity of service providers to respond to the needs of the children, youth, and families they serve to ensure interventions are implemented effectively and efficiently.

With respect to interventions, the government's MACY-RAP committee has responded to our office that there has been increased funding for counselling services through Klinic Community Health Centre ("Klinic") and The Laurel Centre. In reality, there are age restrictions on each of these programs. The Laurel Centre serves youth ages 16 and older (The Laurel Centre, 2020). With respect to Klinic, their team confirmed for us that they "do not provide counselling services to children and youth under the age of 18" (Klinic staff, Interview, March 16, 2020). Klinic noted that they will always try to refer children and youth to other services where possible and that reproductive health services are available through their Teen Clinic Program for children 12 and older (Klinic Inc., 2020). It is important to also note that these programs, while important in their own right, are only available to youth that reside in Winnipeg. Further, these age restrictions limit the availability of services when they are needed: when trauma occurs during early childhood. Importantly, of the youth in this report, 23% died by suicide by age 13, 73% died by suicide by age 16, and 82% would not have been able to access either service due to their geographic location.

Some other services are available outside Winnipeg, but as the Virgo Report found, it is difficult to understand what services are available across the province and gaps exist in many areas. Plainly, the Manitoba government's response to the Manitoba Advocate's 2018 recommendation about early trauma is insufficient and does a disservice to the many children in our province who continue to languish on waitlists or who are left to navigate their pain on their own. Following from earlier recommendations made in this report, families and service providers need to know what services are available.

RECOMMENDATION FOUR: HELP FAMILIES LEARN WHERE THE RIGHT RESOURCES ARE

RECOMMENDATION FOUR: In line with Article 24 of the *United Nations Convention on the Rights of the Child*, the Manitoba Advocate for Children and Youth recommends that the Government of Manitoba conduct an annual review of what therapeutic trauma interventions are available to children and youth in Manitoba and create an inventory of resources, whether the resources require formal referrals from service providers or are open for self-referrals, any associated eligibility criteria (age, location, care status, etc.) and promote the annual inventory and its findings in the public.

OUTCOMES:

- The annual review should focus on services for children and youth from birth to 17, be compiled in a document organized by health authority region that includes a list of program names and contact information, who the program serves, intended program outcomes, eligibility and referral requirements and criteria, and occupancy rates.
- The resulting annual inventory should be accessible to all Manitobans, taking preferred languages into consideration.
- This document should be available in web format and distributed in print to agencies and organizations that serve the public throughout each region.

IMPACT FOR CHILDREN AND YOUTH:

By ensuring service providers and families have knowledge of what services and supports are available in each health region, including contact information and descriptions for each service and support, there will be fewer barriers for children and youth to access the appropriate interventions to address their experiences of trauma, reducing the effects that trauma can have on health and development as children grow.

Rural Youth Have the Right to Equal Service Quality and Availability

FINDING: Children and youth in rural and remote communities across the province face additional barriers to equitable mental health and addictions services and supports due to limited service availability and inconsistent quality of resources.

Service availability varies wildly across Manitoba and this concern is discussed at length in the Virgo Report. The disparity is felt more acutely by children and youth in Manitoba, as there are fewer services available along the continuum compared to the adult system. For example, adult acute psychiatric inpatient care is offered at five different hospitals throughout the province but there is only one acute paediatric inpatient unit in Manitoba, which is located in Winnipeg at the Health Sciences Centre. Similarly, there are only two residential addictions treatment facilities for youth in the province, the Addictions Foundation of Manitoba's Compass Program and Whiskey Jack while the number of options for adults is much higher.

Despite the fact that youth-serving resources are already few in number and the need is staggering, service providers told our office during this investigation that resources have been cut at the Compass Program, making the existing program even more difficult to access. With respect to mental health crisis stabilization, all five health regions across Manitoba have at least one mental health crisis stabilization resource for adults, yet only three have short-term crisis stabilization units (with no acute psychiatric care) dedicated to youth only: (1) the Crisis Stabilization Unit in Winnipeg, (2) Child and Adolescent Treatment Centre in Brandon, and (3) Hope North Recovery Centre in Thompson. One region does offer a stabilization unit that youth 15 years or older may access alongside adults.

If youth require addictions stabilization only, only two youth resources exist in Manitoba: the Youth Addictions Stabilization Unit in Winnipeg and two beds at the Hope North Recovery Centre in Thompson. Clearly then, most of the youth mental health and addictions services in Manitoba are clustered in urban centres creating barriers for those children, youth, and families across the province who live in rural communities.

Arguably, these disparities are felt to the greatest degree in Manitoba's northern region – simultaneously the portion of the province that has the greatest prevalence of youth substance use disorders and, by far, the highest rates of suicide among adolescents age 13 to 19 (Chartier et al., 2016). Through their research, the authors of the Virgo Report (2018) found:

...in the Northern Region...the remote nature of many communities, significant challenges related to transportation, the rapid escalation of opioid addiction, the extremely high rate of suicide (in several communities said to be "*basically once a month*"); and the extremely high cost of medical evacuation for crisis management (only to be returned to very little if anything by way of support) were cited as extremely difficult circumstances in the face of very limited resources (p. 108, emphasis in original).

Service providers from the north also confirmed these inequities during interviews with our office. The Northern Health Region covers an area of 396,000 km². This represents a significant portion of the province of Manitoba and service providers there note that this severely impacts service access for residents. At present, there are no inpatient child and adolescent facilities outside of Thompson in the north. Flin Flon, a city in the north, and towns such as The Pas, are over five hours away from Thompson. The same barriers exist for community-based services, which frequently have long waitlists due to their sparse availability and minimal capacity. For example, there are two community mental health service providers in both The Pas and Flin Flon, both of which have populations of over 5,000 people each. This number is not inclusive of those families and communities in close proximity to these centres that also would access services there. Service providers in the north told us that services are perpetually at capacity and if more services were to be available, they would certainly be accessed (Service provider, Interview, January 17, 2020). Services outside of Thompson, Flin Flon, and The Pas are scarcer still.

These service inequalities disproportionately impact First Nations and Metis communities in Manitoba. When meeting with child and family services agencies and authorities for this report, many commented that Indigenous communities do not have the resources within their communities to serve the children and youth that reside there. Coinciding with the findings of this report, resources are not available until children and youth are in crisis. When those resources are required, they can be several hundreds of kilometers from homes and communities. As one service provider commented to us, "Indigenous Peoples are Manitobans too!"

The federal and provincial jurisdictional barriers that exist in our systems and in our province have created cracks through which where children and youth are falling. Sixteen of the 22 youth in this report resided in a rural community for either the entirety of their lives or for intermittent periods. Of those 16 youth, eight had to travel to an urban centre, sometimes many hours away from their homes and families by plane or vehicle, to receive an assessment or short-term treatment during a crisis relating to their mental health or addiction. One health professional told us that the cost of this type of evacuation was \$12,000 to \$20,000 for a flight one way.

In the 2018-2019 fiscal year, 3% of children and youth seen by the youth mobile crisis service in one northern city were medivaced to Winnipeg. That number, however, would actually be much higher as it does not include children who were medivaced directly from First Nations communities throughout the north. Using these numbers, the total cost for these children and youth to receive emergency mental health care would have been \$156,000-\$260,000. Of the 22 youth included in this report, four were medivaced to an urban centre for emergency mental health care one or more times. Another service provider told us that the accessibility of crisis response for children and youth in the north is "nil," and while being medivaced to a larger centre is the only option at present, it is not the best one, as it causes more disruption at a time when a child or youth is already in crisis (Service provider, Interview, January 17, 2020). What's more, when these youth return to their community, the care they need is not easily accessible or even always available, as discussed above. *The First Nations Mental Wellness Continuum Framework* also described this gap, stating:

With comparatively few mental health resources available on reserve, many First Nations people facing mental health challenges must travel outside their communities to access services, which are often not culturally competent or safe. They often receive little to no follow-up or continuing care upon returning to their community (Health Canada, 2015, p. 27).

As a result of the lack of appropriate resources available in many communities, few other services exist. Too often, the responsibility for mental health and addictions care is left at the feet of child and family services workers, who are frequently overburdened by their existing responsibilities and who are not trained in mental health or addictions. Mental health professionals are specialists in their field and require a great deal of training as part of their role. Because mental health and addictions require healthcare responses, that is the system which ought to step up. And yet, in Manitoba, that work continues too frequently to fall at the feet of CFS. We repeatedly heard from service providers that the child and family services system acts as a catch-all resource, picking up the slack from all of the other systems. Service providers spoke to us about entire provincial health authorities within Manitoba refusing to provide mental health services to children and youth connected to child and family services. Disturbingly, parents and families are being encouraged by some service providers to place their child or youth in the care of child and family services, even in the absence of any protection concerns, in order to gain access to health services to which all children and youth have a right to access.

All Manitoba children and youth deserve equitable access to mental health and addictions care and have a right to services and supports that are non-discriminatory and informed by and integrate their unique cultural values and ways of healing. One youth, Dawn, who died by suicide at age 13, experienced many of the barriers discussed in this section.

Dawn: Access to Health Care is a Human Right

Dawn resided in a small community in rural Manitoba. She was musically gifted and could play many instruments. At the time of her death at age 13, she was in the care of CFS and resided with some of her siblings in a kinship home.

Dawn's early years were difficult. Both of her parents struggled with alcohol misuse and Dawn was frequently left without a sober caregiver, was exposed to unsafe adults, witnessed violence between adults, and experienced neglect. Dawn's family had extensive involvement with CFS and by age 3, Dawn had been apprehended three times and had resided in five short-term placements, many of which were emergency shelters or hotels.

When Dawn was 3 years old, she was removed from her mother's care for the last time by CFS and placed with a family member in a kinship home. Dawn's parents attempted to address their addictions to alcohol but were unable to maintain long-term sobriety. A permanent order was granted to the CFS agency when Dawn was 7 years old. That same year, Dawn's father died by suicide. Dawn did not receive counselling or therapeutic support after his death.

By age 12, Dawn had begun to self-harm and was referred to a mental health worker through the community mental health program and to a separate family therapist. Dawn began to meet with her mental health worker at least monthly and treatment plans were developed to address Dawn's symptoms of trauma-based anxiety, attachment issues, and adjustment disorder mixed with anxiety and depressed mood. Dawn was also meeting with a psychologist through her school due to declining grades, increasing frustration at school, symptoms of depression and anxiety, and a general inability to cope. An assessment by Dawn's school found her to be living with low cognitive abilities.

Despite the support Dawn was receiving, she continued to self-harm as a mechanism through which to cope with her feelings. She attended emergency departments at hospitals five times in six months at age 13 to receive treatment following self-harm and the two suicide attempts she experienced during that time. Dawn spent approximately one month, through two separate admissions, in the acute inpatient psychiatric unit, located several hours from her home and was prescribed medications intended to treat anxiety and depression. After one suicide attempt, Dawn disclosed that a peer she was close to had died by suicide one day prior. After she was assessed to have stabilized, Dawn was discharged from hospital with a recommendation that she follow-up with her mental health worker, family therapist, and physician. Dawn was also assessed by mobile crisis services after expressing suicidal ideation on one occasion. Dawn engaged in creating personal safety plans while admitted to

hospital, during sessions with her mental health worker, and when assessed by mobile crisis services. Dawn's mental health worker completed two formal suicide risk assessments in the months preceding Dawn's death, during which Dawn denied suicidal ideation or a plan. Mobile crisis services suggested to Dawn that she could benefit from counselling or treatment to manage suicide thoughts and self-harm behaviour, although Dawn was already accessing these resources.

At the age of 13, Dawn died by suicide in her home community. Just three days prior, Dawn met with her mental health worker for the last time and created a personal safety plan and was provided a copy to take home.

Dawn was one youth who resided in a rural, isolated community and had to travel great distances to receive the mental health services she needed and to which she had a right to receive. She and her caregivers were required to travel many hours to attend appointments with mental health workers, private therapists, physicians, and psychiatrists. Dawn was, at times, flown to an urban centre when she required emergency mental health care. Dawn had to leave her family, her friends, and her community every time she required emergency mental health care because those services were only available hours away from her home.

Youth Service Hubs and Focal Points: Increasing Service Integration across the Continuum

One solution to the issue of equal access that impacted Dawn and many others is the expansion of youth hubs, one of which already exists in Winnipeg, to additional rural areas across Manitoba. A youth hub is a "one-stop-shop" that houses various services and supports in one central location, thus ensuring that services are central, accessible, and able to be integrated with one another. The Virgo Report (2018) describes some positive attributes of the model, which include "connecting treatment and support with prevention and health promotion in a holistic way" (p. 116).

While the youth hub model began in Australia under the project name *Headspace*, it has been adapted in seven provinces and one territory across Canada, including in Manitoba (Halsall et al., 2019). The NorWest Co-op Youth Hub in Winnipeg is designed for youth and young adults ages 14 to 24 and offers mental health, primary care, addictions, employment, and recreation activities, through various service providers including the Addictions Foundation of Manitoba, Youth Employment Services, and the Manitoba Adolescent Treatment Centre (NorWest Co-op Community Health, 2020). Other provinces, including Ontario and British Columbia, have expanded their hub model to serve various locations

and populations. While most hubs offer a range of services, including primary care, mental health, addictions, social and vocational services, there appears to be variation in the type of services offered under those broad umbrellas. Other provinces have included solution-focused brief therapy, motivational interviewing, trauma-focused cognitive behavioural therapy (TF-CBT), dialectical behavioural therapy (DBT), and mindfulness in their delivery of mental health services (Halsall et al., 2019).

When interviewed, representatives from the NorWest Co-op Youth Hub ("Youth Hub") in Winnipeg reported they see value in the organic connections and relationships youth build with one another and with supportive resources and noted that most youth who come to the Youth Hub come back (Service provider, Interview, January 16, 2020). In getting youth to attend the hub, service providers noted there was also value in building connections with youth in the community in their environments. For example, Youth Hub service providers noted that connections made with youth when staff attended a local school a few days a week, or hosted programming at a local community centre, promoted natural relationship building and familiarity. With that existing relationship, youth were more likely to attend the Youth Hub (Service provider, Interview, January 16, 2020).

ACCESS Open Minds, a pan-Canadian service transformation and research project aimed at transforming the delivery of youth mental health services across Canada, noted a similar need. At one of their youth hub sites, they noted it was not enough for a space to merely exist for youth, rather, service providers must be out in the community engaging actively by hosting and participating in events (ACCESS Open Minds, 2018). They note from there, relationships can be built and referrals can be made as required. While there is a growing evidence base for these relatively new models to Canada, it is clear that various provinces have utilized these centralized hubs as a solution to integrate and cohesively bolster a fragmented system of services to improve outcomes for youth.

Further to the youth hub model, the Virgo Report recommends the development of "focal points" across Manitoba. This recommendation was initially made in the *Clinical Preventative Services Planning for Manitoba Report* (Health Intelligence, Inc. and Associates, 2017, also known as "the Peachey Report"), which was submitted to the Government of Manitoba. While the youth hub model acts to integrate and coordinate services and supports for mild to moderate mental health and addictions concerns, focal points:

...integrate several core services required to respond effectively to the most immediate crises, and to bolster the capacity in the ED [emergency department] setting to support people with SUA/MH [substance use and addiction/mental health] challenges, including through access to psychiatric assessment and linkage to community-based services as appropriate (Virgo Planning, 2018, p. 222).

The Virgo Report proposes that focal points would act to bridge regional inequality gaps that exist across the province and recommendation 2.11 of the Virgo Report (2018, p. 225) suggests that focal points be made up of six core services including:

- Capacity for SUA [substance use and addiction] and co-occurring disorders support, including screening and assessment.
- 24/7 access to psychiatric consultation and acute assessment/treatment services.
- A core set of professionals in addition to psychiatrists e.g., Clinical Psychologists and Psychiatric Emergency Nurses (PENs). These professionals should also have capacity to support people with primary SUA challenges.
- Cross-trained mental health and addiction liaison workers co-located in EDs and other hospital programs and affiliated with a nearby integrated community team as a core service of the model, in lieu of cross-trained PENs, if PENs are not available.
- Infrastructure and staffing (i.e., facility suitability) to ensure safety and security of patients and staff.
- Linkage to community mental health and addictions services, including centralized intake.

Additionally, both of these models could be integrated and adapted to meet the needs of individual Indigenous communities using the components of the *First Nations Mental Wellness Continuum Framework* (2015) continuum of essential services: health promotion, prevention, community development and education; early identification and intervention; crisis response; coordination of care and care planning; detox; trauma-informed treatment; and support and aftercare. Furthermore, supporting individual communities to develop and take ownership of their youth hubs and focal points would ensure that their continuum of services could be culturally relevant and designed to meet the unique needs of the community they serve.

When we interviewed service providers in the north as part of this investigation, they told our office that "psychological services are in short supply" in their region and are greatly needed (Service provider, Interview, January 17, 2020). They noted that the addition of psychiatry consultations to their service repertoire could reduce the need to medivac children to Winnipeg, which is costly as well as physically and mentally draining for children, youth, and their families.

With respect to service implementation, youth on MACY's Youth Ambassador Advisory Squad (YAAS!) advocated for alternative spaces to emergency departments. They reported that when accessing an emergency department for a mental health concern, emergency departments were too busy and are not private. In their experience, they are clinical spaces that focus heavily on medical concerns, as one youth stated "pain exists on the inside but they're only interested in treating the outside" (YAAS! member, Interview, January 22, 2020). They see value in a mental

health-focused crisis space that is non-judgemental, non-stigmatizing, child-centred, and where they can speak openly and honestly with service providers about their needs. Indigenous ways of healing should be incorporated into treatments, and a culture room should be available, in addition to Elders to support youth in crisis.

Similar to the Virgo Report (Virgo Planning, 2018), however, the *First Nations Mental Wellness Continuum Framework* (Health Canada, 2015) identifies many current barriers to accessible, coordinated, and quality mental health and addictions services including:

- Difficulty accessing communities due to rural or remote locations;
- Provincial services that are not culturally competent or safe;
- Service quality issues due to little or no clinical supervision or support to workers delivering federally-funded mental wellness programs;
- Limited human and financial resources;
- Jurisdictional issues; and
- Poor integration of services.

The Virgo Report commented that the "overall system of services will not improve significantly in terms of access or coordination without a concerted and sustained effort to better meet the needs of the province's Indigenous Peoples" (2018, p.236). The lack of services available in rural and remote communities in Manitoba could be described as a "navigation to nowhere" issue encountered by others attempting to improve accessibility and coordination of services (Valaitis et al., 2017, p. 9). Without a concerted and coordinated effort on the part of the provincial and federal governments to enhance the services available across the continuum in rural and remote communities in Manitoba, little change with respect to mental health and addictions outcomes may be seen. Both the provincial and federal governments are currently investing dollars to respond to youth mental health and addiction crises when they occur. Those investments, however, would serve children and youth better if they were used to build locally available and culturally safe services and supports that acted to prevent crises before they occurred, such as youth hubs and focal points.

RECOMMENDATION FIVE: CREATE MORE YOUTH HUBS

RECOMMENDATION FIVE: The Manitoba Advocate for Children and Youth recommends that the Department of Health, Seniors and Active Living, in collaboration with rural communities in Manitoba, and the federal government, where applicable, implement recommendation 4.8 of the Virgo Report:

Building upon the successful experience of the NorWest Youth Hub and lessons learned from the experience of other provinces, develop a provincial plan for scale-up of the youth hub model, or similar models of integrated youth services, taking advantage of support from philanthropy as it may be available (Virgo Planning, 2018, p. 235).

OUTCOMES:

- Develop a provincial plan to initiate scale-up of the youth hub model based on a province-wide gap analysis assessment of need to determine which populations would best benefit from this resource. Special consideration must be provided to rural and remote locations throughout the province.
- Review the considerable literature and experiences in other Provinces to engage individual communities to guide the implementation of their youth hubs.
- Integrate multiple access points into communities to promote youth engagement in the hubs, including offering services in places where children are, such as in schools, community centres, health care facilities, and more.

IMPACT FOR CHILDREN AND YOUTH:

When services and supports are available locally and integrated in one location, youth are more likely to engage with supportive professionals and programming that could act to enhance their overall health and wellbeing. These early interventions could prevent mental health and addictions concerns from worsening and resulting in complex crises over time.

RECOMMENDATION SIX: CREATE FOCAL POINTS OUTSIDE OF WINNIPEG

RECOMMENDATION SIX: The Manitoba Advocate for Children and Youth recommends that the Department of Health, Seniors and Active Living, in collaboration with rural and First Nations communities in Manitoba, and the federal government, where applicable, implement recommendation 2.11 of the Virgo Report, as summarized below:

In the RHAs other than the WRHA, create mental health hubs (as identified in the Peachey report), with a view to:

- (a) developing these as integrated regional mental health and substance use/addictions (SUA) "focal points", and
- (b) harmonizing a core set of regional services and supports to the hospital emergency departments and crisis services including:
 - Screening, assessment, and support for SUA.
 - 24/7 access to psychiatric consultation and acute assessment/treatment services.
 - A core set of professionals in addition to psychiatrists with capacity in SUA support e.g., clinical psychologists and psychiatric emergency nurses
 - Cross-trained mental health and addiction liaison workers co-located in hospital emergency departments/other hospital programs.
 - Infrastructure and staffing to ensure safety and security of patients and staff.
 - Links to community mental health and addictions services, including centralized intake (Virgo Planning, 2018; full wording may be found at p. 225).

OUTCOMES:

- Ensure that each focal point has the ability to service children and youth, unless other specialities housed at a larger centre are required.
- Develop a provincial plan to initiate scale-up of focal points in each of the five regional health authorities across Manitoba.

IMPACT FOR CHILDREN AND YOUTH:

Access to psychiatric and other professional supports in a locally available setting will act to ensure that children and youth will be assessed close to their homes and families, avoiding the stressful and costly medivac procedure. In addition, mental health or addiction liaison workers, such as a professional in a mental health navigator role, and a form of centralized intake integrated at a single location, would

ensure children and youth in crisis would be connected to supportive community resources prior to be discharged and a professional would be connected to follow-up with the child or youth in the community to ensure their plan was effective.

Recommendation in Action: Enhancing Community Wellness with a Continuum of Essential Services

Eskasoni First Nation is an excellent example of how a small community in Canada integrated their continuum of mental health and addictions services to better meet the needs of children and youth, while also integrating the services available to enhance overall community wellness (Eskasoni Mental Health Services, 2018; ACCESS Open Minds, 2020). Eskasoni First Nation is a band government of the Mi'kmaq located on Cape Breton Island, Nova Scotia. The community has a population of roughly 3,752 who live on-reserve and 660 members who live off-reserve. It is a rural community that was selected to be a part of the ACCESS Open Minds research project funded by the Graham Boeckh Foundation and Strategy for Patient-Oriented Research. The project seeks to build upon the array of services already available in communities to engage young people in different ways, improving the overall wellbeing of individuals and the community. Eskasoni Mental Health Services website (2018) states "this will be done through collaboration with youth, families, caregivers, community organizers, and service providers to ensure seamless access to care and to reduce gaps in services across organizations. This care will be delivered in youth-friendly ways based on the principles of inclusion, respect, participation, empowerment, and hope."

Eskasoni Mental Health Services has integrated the essential continuum of services suggested in Health Canada's (2015) *First Nations Mental Wellness Continuum Framework*, many of which coincide with the recommendations of the Virgo Report (2018), and form the foundation for the recommendations the Manitoba Advocate is making in this report. These include organizing service delivery into the tiered model of care. For example, Eskasoni First Nation has integrated universal health promotion and prevention activities at Tier 1 (e.g., parenting programs, various activities including cultural, ceremonial, and social enterprise) with early interventions for mild to moderate mental health and addictions concerns at Tiers 2 and 3 (e.g., individual and group therapeutic interventions, culture camps, youth programming). More intensive interventions for those with complex needs are at Tiers 4 and 5 (e.g., crisis intervention services and community-based case management).

Within the Eskasoni First Nation community, one main office provides connection to six teams of professionals who provide integrated mental health and wellness services. The services offered to community members include:

- The ACCESS Open Minds Program: individual and group therapeutic interventions, youth programming, youth educational sessions, social enterprise, art therapy, music lessons, a cyber cafe, gaming and movie nights, library, cultural activities and ceremonies, psychoeducational assessments, hormone readiness assessments
- **Community Access/Crisis/Distress/Comfort Line**: 24/7 toll free and online (Facebook, MSN, text, WhatsApp, Twitter), as well as inperson crisis intervention and referral services, central intake, training (ASIST, Safe Talk, Mental Health First Aid), traditional craft events and gamer nights
- **Community-Based Case Management**: case management of high-needs clients involved with multiple service organizations, advocacy, special needs support group, family and carers council
- Youth Clinical and Therapeutic Support: clinical support services for youth, social/life skills, recreation, sports, cultural activities and events, youth advocacy, culture camps, youth programming
- **Clinical/Therapeutic Adult Support**: individual, group, marital, and family clinical support services, parenting programs, domestic violence intervention program
- **Residential School Support**: emotional support for former residential schools students, referrals to appropriate service providers, and cultural support services and access to traditional healers/elders, traditional teachings and activities

The staff compliment – roughly 25 individuals who work together in the six teams delivering the services above to provide a "Ladder of Care" – includes those who act as peer supports or have lived experience, paraprofessionals, professionals who hold university degrees in social work or another social science at the Bachelor or Masters levels, family physicians, and a consulting psychiatrist.

Many of these services are integrated into centralized hubs which are accessible to community members. The hubs were developed to include a range of activities, from the movie and gamer nights to therapeutic interventions and more specific youth programming, so as to not be identifying for those who access them. The services selected were designed and implemented with client and community input, as well as through research partnerships. Eskasoni Elders proposed that the services offered included First Nations cultural practices and teachings alongside Western therapeutic interventions, termed a "two-eyed seeing approach," which was carried out.

While a full evaluation of the project is in progress, early data suggest that children and youth are able to access these community-run services more quickly than they would provincially-funded services, and youth from the community are engaging readily in the services offered.

71

Families Need System Navigators, or Co-Pilots

FINDING: The current continuum of youth mental health and addictions care is difficult for children, youth, and their families to navigate due to its complicated, multi-system nature, which is often delivered in silos. Knowledgeable navigators are needed who are dedicated to assisting children, youth, and families to navigate the continuum, track progress, evaluate the effectiveness of interventions, and initiate changes to a plan that is not meeting the intended objectives.

The current continuum of youth mental health and addictions care is inherently difficult to navigate. Not only are youth mental health and addictions services delivered through separate systems, services within each system belong to different organizations that have various funding sources and governance structures. These divisions are further complicated by jurisdictional barriers between provincial and federal services. All of this means that children, youth, and their families are forced to traverse complex systems made up of organizations that have various referral processes, different entrance criteria to access services, and are delivered out of multiple offices located in separate areas of the province. When interfacing with the behemoth that is the mental health and addiction system, families and other care providers are required to take the lead in delivering on the care plans (even when they may be incapable or unfamiliar with the system) and despite any disenfranchisement or disempowerment they may be experiencing. For families and service providers that are at their breaking point simply trying to keep a child or youth alive, this can be an overwhelming tangle of phone calls, appointments, meetings, medications, short-term treatment plans, assessments, additional consults, crisis calls, emergency response units, and more. Further, a family's efforts may not even result in that child or youth accessing services if they are deemed ineligible for a program or placed on a lengthy wait list. As one service provider we interviewed described, "it's confusing, people don't know where to go, what to do, then they get frustrated" (Service provider, Interview, November 19, 2019).

The Manitoba Advocate (2020) shared one such story with Manitobans recently, *The Slow Disappearance of Matthew: A Family's Fight for Youth Mental Health Care in the Wake of Bullying and Mental Illness*. Matthew struggled with his mental health for six years during his adolescence. As a result, Matthew had many contacts with community supports, including school-based and community-based psychologists, psychiatrists, public and private therapists, occupational therapists, doctors, police officers, paramedics, mobile crisis teams, and CFS staff. What resulted was a patchwork of interventions that were ill-coordinated and, ultimately, ineffective at engaging him in treatment or offering him long-term help.

The service barriers experienced by Matthew and the 22 female youth whose stories informed this report, are a shared concern for many other Manitobans. Questionnaire responses from multiple stakeholder groups compiled in the Virgo Report summarized that "all stakeholder groups

identified a <u>lack of awareness</u> of, and <u>difficulties with, service navigation</u>, as significant barriers to accessing services" (2018, p. 153, emphasis in original). Systemic barriers to accessing the services and supports these youth needed often translated to barriers that kept them from being healthy and well.

These obstacles have, in part, contributed to a crisis-oriented service delivery model in Manitoba. As the Virgo Report notes, "the current capacity and nature of services available means that things don't get addressed until the situation is severe and often in crisis mode" (2018, p. 108). This mode of service delivery was also noted in the experiences of these 22 youth. Many youth were accessing broadly available services when they needed help, such as health care facilities or mobile crisis services; and yet, that access did not always result in hospitalization, treatment, or connections to supportive community resources for ongoing support. Likewise, being admitted to a mental health or addictions treatment resource did not always promote positive outcomes because systemic obstacles to accessing services on the continuum complicated a family or service provider's ability to carry out treatment plans after a resource was accessed. In fact, 11 of the 22 youth had repeated contact with hospitals or crisis resources. The act of repeatedly cycling through services is concerning as these are critical opportunities for intervention, but, more importantly, suggest that the intervention available at that access point does not match the needs of the youth. Further, previous suicide attempts are one of the best indicators for suicide risk (Bridge et al., 2006; Kirmayer et al., 2007 as cited by Manitoba Advocate, 2016). The link between mental health concerns and substance misuse is also well established and the misuse of alcohol or other drugs is the most prevalent risk factor for suicide, secondary only to depression (Centre for Suicide Prevention, 2014).

One factor that may have contributed to these negative outcomes was a lack of follow-up and support after these youth accessed services on the current continuum of mental health and addictions care. Below is a summary of what occurred when a youth accessed a health care facility or crisis resource for either mental health or addictions challenges, or both, based on our observations and interviews with service providers:

- 1. Assessments were conducted by health care professionals, including nurses, physicians, and, if necessary and available, psychiatrists to determine that youth's immediate suicide risk.
- 2. If the youth was deemed at a low risk for suicide, they were discharged from the service with a discharge plan, which was often a suggestion to follow-up with their family doctor and a list of local crisis services/phone numbers the youth could contact in the future.

- 3. If a youth was deemed at risk for suicide and it was not safe to discharge the youth (i.e., they continued to express suicidal intent), that youth might be referred to short-term crisis stabilization or hospitalized in an acute inpatient psychiatric setting, also designed to promote short-term stabilization.
- 4. When a youth had stabilized from the immediate crisis and was no longer expressing suicidal ideation or verbalizing a plan, the youth would be discharged from the service with a discharge plan. Many times these plans were repetitive if the youth had accessed the service multiple times.

Based on the 22 investigations completed for this special report, seven of the youths were admitted to a crisis stabilization unit or an acute paediatric inpatient psychiatry unit prior to their deaths. The average length of stay was 7.5 days, with the longest stay being 28 days and the shortest being two days. Of those seven youth, five were admitted on at least one occasion with two having been admitted up to three times in a six and eight month period, respectively. Only one youth received services from an addictions treatment resource, despite 11 of the youth being known to have addiction concerns. For some, their addictions were clearly documented by service providers and spanned multiple years.

Regardless of the resource accessed, a prevailing theme was the absence of support and follow-up that occurred when these youth were discharged from both mental health and addictions services and placed back into the community. Health Canada (2015) states, "a crucial component of crisis response is coordinated and timely follow-up" (p. 16). For the 14 youth who accessed a health care facility or mobile crisis service and the seven youth who accessed crisis stabilization units or the acute inpatient psychiatric unit, that critical follow-up was missing. None of the youth had a professional from these resources reach out to them or their families after their discharge to determine if the discharge plan was being used or was effective. This is not, however, simply a fault of the professional. For many health care facilities, crisis stabilization services, and the acute inpatient psychiatry unit, follow up is not required to ensure that the discharge plans created for children and youth are being followed and meeting their needs. Nor is there any way to trigger a reassessment, apart from the youth returning to a hospital or calling a regional mobile crisis team. The role of the inpatient resources is to ensure the child or youth is safe while they attend their facility and receive the short-term treatment they need to return safely to the community. At that time, onus is placed on youth, their families, and community service providers, if they are involved, to traverse a complicated and sometimes disjointed system of mental health and addictions organizations.

One service provider described the importance of these crisis and stabilization resources, but also noted that for children and youth who repeatedly access them, they can just be a Band-Aid solution when not paired with the appropriate community supports (Service provider, Interview, December 3, 2019). As we observed for many youth in this report, children and youth who have been referred to a community

resource but then had difficulty accessing that resource, often see their files closed. One service provider noted that "it's difficult to get back into the system if you've fallen through" (Service provider, Interview, December 3, 2019). Many youth then reach a point of crisis once again and reaccess the same emergency and crisis resources, at which point "they go back through and start again" (Service provider, Interview, December 3, 2019). This process is inherently flawed, and as one youth on MACY's Youth Ambassador Advisory Squad (YAAS!) noted, "we shouldn't have to jump through hoops to get help" (YAAS! Member, Interview, January 15, 2020).

The story of Jasmine, who died at age 17 by suicide, illustrates a breakdown in follow-up and support on the continuum and what can happen when a child is discharged from a service without support and follow-up.

Jasmine: Where a Mental Health Navigator Could Have Made a Difference

Jasmine resided in a rural community in Manitoba. She had several siblings and lived with her family at the time of her death at age 17. Prior to her death, Jasmine had hopes to graduate and then continue her education.

Jasmine's family had sporadic contact with CFS prior to her adolescence but Jasmine was not the focus of those contacts, rather CFS involvement centred on Jasmine's older siblings, as well as Jasmine's mother's alcohol misuse, and Jasmine's mother physical assault of a minor. When Jasmine entered adolescence she began to struggle academically and exhibit behavioural issues at school. Jasmine encountered increasing difficulty when she entered into high school and was subsequently referred to the school guidance counsellor, an individual she would develop a positive relationship with in the following years. At the same time, the CFS agency closed their file with Jasmine's family, noting that they had no concerns and Jasmine's mother did not feel that she required CFS support.

When Jasmine was 16 years old, she expressed suicidal ideation with a plan. She was transferred from a hospital emergency department to a crisis stabilization unit where she remained for four days. While admitted, she disclosed three previous suicide attempts, frequent suicidal ideation, panic attacks, and depressed mood. Cannabis use was documented to be a concern for Jasmine's parents, as was parent-child conflict. Jasmine spoke of recent stressors in her life such as a friend dying by suicide and the relationship with her boyfriend having recently ended. When she was assessed to have stabilized, she was discharged with a plan to continue to see her school guidance counsellor, access supports through the community mental health program, follow-up with her regular physician, and contact crisis supports if needed. A referral was sent by the crisis stabilization unit to the community mental health program.

Just over one month later, Jasmine was again admitted to the crisis stabilization unit for suicidal thoughts. At that time she was no longer regularly attending school but was maintaining contact with the school guidance counsellor. While admitted in the crisis stabilization unit, Jasmine underwent a psychological assessment which indicated her IQ fell in the very low range and she exhibited symptoms consistent with ADHD. She was subsequently diagnosed with mix substance abuse, ADHD, and borderline intelligence. She was prescribed medication to treat symptoms of ADHD. After eight days, she was discharged with an identical aftercare plan as she had been given the previous month.

The following year, Jasmine's mother contacted the regional mobile crisis service because Jasmine had been consuming alcohol, self-harming, not attending school, and not eating for a period of days. She was struggling due to relational issues with her boyfriend. Jasmine was no longer taking her medication to treat her ADHD symptoms but had been prescribed additional medication by her regular physician to treat depression and anxiety. Jasmine continued to see the school guidance counsellor but had not engaged with the community mental health program. Jasmine's mother requested admission to the crisis stabilization unit, but documentation does not show that she was admitted.

Just two months later, Jasmine's school contacted CFS about her poor school attendance. Although a CFS intake file was opened to address that issue, before the CFS agency could follow-up on the report, they learned Jasmine had been hospitalized following a suicide attempt. Jasmine died shortly after as a result of her injuries.

Jasmine's story is just one example of how a lack of follow-up and support to navigate the mental health and addictions systems can be detrimental to a youth's wellbeing. In fact, many sources cite that a large proportion of children and youth do not receive the necessary treatment they require (Canadian Mental Health Association, 2014; Brown et al., 2014; Chartier et al., 2017). Literature also shows that a lack of follow-up can have disastrous impacts. One Canadian study found that a lack of follow-up after hospitalization was associated with readmissions, substance use relapse, self-harm, an exacerbation of psychosocial stressors, and suicide (Butler et al., 2017).

A viable solution that would act to fill this gap and assist children, youth, and their families to navigate Manitoba's complex mental health and addictions continuum of care would be a youth mental health and addictions navigation program – a recommendation that is supported by many experts. A number of service providers interviewed by MACY stated that a support person being assigned after a child accesses an emergency or inpatient resource could make a "very, very big difference" to whether that child or youth accesses outpatient support (Service provider, Interview, December 3, 2019). Further, the Virgo Report's recommendation to "expand and accelerate services and supports to family

members and other loved ones including increased support for family navigator services" (2018, p. 224). A recommendation for a navigation support is also listed as a priority for action in the *First Nations Mental Wellness Continuum Framework*, which states, "system navigators...are natural advocates as they provide support, bridge gaps, connect-the-dots in and across services, and reduce communication gaps for clients in the system" (Health Canada, 2015, p. 52).

While these programs may be known by different names across North America, this model of support and advocacy has the potential to improve access to youth mental health and addictions services across the province and in doing so, improve both short- and long-term outcomes for children and youth struggling with mental health and addiction challenges (Rollins et al., 2018). These programs can support children, youth, and their families, accessing services and supports and assist in matching that child or youth's need to the appropriate program. One way to achieve this would be to have dedicated and trained mental health service providers acting as case managers and care coordinators (Health Canada, 2015). With these additions to the mental health and addictions system, connectivity to supports and services would likely increase overall, and importantly, children and youth would have access to community-based mental health advocates to evaluate their changing needs and ensure plans are evaluated and altered as necessary to enhance that child or youth's mental health and wellbeing.

One program, called the Family Navigation Project, began in Toronto, Ontario in 2013, following feedback from parents that they were having difficulty navigating a complex system of mental health and addictions services to access the supports their children and youth needed. As a result, the Family Navigation Project was born and helps to connect youth and young adults age 13 to 26, and their families, to resources in the mental health and addictions systems free of charge. The process begins with an intake phone call or email and participants are assigned a navigator within two business days. Navigators are graduate-level clinicians with extensive knowledge of mental health and addictions services. Through a careful review of the participant's social and medical history, a navigation plan is developed and, if approved by the youth and their family, the plan is mobilized by the navigator. The navigator continues to have contact with the family to ensure the plan is successful. If the plan is not successful, the navigator remains involved to offer problem-solving and support until the family is happy with the plan or until all available resources have been exhausted. The results of the program have been favourable with 90% of families satisfied with the assistance they received (Markoulakis et al., 2016).

Similarly, MACY's Youth Ambassador Advisory Squad (YAAS!) members also voiced the need for system navigators to assist youth and their families in traversing the complex network of mental health and addictions services. They noted there would be value in having a "co-pilot" to help youth connect to resources at all stages of their mental health journeys. They envisioned a navigator program could encompass a telephone

resource, which one youth called a "mental health 311" line, and support persons that can walk alongside youth to help them connect to the help they need. One youth told us that being handed a piece of paper with a list of phone numbers to call on her own when discharged from a crisis resource was not helpful. Many youth voiced that it would be much more meaningful for a professional to connect with youth and begin building a relationship and understanding their needs while they are admitted so they knew who their supports were, and what their roles were going to be, before they returned to the community. As one youth who has extensive experiential knowledge of the youth mental health system stated, "stop giving me a number and start giving me a person" (YAAS! Member, Interview, January 15, 2020).

The 22 youth profiled in this aggregate report may have benefited and their trajectories impacted positively if the appropriate treatments and supports had been coordinated and implemented in a timely and comprehensive manner. What is clear from the stories presented in this report is that often the children and youth were not accessing services until times of crisis. This is a common concern we see in our advocacy work across Manitoba, and that which we see in the child death reviews we complete each year. The addition of a mental health and addictions navigation resource has improved outcomes for youth in other provinces in Canada and could improve the outcomes for children and youth in Manitoba if it was implemented meaningfully, with the populations being served engaged in the planning process.

The Slow Disappearance of Matthew: A Family's Fight for Youth Mental Health Care in the Wake of Bullying and Mental Illness (Manitoba Advocate, 2020), recommended the implementation of mental health navigators:

The Manitoba Advocate for Children and Youth recommends that Manitoba Health, Seniors and Active Living develop, implement and fund mental health and addictions system Navigators, who act as case managers for children and youth who are accessing the upper tiers of the youth mental health and addiction system, similar to Ontario's model. These Navigators should be knowledgeable and well-trained and offer case coordination and rapid response services to ensure children and youth know their health care plan, can access appropriate services, and ensure case reviews are initiated when services are not effective. Further, much like the requirement for child and family services workers, mental health and addictions Navigators should provide services in accordance with provincial standards of care that change in their intensity and frequency according to the assessed levels of risk to a child or youth (p.77).

We take the opportunity here to highlight this important recommendation knowing that mental health navigators could have made a great deal of difference in the lives of the 22 girls in this report.

The Top Tier on the Continuum Requires Special Investments

FINDING: Manitoba lacks intensive services and supports at the top tier of the youth mental health and addictions continuum to meet the needs of youth with complex challenges and who are at a high risk of harm or death.

Based on the information compiled for the purposes of this report and many others by our office, a significant gap on the current continuum of mental health and addictions care are services and supports for youth who are at a high risk to come to harm due to their mental health needs or addictions. These are the services at Tier 5, the uppermost tier in the tiered model of care referenced throughout this special report. This select group of youth have intensive treatment needs and may require highly specialized inpatient or residential treatment settings.

For these 22 youth, the impact of trauma on their lives was tremendous, and in the absence of early intervention and treatment, the effects of their cumulative trauma contributed to poor mental health and the development of unhealthy coping mechanisms, such as alcohol and substance misuse. Eleven of 22 youth, or 50%, struggled with co-occurring mental health and addictions challenges. This made these youth vulnerable to sexual exploitation, to physical harm, becoming involved with the justice system, and increased their risk to die by suicide, homicide, or overdose. The number of opportunities they had to develop healthy relationships, engage and achieve success in their education, and succeed overall dwindled over time, overshadowed by their daily need simply to survive. For these youth, the youth mental health and addiction systems were not successful in meeting their needs, which, for many, were complicated by overwhelming trauma histories and complex mental health and addiction concerns that remained unaddressed. These youth cycled repeatedly through the services available on all steps along the current service continuum but progressively deteriorated with respect to their health and mental wellness.

The Manitoba Advocate has voiced the need for improved support and services across the continuum of mental health and addictions care, but especially for youth in the top Tier 5 of service need who are living with addictions and are also being sexually exploited. The Manitoba Advocate highlighted this concern in two previous public special reports: *A Place Where it Feels Like Home: The Story of Tina Fontaine* (2019) and *In Need of Protection: Angel's Story* (2018c). In addition to the child-specific public reports, the Manitoba Advocate also released a Statement of Concern (Manitoba Advocate, 2018a) in September 2018, regarding the child and youth mental health and addictions system's ability to meet the needs of young people. The Statement of Concern was issued to inform the public and urge the provincial government to enact the strategy and take meaningful action on the important work of the Virgo Report (2018). As described in this special report, some early work has indeed begun, and

this is encouraging. Recently, the Manitoba government announced an investment that includes adding four beds to Project Neechewam, a nonprofit organization which provides support and stabilization services for youth experiencing mental health crises, living with an addiction, and who are being sexually exploited by adults. Additional funding was likewise announced by the province for StreetReach, to add mental health workers and addictions counsellors to the teams providing outreach to youth who are sexually exploited. In the public announcement, the Minister of Families noted the funding for these initiatives was partly to move forward on their counter exploitation strategy, as well as to respond to key recommendations made in the Virgo Report and in reports from the Manitoba Advocate (CBC, 2019). At present, there are no long-term treatment resources available to meet complex mental health needs. Outpatient and community resources are also sparse. This was an area noted as a gap by Health Canada (2015), which reported:

...access to psychiatrists and psychiatric care is vital but non-existent in many communities. People who survive suicide attempts are often released from intensive care units at the hospital and put on waiting lists that can be long (e.g. up to a year) (p. 18).

While the recent provincial investments are important early steps, the pressure on the mental health and addiction system remains untenable. Manitoba children, youth, young adults, and their families continue to await additional investments and action on services that respond to the highest needs, the most complex traumas, and the youth who exist in the top tier of needs. Those youth, the ones who may have a diagnosed mental illness, who may be sexually exploited, living with an addiction, experiencing housing instability and who may be in and out of custody, remain untethered to meaningful services that can be tailored to meet their very complex needs.

Noelle: Late Identification, Rapid Decline

Noelle died by suicide at age 14 within eight months of her first contact with the mental health system. She accessed a number of services available on the current continuum, including mental health crisis services and acute inpatient services, none of which were successful in achieving positive mental health outcomes, and her mental health and overall wellbeing declined very quickly once she came to the attention of the system.

Noelle resided in both urban and rural settings in Manitoba throughout her life. Her family had some contact with the CFS system when she was under the age of two due to substance misuse by her mother and child neglect. Child and family services arranged for Noelle to be cared for by her father and an extended family member and CFS closed their file.

Noelle had no further involvement with designated services until she was 14 years old and expressed suicidal ideation. A regional mobile crisis team was contacted but, when Noelle was unable to contract for safety, she was transported to a hospital emergency department by police. Noelle shared with a nurse that she had been feeling suicidal ideation and self-harming for several months. She was admitted to an acute inpatient psychiatry unit for children and youth where she remained for seven days. While there, she was diagnosed with having had a major depressive episode and unspecified anxiety, and she was prescribed medications to treat the symptoms of each. Noelle was discharged from the psychiatric unit with a plan that Noelle should follow-up with her CFS worker, her family doctor, a community mental health worker as arranged, and to continue to follow-up with her school guidance counsellor as needed. Noelle was discharged to an extended family member's care, but had been apprehended by CFS while admitted because her father was assessed as being unable to care for her. Noelle did not attend any scheduled appointments with the community mental health program after her discharge.

Eighteen days after Noelle was discharged from hospital, she self-harmed. She was transported to an emergency department by ambulance for treatment of her injuries. Noelle told hospital staff she was not suicidal and did not have a plan to die by suicide. She was discharged from hospital with no recommended follow-up. Four days later, Noelle again attended the same emergency department and was unable to contract for safety. She was subsequently admitted to the acute inpatient psychiatry unit for a second time in less than a month. She was admitted for five days before being discharged with a plan that she should attend follow-up appointments as scheduled, take her medications as prescribed, use crisis services and community resources as needed, and to have a balance between structured activities, leisure activities, and sleep. CFS removed Noelle from her extended family member's home due to her care needs and she was discharged from hospital to an emergency CFS shelter. Noelle became a temporary ward of CFS.

In the following weeks, Noelle expressed suicidal ideation five times and continued to self-harm regularly. A mobile crisis resource was contacted on one occasion, and although Noelle did not want to speak with them, she agreed to speak with the emergency CFS shelter staff about her feelings. The fifth time Noelle expressed suicidal ideation, she agreed to be assessed at a hospital emergency department. Police transported her there but she was quickly discharged as she did not express suicidal ideation to hospital staff. Noelle was referred for an assessment with a psychiatrist in the community and was given contact numbers for crisis services. Documentation of further assessment could not be found. Since entering into CFS care, Noelle had disclosed that she was physically abused by a parent and her CFS worker learned that she had been sexually abused as a child. An abuse investigation was opened by CFS and local police to look into Noelle's allegations but both files were closed when she was unable to provide further information during follow up interviews.

The following month, within a period of one week, Noelle wrote three notes where she expressed suicidal ideation. Emergency medical services were contacted and police transported Noelle to be assessed at an emergency department. By the time she was seen by medical staff, she denied further suicidal ideation and was discharged each time.

In the last three months of Noelle's life, she continued to self-harm regularly. She was moved to a specialized placement by CFS that would be able to provide her with more support than the emergency shelter where she had been residing. Days after the move, however, she expressed suicidal ideation again and was transported by police to an emergency department for an assessment. The psychiatrist that assessed Noelle felt it would not be helpful for her to be admitted and suggested she attend counselling; she refused and was discharged. Within weeks, Noelle attempted suicide. She was once again transported to be assessed at an emergency department; on the way there she attempted suicide again. When Noelle arrived at hospital, the doctor who assessed her indicated Noelle was only testing her new caregiver and discharged Noelle once she promised not to hurt herself further. Noelle later disclosed she had recently tried cocaine.

After that, Noelle's mental health quickly declined. She displayed signs of depression, would cry uncontrollably, self-harmed, and attempted suicide. She was assessed a further time at an emergency department, prescribed medication to treat her anxiety and was discharged. After taking the medication, Noelle appeared to have a seizure. She was transported back to hospital where she began to hyperventilate and cry uncontrollably. She was assessed and admitted to the acute inpatient psychiatry unit for the third time in six months, where she remained for eight days. She was then discharged with a plan that she should follow-up with her CFS worker, a community mental health worker, continue to take her medication as prescribed, utilize healthier coping strategies when feeling overwhelmed, attend all follow-up appointments, and find a balance between structured activities, leisure activities, and sleep. A referral was made to the community mental health program while Noelle was in hospital and a worker was present at her discharge meeting.

Noelle met with her community mental health worker once to assess her needs and determine an appropriate treatment plan. Noelle died by suicide before a plan could be implemented. She was 14 years old.

In the last two months of her life, Noelle attended hospital emergency departments five times for suicidal ideation or attempts. She was struggling on a daily basis to function. Community services and supports were not implemented early enough and when they were, they were insufficient to keep Noelle safe. Noelle did not benefit in a sustained way from the revolving door of crisis-assessment/short-term hospitalization/discharge with the same plan for follow-up. Noelle's mental health challenges were so pervasive that they affected every part of

her functioning. She displayed a level of need that ought to have placed her in the top tier of service needs, but the limits to services available meant her mental health needs were not adequately supported by the provincial youth mental health system. Noelle was a child who might have benefitted from long-term mental health treatment setting to ensure her safety and provide her with much needed assessment and sustained mental health treatment.

Persistent Underfunding of the Youth Mental Health and Addictions System

While Noelle's needs were primarily mental health-focused, many other youth struggle concurrently with both mental health and addictions challenges. The youth addictions system in Manitoba also lacks long-term treatment options. *The Youth Drug Stabilization (Support for Parents) Act* in Manitoba allows parents and caregivers to seek an apprehension order to involuntarily admit a young person to the Youth Addictions Stabilization Unit (YASU). YASU is a short-term detox and stabilization unit in Winnipeg for youth struggling with severe substance misuse, but only for up to seven days. This short stay is wildly insufficient to provide any lasting intervention for the youth who are struggling with severe addictions, including those from opioids or methamphetamines. For those youth, seven days is simply inadequate.

Manitoba youth need highly specialized and long-term mental health and addictions treatment for youth like Noelle and many others, who currently cycle in and out of emergency medical services, never receiving the intensive therapeutic interventions that they actually need. For example, according to the Virgo Report (2018), there are an estimated 18,772 youth and young adults between ages 15 and 25 whose mental health and addictions needs place them in Tiers 4 and 5 of the tiered model, representing the most extreme and pressing need for specialized and intensive services. The persistent underfunding of the youth mental health and addictions system in our province means responses are short-term, mismatched, and focused on addressing crisis in the moment. Noelle's story is an important illustration of how short-term planning can come at a devastating cost. While expansions of four beds here, six beds there are important and absolutely needed, Manitobans must understand that those commitments represent only a drop in the bucket of what is actually required to meet the current need. In fact, the health system experts commissioned by the Province of Manitoba and who authored the Virgo Report stated that the province is responding to only 8.8% of the addictions service need in Tiers 3, 4, and 5. They reported that of the estimated 64,931 youth and young adults who have moderate to severe and complex addiction support needs, the current services only cover 5,701 individuals, a massive shortfall of 91.2%, or 59,230 young people.

Our province continues to see youth lost at alarming rates due to overwhelming mental health and addictions challenges that are often borne out of severe and traumatizing victimization in childhood, and which eventually overtake their lives. Safe and secure, home-like treatment facilities, where youth can be surrounded and supported medically, emotionally, therapeutically, culturally, and spiritually to heal and regain the strength of their spirits, are urgently needed in Manitoba. This type of intervention exists on that far end of the continuum for youth in the top tier of need and thus, is not appropriate for every youth, or even most youth. We are encouraged to hear the call for this type of specialized safe and secure support growing in our province and we were pleased to have been recently asked to write a letter in support of a community's application to develop this very type of service for their members.

In supporting children and youth to express their important viewpoints and opinions, we also understand that children and youth have the right to be protected from circumstances and experiences where they are in danger, such as when they are harmfully addicted to alcohol or other substances, or are experiencing a life-threatening mental health crisis. During our investigation of Tina Fontaine's death (Manitoba Advocate, 2019), we spoke to MACY's Youth Ambassador Advisory Squad (YAAS!). We asked members about what is needed for youth who have the most complex and intensive needs, and YAAS! members were clear in their support of safe and secure, home-like residential treatment options. As one member who lives with significant addiction issues explained, **"I don't care what you want to call it, just don't let me leave once I get there."**

More recently, when asked what YAAS! felt the government's responsibility is with respect to delivering mental health services for youth, members explained that they believe the provincial government should be responsible to find an appropriate treatment resource for every child or youth. These treatments should be centred on what the child or youth needs and not simply serve the status-quo of the current systems. No child or youth should be turned away when they are asking for help or are in crisis. What we often see is that mental health and addiction services are structured in ways that benefit the system and prioritize the needs of the adults who work inside of them. Services and programs have unnecessary barriers to entrance, such as:

- Limited intake hours
- No re-entry for a period of time after discharge
- Zero tolerance on behaviours commonly associated with addictions and mental health disorders
- Restrictions on smoking
- Restrictions on what clothing a youth can wear

84

• Staff who are perceived as uncaring and judgmental towards youth in crisis

Further, we frequently hear professionals put the onus of successful engagement on the shoulders of youth, absolving themselves from their duty of care. Instead of understanding that the responsibility lies with adults to successfully engage a young person in the treatment they need, children and youth are frequently labelled as "resistant" or "oppositional" and summarily refused services. We read about this in countless files, hear this experience from countless youth, and hear it directly from professionals during meetings. While certainly some children and youth are challenging to engage in treatment, as adults and care providers, the responsibility is ours to work harder to engage them, and if we cannot, we ought to examine the rules and restrictions that govern our services as well as our own baggage and beliefs.

Of the 22 girls highlighted in this report, five attempted suicide multiple times in short periods, five were being sexually exploited by adults, and 11 were using significant amounts of alcohol or other drugs. Many of these youth were unable to access treatment resources and, while individuals from many programs supported them, there was no long-term treatment resource available to support them to overcome their mental health and addiction challenges and find safety and hope for the future. *The First Nations Mental Wellness Continuum Framework* also notes gaps in the continuum of mental health and addictions care in Canada, including "a lack of access to: culturally based treatment supports; more specialized supports for those with complex needs; and detox and treatment services focused on the needs of children and families" (Health Canada, 2015, p. 18).

RECOMMENDATION SEVEN: CREATE LONG-TERM TREATMENT FOR YOUTH WITH THE HIGHEST NEEDS

RECOMMENDATION SEVEN: The Manitoba Advocate for Children and Youth recommends that the Government of Manitoba develop an inpatient or community-based long-term treatment resource that offers stabilization, assessment, treatment, and aftercare for youth who are at the top tier of mental health and addictions care needs, and for whom less intensive options have been ineffective.

OUTCOMES:

• Review national and international best-practice and evidence-informed research from experts in the areas of youth mental health and addictions.

- Using information gathered from experts and in consultation with community stakeholders, including Indigenous leadership, Elders, and children and youth, develop a plan for a provincial application of a long-term treatment model. The model must be culturally informed and safe and staff must be culturally competent.
- Put into practice the treatment model and evaluate its effectiveness in achieving the intended outcomes.

IMPACT FOR CHILDREN AND YOUTH:

Youth will have access to a long-term resource in their province that provides wrap-around assessment, treatment, and aftercare for their complex mental health and addictions needs. This resource would reduce the risk of further decline by accessing meaningful interventions that promote positive mental health and wellbeing.

Interventions Improve when Services Talk to Each Other

FINDING: Manitoba children and youth require improved cross-service communication and coordination to enhance the delivery of mental health and addictions services essential in promoting the safety and wellbeing of children and youth.

In addition to enhancing the range and quality of services available on the youth mental health and addictions continuum of care, there must be improved cross-service and sector communication and collaboration in order to ensure a functioning child-centred continuum for children and youth. Many youth whose stories were included in this report were involved with multiple designated services in various combinations, including child and family services, mental health, addictions, youth justice, education, and victim supports. As shown in the figure below, all 22 youth had documented involvement with child and family services, 17 with mental health, eight with education, five with youth justice, five with victim support, and four with addictions. It is important to underscore here that these numbers only include services that were involved and does not accurately reflect the actual needs of the 22 youth, since many of them were denied services, were unable to access them, or for other reasons, the appropriate systems were not providing service.

Manitoba Advocate for Children and Youth (2020)

Designated Services Involved	Number of Youth Who Had Contact With Service
Child and Family Services	22
Mental Health	17
Education	8
Youth Justice	5
Victim Support	5
Addictions	4

Figure 5 - Systemic involvement of the 22 youth.

Extensive systemic involvement should have ensured that these youth did not fall through the gaps along the continuum of care. Unfortunately, our office consistently finds a lack of communication and coordination between youth-serving systems. One youth, Claire, who died by suicide at age 16, was greatly impacted by a lack of information sharing and co-ordinated planning by the systems involved in her life.

Claire: Ill-Coordinated Services Leave Youth at Risk

Claire resided between two rural communities in Manitoba. She had a small sibling group. She resided between her mother's care and the care of CFS in her early years before being reunified to her father's care at age six. She resided between her mother and father's homes during her adolescence. Claire was described as artistic and loved to be outdoors.

Claire's family had extensive involvement with CFS which began when she was an infant. Between her birth and the age of 13, Claire was apprehended six times. Child protection concerns that prompted CFS involvement included alcohol use by Claire's parents, alcohol use by Claire and one sibling in their adolescence, child neglect and abandonment, physical and sexual abuse of Claire and one sibling, Claire's parents utilizing unsafe caregivers, intimate partner violence, and the mental health concerns of each family member. Claire had eight placements during her early childhood years. Although follow through by Claire's parents with their CFS case plans was sporadic, Claire and her sibling continued to be returned to their parents' care despite the frequency with which reports of child protection concerns were received by the CFS agencies involved.

Claire was sexually abused by two individuals in her early childhood, but the perpetrator was charged on only one of the occasions. That individual pled guilty, was convicted, and was placed on the provincial Child Abuse Registry. Claire suffered from a number of emotional and behavioural disturbances which impacted her functioning at home and at school. Although Claire's supports discussed having her and a sibling assessed for FASD given their behaviours and their mother's disclosure that she had used alcohol during her pregnancies, no formal assessment was ever arranged for Claire. Claire did attend therapy for six months to address trauma associated with the sexual abuse, but that therapy ended when she was reunified to her parent's care.

Claire became involved with the criminal justice system at the age of 13 and over the next three years, Claire was convicted of over 30 offences. On many occasions, when Claire had contact with law enforcement, she was under the influence of alcohol or cannabis. At the age of 13, Claire was the subject two probation orders, both of which had conditions to abstain from alcohol and substance use. The following year, when Claire was 14 years old, she was sentenced to a deferred custody and community supervision order to be followed by a two year probation order. As Claire continued to accrue further charges and breach her court ordered conditions, she began to be sentenced to time in custody at correctional centres. At the age of 14, Claire spent a total of six days on three separate occasions in custody, while at the age of 15, she spent a total of nearly 90 days in a youth correctional facility during six separate admissions. Her admissions were due to suspensions of her deferred custody order and breaches of her court ordered conditions.

Claire was assessed by probation services just before she turned 15 and her risk and need level was noted to be high. Many of Claire's supports documented that she was easily influenced by negative peers. Claire's probation plan included referring Claire to a youth justice community program and implementing the Intensive Support and Supervision Program (ISSP) to enforce her curfew condition. The youth justice system also recognized that Claire's criminal behaviour was closely linked to substance misuse and referred her to addictions programming three times. Claire met with an addictions worker on four occasions when she was 15 and on three occasions when she was 16. Based on information shared in those appointments, Claire's addictions counsellor assessed that Claire had a harmful level of involvement with alcohol and substances. The plan made with Claire and her parents when she was 15 years old was to refer her to a residential treatment program. That plan did not proceed prior to Claire's death.

As with other areas of Claire's functioning, she struggled with her mental health and wellness in her adolescence. When Claire was 13 years old, she expressed suicidal ideation. She was later taken to a local hospital emergency department for a mental health assessment and was under

the influence of alcohol when found. At hospital, Claire denied current suicidal ideation and was willing to contract for safety. She was discharged to her parent's care with a suggestion that she follow-up with her family doctor for further treatment. There was no evidence that this occurred. Claire's family informed her addictions worker but the other services remained unaware. Two years later, Claire participated in another mental health assessment while incarcerated after she had self-harmed. She denied further suicidal thoughts or a plan but her alcohol and substance misuse and symptoms of depression and anxiety were noted to be concerns. While Claire's probation officer did send a referral for Claire to receive counselling in her community, we found no evidence of that support being provided. It was not documented if Claire's family or her addictions worker was informed that an assessment had occurred and for what reason. Additionally, Claire's school attendance was greatly impacted by her mental health, substance misuse, and criminal involvement. Her attendance was poor throughout her high school years.

In the last six months of her life, Claire was identified as a victim of sexual exploitation and an adult male was charged with sexually exploiting Claire and other young girls. She last met with her addictions worker two months before her death, and while that worker attempted to contact both of Claire's parents to follow-up with planning for Claire to enter into a residential treatment program, the worker was not successful in making contact. Claire's family did approach a local health centre for Claire to access counselling, but two intake appointments were missed. Claire died by suicide at the age of 16. Her involvement with the justice system along with bullying by peers had been recent sources of stress. Claire had cocaine and alcohol in her system at the time of her death.

In Claire's case, the designated services involved in her life rarely communicated with one another or coordinated their interventions. As a result, the services delivered to Claire and her family were ill-coordinated and, essentially, ineffective. As was observed in other reports by our office, the systems involved interacted passively with one another, never intervening in a collaborative way to support Claire as her danger increased in the community. When referrals were made to addictions supports and counselling resources, there was no follow-up by the services involved in her life to help her engage. Claire's behaviours were viewed by the systems in her life as delinquent and the onus was placed on her to engage with multiple services simply because she was court ordered to do so. Claire was rarely viewed as a survivor, struggling to carry the enormous weight of her trauma at such a young age. Perhaps most concerning, many systems appeared to give up on Claire as opposed to taking initiative and working together with Claire and her family to find solutions.

A lack of cross-service and -sector communication has also been noted in three previous public reports released by the Manitoba Advocate. In *Documenting the Decline: The Dangerous Space Between Good Intentions and Meaningful Interventions* (Manitoba Advocate, 2018b), the Manitoba Advocate made the following recommendation with respect to information sharing:

89

The Manitoba Advocate for Children and Youth recommends that the Province of Manitoba respond to the persistent lack of coordination between services for children and youth by developing and implementing a provincial strategy to train service providers on the requirement to share information across systems and ensure children and youth are at the centre of all service provision. This is to be developed, delivered, and evaluated in consultation with Manitoba Education and Training, Manitoba Families, Manitoba Justice, and Manitoba Health, Seniors and Active Living (Manitoba Advocate, 2018b, p. 49).

The Government of Manitoba had previously attempted to improve coordination and information sharing between services and sectors by passing *The Protecting Children (Information Sharing) Act* in 2017. The intent of this legislation is to promote information sharing among service providers to allow for informed planning and decision making, thus creating a collaborative and multidisciplinary approach to the delivery of services for children, youth, young adults, and their families. Despite the good intent of this legislation, we continue to work with children and youth where systems doggedly continue to operate in silos and protect their own information at the expense of good service for children and youth. It is vital that when youth are accessing multiple services, that service delivery including assessments, planning, service provision, and evaluation, are shared and co-developed in a coordinated, care-team manner. Breakdowns in communication between multiple service sectors inevitably result in the delivery of disjointed services that do not consistently promote positive mental health and addictions outcomes for these youth, or worse, push children and youth towards more elevated risk.

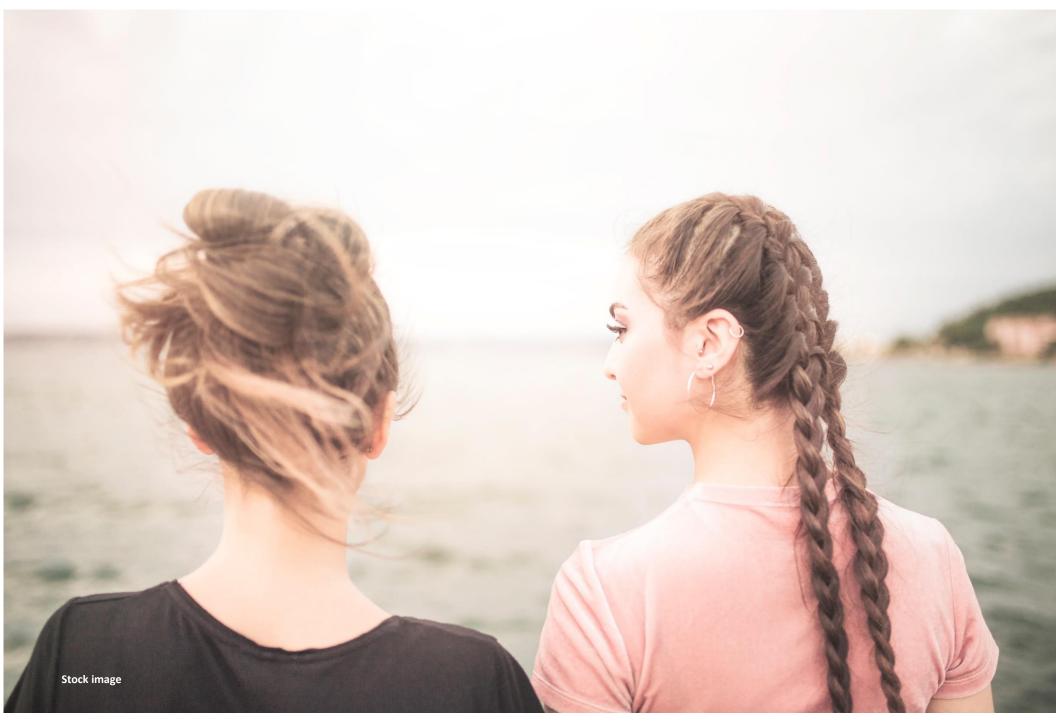
Multiple service providers interviewed for this report also noted barriers to coordination including limited communication between systems, a lack of understanding with respect to roles, and regular turnover of service providers. One service provider commented that when organizations are working in silos and there is no connecting support, "the right hand doesn't know what the left hand is doing" (Service provider, Interview, December 3, 2019), resulting in disjointed treatment and service plans. The youth on MACY's Youth Ambassador Advisory Squad (YAAS!) also noted that there is minimal communication and connection between supports and systems.

The Manitoba Advocate also acknowledges the all-of-government approach that has been taken with the development of the provincial government's Manitoba Advocate for Children and Youth-Recommendations Action Planning (MACY-RAP) committee, which includes deputy ministers from the departments of Families, Justice, Health, Seniors and Active Living, and Education. The committee acts to ensure cross-departmental and within-department communication and collaboration when taking action and responding to MACY's recommendations. We are encouraged by this leader-engaged approach by government to integrate communication, but barriers to systemic cooperation remain deeply ingrained in Manitoba's systems. The above recommendation from 2018 remains open and in progress but our office has yet to see that

the Province of Manitoba has developed and implemented a strategy to train service providers on *the requirement* to share information across systems. Further work must be done to meet the intent of the 2018 recommendation and ensure this approach to communication filters through all levels of public service systems, including ensuring that service provider know of their obligation and responsibility to share information and coordinate plans across services and systems.

A driving force for the Virgo Report was improving the coordination of services and supports across the mental health and addiction services in Manitoba. Given this intent, the findings of the Virgo Report (2018) indicated there are significant gaps in the area of service coordination, which mirrors the findings of this, and other MACY reports. Given the growing complexities and needs of those accessing mental health and addictions services, these coordination and collaboration issues impact many provincially and federally delivered services.

In an attempt to address barriers to service coordination, multiple positive recommendations were made in the Virgo Report (2018) to enhance coordination of mental health and addictions services across the province, including altering the framework with which services are delivered to create a continuum of services made up of multiple tiers, the co-location of various services in community hubs and focal points, and implementing system navigators. Changes must be made if we wish to improve circumstances for children, youth, young adults, and their families who are experiencing mental health and addictions challenges. In the end, the health and wellness of children and youth in Manitoba will continue to depend on all Manitobans to pull together to ensure young people have the services and supports that they need throughout each stage of their lives and that those services are well coordinated, nimble, and evolving to the changing needs of young people.



APPENDICES

Appendix A: Findings and Recommendations Summary

A Tiered Model, Where Services Match Needs

FINDING: Manitoba children and youth urgently need a continuum of mental health and addictions services to be developed and delivered through a tiered model that is fulsome, not interrupted by barriers to accessing service, and which includes tailored support for children and youth as they transition from one tier to another along the continuum.

RECOMMENDATION ONE: CONDUCT A GAP ANALYSIS

The Manitoba Advocate for Children and Youth recommends that the Department of Health, Seniors and Active Living conduct a gap analysis of the youth mental health and addictions system, based on the tiered model proposed in the Virgo Report. The gap analysis ought to speak to the overall transformation framework and strategic plan for child and youth mental health and addictions services. Further, the Manitoba Advocate recommends the gap analysis, framework, and strategic plan is released publicly to Manitobans.

RECOMMENDATION TWO: DEMONSTRATE EQUITABLE ACCESS TO SERVICES

The Manitoba Advocate for Children and Youth recommends that the Department of Health, Seniors and Active Living demonstrates its framework and strategic plan for transformation of the youth mental health and addictions systems in Manitoba ensures equitable access to services across all areas of Manitoba, which are tailored to the unique needs of children and youth in our province.

Early Trauma Requires Targeted Intervention

FINDING: Manitoba children and youth need improved early recognition of trauma by service providers and timely intervention to combat the effects of childhood trauma, which increases the risk for co-occurring substance misuse and mental health challenges, including the risk for suicide in children, youth, and young adults.

RECOMMENDATION THREE: TRAIN WORKERS ON TRAUMA AND ITS EFFECTS

The Manitoba Advocate for Children and Youth recommends that the Government of Manitoba provide early childhood trauma education and training about trauma and its effects to service providers across all government departments delivering services to children and youth.

RECOMMENDATION FOUR: HELP FAMILIES LEARN WHERE THE RIGHT RESOURCES ARE

In line with Article 24 of the United Nations Convention on the Rights of the Child, the Manitoba Advocate for Children and Youth recommends that the Government of Manitoba conduct an annual review of what therapeutic trauma interventions are available to children and youth in Manitoba and create an inventory of resources, whether the resources require formal referrals from service providers or are open for self-referrals, any associated eligibility criteria (age, location, care status, etc.) and promote the annual inventory and its findings in the public.

Rural Youth Have the Right to Equal Service Quality and Availability

FINDING: Children and youth in rural and remote communities across the province face additional barriers to equitable mental health and addictions services and supports due to limited service availability and inconsistent quality of resources.

RECOMMENDATION FIVE: CREATE MORE YOUTH HUBS

The Manitoba Advocate for Children and Youth recommends that the Department of Health, Seniors and Active Living, in collaboration with rural communities in Manitoba, and the federal government, where applicable, implement recommendation 4.8 of the Virgo Report:

Building upon the successful experience of the NorWest Youth Hub and lessons learned from the experience of other provinces, develop a provincial plan for scale-up of the youth hub model, or similar models of integrated youth services, taking advantage of support from philanthropy as it may be available (Virgo Planning, 2018, p. 235).

RECOMMENDATION SIX: CREATE FOCAL POINTS OUTSIDE OF WINNIPEG

RECOMMENDATION SIX: The Manitoba Advocate for Children and Youth recommends that the Department of Health, Seniors and Active Living, in collaboration with rural and First Nations communities in Manitoba, and the federal government, where applicable, implement recommendation 2.11 of the Virgo Report, as summarized below:

In the RHAs other than the WRHA, create mental health hubs (as identified in the Peachey report), with a view to:

(a) developing these as integrated regional mental health and substance use/addictions (SUA) "focal points", and

(b) harmonizing a core set of regional services and supports to the hospital emergency departments and crisis services including:

- Screening, assessment, and support for SUA.
- 24/7 access to psychiatric consultation and acute assessment/treatment services.
- A core set of professionals in addition to psychiatrists with capacity in SUA support e.g., clinical psychologists and psychiatric emergency nurses
- Cross-trained mental health and addiction liaison workers co-located in hospital emergency departments/other hospital programs.
- Infrastructure and staffing to ensure safety and security of patients and staff.
- Links to community mental health and addictions services, including centralized intake (Virgo Planning, 2018; full wording may be found at p. 225).

Families Need System Navigators, or Co-Pilots

FINDING: The current continuum of youth mental health and addictions care is difficult for children, youth, and their families to navigate due to its complicated, multi-system nature, which is often delivered in silos. Knowledgeable navigators are needed who are dedicated to assisting children, youth, and families to navigate the continuum, track progress, evaluate the effectiveness of interventions, and initiate changes to a plan that is not meeting the intended objectives.

The Top Tier on the Continuum Requires Special Investments

FINDING: Manitoba lacks intensive services and supports at the top tier of the youth mental health and addictions continuum to meet the needs of youth with complex challenges and who are at a high risk of harm or death.

RECOMMENDATION SEVEN: CREATE LONG-TERM TREATMENT FOR YOUTH WITH THE HIGHEST NEEDS

The Manitoba Advocate for Children and Youth recommends that the Government of Manitoba develop an inpatient or community-based long-term treatment resource that offers stabilization, assessment, treatment, and aftercare for youth who are at the top tier of mental health and addictions care needs, and for whom less intensive options have been ineffective.

Appendix B: Acronyms

ACEs	Adverse Childhood Experiences
ACYA	The Advocate for Children and Youth Act
ADHD	Attention Deficit Hyperactivity Disorder
AFM	Addictions Foundation of Manitoba
AFN	Assembly of First Nations
СВТ	Cognitive Behavioral Therapy
CFS	Child and Family Services
DBT	Dialectical Behaviour Therapy
DIA	Designated Intake Agency
ED	Emergency Department
FASD	Fetal Alcohol Spectrum Disorder
MACY	Manitoba Advocate for Children and Youth
MACY-RAP	The provincial government's Manitoba Advocate for Children and Youth – Recommendations Action Planning
MATC	Manitoba Adolescent Treatment Centre
МКО	Manitoba Keewatinowi Okimakanak Inc
PCISA	The Protecting Children (Information Sharing) Act
PEN	Psychiatric Emergency Nurse
SCO	Southern Chiefs Organization
SUA	Substance Use and Addictions
SUA/MH	Substance Use and Addictions/Mental Health
TF-CBT	Trauma focused Cognitive Behavioural Therapy
UNCRC	United Nations Convention on the Rights of the Child
YAAS!	Youth Ambassador Advisory Squad
YASU	Youth Addictions Stabilization Unit
YES	Youth Employment Services

Appendix C: Terms of Reference

The Manitoba Advocate for Children and Youth is notified of all deaths of children, youth, and young adults up to age 21, holds the legal responsibility to assess each death, and the discretion to further review or investigate the public services that were or which should have been providing support to the young person or to their family.

Section 20 of The Advocate for Children and Youth Act (ACYA) describes the Advocate's jurisdiction and purpose for conducting a review:

Jurisdiction to review — death of child or young adult

20(3) After receiving notice of the death of a child or young adult from the chief medical examiner under The Fatality Inquiries Act, the Advocate may review

(a) a child's death, if the child or his or her family was receiving a reviewable service at the time of the death or in the year before the death; and

(b) a young adult's death, if the young adult was receiving services under subsection 50(2) of The Child and Family Services Act at the time of the death or in the year before the death.

Purpose of review

20(4) A review under this section may be conducted for the following purposes:

(a) to determine whether to investigate the serious injury or death under section 23;

(b) to identify and analyse recurring circumstances or trends

(i) to improve the effectiveness and responsiveness of reviewable services, or

(ii) to inform improvements to public policies relating to designated services.

Following the review of a death, the Manitoba Advocate has the discretion to initiate a comprehensive investigation of public services. Section 23 of the ACYA outlines the conditions for an investigation:

Investigations of serious injuries and deaths

23(1) The Advocate may investigate a serious injury or death of a child or young adult if, after completing a review under section 20, the Advocate determines that

(a) a reviewable service, or related policies or practices, might have contributed to the serious injury or death; and

(b) the serious injury or death,

(i) in the case of a child, was or may have been due to one or more of the circumstances set out in section 17 of The Child and Family Services Act (child in need of protection),

(ii) occurred in unusual or suspicious circumstances, or

(iii) was, or may have been, self-inflicted or inflicted by another person.

The ACYA provides broad powers to access electronic or paper documents and other file recordings, as well as to compel, via an order to comply, any person to appear before the Advocate to answer questions the Advocate deems necessary to complete the investigation. Section 25 of the ACYA describes these powers:

Right to enter and inspect

25 For the purpose of an investigation under this Part, the Advocate may at any reasonable time enter and inspect any place where a reviewable service being investigated is or was provided.

"Stop Giving Me a Number and Start Giving Me a Person"

Manitoba Advocate for Children and Youth (2020)

Power to compel persons to answer questions and order disclosure

26(1) For the purpose of an investigation under this Part and subject to subsection 17(3) (privileged information), the Advocate may make one or both of the following orders:

(a) an order requiring a person to attend, personally or by electronic means, before the Advocate to answer questions on oath or affirmation, or in any other manner;

(b) an order requiring a public body or other person to produce for the Advocate a record or other thing in the person's custody or under his or her control.

Order to comply

26(2) The Advocate may apply to the Court of Queen's Bench for an order directing a public body or person to comply with an order made under subsection (1).

As of March 15, 2018, the Manitoba Advocate may make special reports public about any matter dealt with under the ACYA. Section 31 of the ACYA describes this responsibility and its limits:

Special reports

31(1) In order to improve the effectiveness and responsiveness of designated services, the Advocate may publish special reports.

31(2) Subject to section 32 (limits on disclosure of personal information), a special report may

(a) Include recommendations for

(i) A minister responsible for the provision of a designated service, and

(ii) Any public body or other person providing a designated service that the Advocate considers appropriate;

(b) Refer to and comment on any matter the Advocate has reviewed or investigated under Part 4; and

(c) Include information the Advocate considers necessary about any matter for which the Advocate has responsibility under this Act.

The purpose of special reports is to examine the services provided to the child and his/her family to identify ways in which those services may be improved to enhance the safety and wellbeing of children. Special reports are intended to give voice to the experience of the child or young adult who has died. As such, they are conducted "through the eyes of the child," that is, with a primary focus on the needs of the child, youth, or young adult.

In carrying out the investigations that inform special reports, Investigators are authorized to examine records and to make necessary confidential copies as required; to interview staff, service recipients, and other service providers; and to exercise any other investigative powers under the ACYA. As such, special reports will include factual information relevant to the events preceding the death of the child, youth, or young adult, may include analysis of those events, and may make formal recommendations to a reviewable body or any other public body or person that the Manitoba Advocate considers appropriate.

Appendix D: References

- ACCESS Open Minds. (2018). Eskasoni First Nation, Nova Scotia Impact Report 2018. <u>https://accessopenminds.ca/resources-guides-downloads/</u>
- Barkman, M., & McCraken, M. (2019, April 16). *Failing grade: Manitoba poverty reduction strategy and budget 2019.* Canadian Centre for Policy Alternatives.

https://www.policyalternatives.ca/sites/default/files/uploads/publications/Manitoba%20Office/2019/04/Failing_grade_Budget_2019.p df

- Bellis, M., & Zisk, A. (2014). The biological effects of childhood trauma. Child and Adolescent Psychiatric Clinics, 23(2), 185-222.
- Bridge, J., Goldstein, T., & Brent, D. (2006). Adolescent suicide and suicidal behavior. Journal of Child Psychology and Psychiatry, 47(3), 372-394.
- Brown, N., Green, J., Desai, M., Weitzman, C., & Rosenthal, M. (2014). Need and unmet need for care coordination among children with mental health concerns. *Pediatrics, 133*(3), 530-537. <u>https://doi.org/10.1542/peds.2013-2590</u>
- Butler, A., Adair, CE., Jones, W., Kurdyak, P., Vigod, S., Smith, M., Lesage, A., Bolton, J., Madi, N., Sareen, J., Enns, M., Rochette, L., Rittenbach, K., Bakal, J., Youngson, E., Clelland, S., Bercov, M., Santana, M., & Goldner, EM. (2017). Towards quality mental health services in Canada: A comparison of performance indicators across 5 provinces. Centre for Applied Research in Mental Health & Addiction. <u>https://accessmentalhealth.ca/wp-content/uploads/2017/08/prov_indic_technical_report_final.pdf</u>
- Canadian Mental Health Association. (2014, November 17). *Child and youth access to mental health promotion and mental health care.* <u>https://cmha.ca/documents/child-youth-access-mental-health-promotion-mental-health-care</u>
- Centre for Suicide Prevention. (2014, May 1). Substance use disorder and suicide. <u>https://www.suicideinfo.ca/resource/substance-use-disorder-suicide-prevention/</u>
- Chartier, M., Brownell, M., MacWilliam, L., Valdivia, J., Nie, Y., Ekuma, O., Burchill, C., Hu, M., & Kulbaba, C. (2016). The mental health of Manitoba's Children. Manitoba Centre for Health Policy. <u>http://mchp-appserv.cpe.umanitoba.ca/reference//MHKids_web_report.pdf</u>
- Choi, N., DiNitto, D., Marti, C., & Segal, S. (2017). Adverse childhood experiences and suicide attempts among those with mental health and substance use disorders. *Child Abuse & Neglect, 69,* 252-262. <u>https://doi.org/10.1016/j.chiabu.2017.04.024</u>
- Eskasoni First Nation, N.S. (n.d.). ACCESS Open Minds. Retrieved March 13, 2020, from https://accessopenminds.ca/our-site/eskasoni-first-nation-ns/

Eskasoni Mental Health Services. (2018). Services: With you every step of the way. https://www.eskasonimentalhealth.org/services-1

- Gerson, R., & Rappaport, N. (2012). Traumatic stress and posttraumatic stress disorder in youth: Recent research findings on clinical impact, assessment, and treatment. *Journal of Adolescent Health*, 52(2), 137-143. <u>https://doi.org/10.1016/j.jadohealth.2012.06.018</u>
- Gibson, S. (2019, July 5). Manitoba has second highest rate of violence against women and girls in northern Canada. *Global News*. <u>https://globalnews.ca/news/5464852/manitoba-has-second- highest-rate-of-violence-against-women-and-girls-in-northern-canada/</u>
- Ginwright, S. (2018, May 31). *The future of healing: Shifting from trauma informed care to healing centred engagement.* Medium.

https://medium.com/@ginwright/the-future-of-healing-shifting-from-trauma-informed-care-to-healing-centered-engagement-634f557ce69c

- Government of Manitoba. (1989). The Fatality Inquiries Act. (1989, C.C.S.M. c.F52). Retrieved from http://web2.gov.mb.ca/laws/statutes/ccsm/ pdf.php?cap=f52 Government of Manitoba. (2017). The Advocate for Children and Youth Act. (S.M 2017, c.8). Retrieved from http://web2.gov.mb.ca/laws/statutes/2017/pdf/c00817.pdf Government of Manitoba. (2018). Manitoba Health, Seniors and Active Living Information Management and Analytics Annual Statistics 2016 – 2017. https://www.gov.mb.ca/health/annstats/as1617.pdf. Government of Manitoba. (2019). Getting the job done budget 2019. https://www.gov.mb.ca/asset_library/en/budget2019/budget.pdf Government of Manitoba. (2019, December 23). More than \$25 million invested in mental health and addictions initiatives in past three months. https://news.gov.mb.ca/news/index.html?item=46578&posted=2019-12-23 Grabish, A. (2019). Manitoba funding 4 new beds in treatment facility for exploited youth. CBC News. https://www.cbc.ca/news/canada/manitoba/manitoba-at-risk-youth-funding-1.5356571 Halsall, T., Manion, I., Iyer, S., Mathias, S., Purcell, R., & Henderson, J. (2019). Trends in mental health system transformation: Integrating youth services within the Canadian context. Healthcare Management Forum, 32(2), 51-55. https://doi.org/10.1177/0840470418808815 Health Canada. (2015). First Nations Mental Wellness Continuum Framework. https://thunderbirdpf.org/wp-content/uploads/2015/01/24-14-1273-FN-Mental-Wellness-Framework-EN05 low.pdf Health Intelligence, Inc. and Associates. (2017). Provincial clinical and preventative services planning for Manitoba: Doing things differently and better. Winnipeg: Manitoba. https://www.gov.mb.ca/health/documents/pcpsp.pdf Jones, R.P. (2019, July 5). Levels of violence against young women in Northern Canada triple rest of country. CBC/Radio Canada. https://www.cbc.ca/news/canada/north/statistics-canada-report-violence-women-north-1.5200914
- Katz A, Kinew KA, Star L, Taylor C, Koseva I, Lavoie J, Burchill C, Urquia ML, Basham A, Rajotte L, Ramayanam V, Jarmasz J, Burchill S. (2019). The Health Status of and Access to Healthcare by Registered First Nation Peoples in Manitoba. Manitoba Centre for Health Policy.
- Kirmayer, L.J., Brass, G.M., Holton, T., Paul, K., Simpson, C., & Tait, C. (2007). Suicide among Aboriginal people in Canada. Aboriginal Healing Foundation. Research Series. http://www.ahf.ca/downloads/suicide.pdf
- Klinic Inc. (2020). In-person counselling. <u>http://klinic.mb.ca/in-person-counselling/</u>
- Lwin, K., Head, S., Wedeles, J., & Nikolova, K. (2015). Breaking barriers: Understanding intimate partner violence in child welfare. Practice and Research Together. Toronto: ON.
- Malone, K.G. (2019, February 15). Manitoba to look at connection between youth incarceration and child welfare. *CTV News*. <u>https://winnipeg.ctvnews.ca/manitoba-to-look-at-connection-between-youth-incarceration-and-child-welfare-1.4299743</u>
- Manitoba Advocate. (2015). *The changing face of youth suicide in Manitoba and the narrow window for intervention: Phase one report.* <u>https://manitobaadvocate.ca/wp-content/uploads/The-Changing-Face-of-Youth-Suicide-in-Manitoba_FINAL_web.pdf</u>
- Manitoba Advocate. (2016). *The changing face of youth suicide in Manitoba and the narrow window for intervention: Phase two report.* https://manitobaadvocate.ca/wp-content/uploads/The-Changing-Face-of-Youth-Suicide P2 web.pdf

- Manitoba Advocate. (2018a). The Manitoba Advocate's statement of concern; A call to action: A mental health and addictions system to meet the needs of children and youth. <u>http://manitobaadvocate.ca/wp-content/uploads/AdvocatesStatement-of-Concern-MH-Addictions.pdf</u>
- Manitoba Advocate. (2018b). *Documenting the decline: The dangerous space between good intentions and meaningful interventions.* <u>http://manitobaadvocate.ca/wp-content/uploads/Final-Circling-Star-2018.pdf</u>
- Manitoba Advocate. (2018c). In need of protection: Angel's story. <u>http://manitobaadvocate.ca/wp-content/uploads/In-Need-Of-Protection-Angels-Story-Dec2018.pdf</u>
- Manitoba Advocate. (2019). A place where it feels like home: The story of Tina Fontaine. <u>https://manitobaadvocate.ca/wp-content/uploads/2019/07/Tina-Fontaine.pdf</u>
- Manitoba Advocate. (2020). *The Slow Disappearance of Matthew: A Family's Fight for Youth Mental Health Care in the Wake of Bullying and Mental Illness.* <u>https://manitobaadvocate.ca/wp-content/uploads/MACY-Special-Report-The-Slow-Disappearance-of-Matthew-Feb2020.pdf</u>
- Markoulakis, R., Weingust, S., Foot, J., & Levitt, A. (2016). The family navigation project: An innovation in working with families to match mental health services with their youth's needs. *Canadian Journal of Community Mental Health*, *35*(1), 63-66. <u>http://doi10.7870/cjcmh-2016-026</u>
- Mental Health Commission of Canada. (2012). *Changing directions, changing lives. The mental health strategy for Canada*. Mental Health Commission of Canada.

https://www.mentalhealthcommission.ca/sites/default/files/MHStrategy_Strategy_ENG.pdf

Mental Health Commission of Canada. (2015). Taking the next step forward: Building a responsive mental health and addictions system for emerging adults. Mental Health Commission of Canada.

https://www.mentalhealthcommission.ca/sites/default/files/Taking%252520the%252520Next%252520Step%252520Forward_0.pdf

- Mental Health Commission of Canada. (2016). *The mental health strategy for Canada: A youth perspective*. <u>https://www.mentalhealthcommission.ca/sites/default/files/2016-07/Youth_Strategy_Eng_2016.pdf</u>
- Mental Health Commission of Canada. (2017). *Suicide Prevention*. <u>https://www.mentalhealthcommission.ca/English/key-priority/mental-health-and-substance-use</u>
- Morgan, C. (2016, May 17). *Fast facts: Manitoba ranked highest for Indigenous child poverty.* Canadian Centre for Policy Alternatives. <u>https://www.policyalternatives.ca/publications/commentary/fast-facts-manitoba-ranked-highest-indigenous-child-poverty</u>
- National Inquiry into Missing and Murdered Indigenous Women and Girls. (2019). *Reclaiming power and place: The final report of the national inquiry into missing and murdered Indigenous women and girls*. <u>https://www.mmiwg-ffada.ca/final-report/</u>
- National Traumatic Stress Network. (2020). Early childhood trauma. <u>https://www.nctsn.org/what-is-child-trauma/trauma-types/early-childhood-trauma</u>
- NorWest Co-op Community Health. (2020). Youth hub.

https://norwestcoop.ca/resource-centres/youth-hub/

Public Health Agency of Canada. (2019). Social determinants of health and health inequalities. <u>https://www.canada.ca/en/public-health/services/health-promotion/population-health/what-determines-health.html</u>

- Rollins, M., Milone, F., Suleman, S., Vojvoda, D., Sgro, M., & Barozinno, T. (2018). Patient navigators: Mapping the route toward accessibility in health care. *Paediatrics & Child Health*, 24(1), 19-22. <u>https://doi.org/10.1093/pch/pxy057</u>
- Rosenberg, L. (2011). Addressing trauma in mental health and substance use treatment. *Journal of Behavioral Health Services and Research*, 38(4), 428-431. https://doi.org/10.1007/s11414-011-9256-9
- Statistics Canada. (2019). *Deaths and age-specific mortality rates, by selected grouped causes* 2013-2017. <u>https://open.canada.ca/data/en/dataset/ec766fd8-926b-4204-b72a-7ccb62b56259</u>
- The Laurel Centre. (2020). Services provided. https://thelaurelcentre.com/services/
- Valaitis, R., Carter, N., Lam, A., Nicholl, J., Feather, J. & Cleghorn, L. (2017). Implementation and maintenance of patient navigation programs linking primary care with community-based health and social services: A scoping literature review. BMC Health Services Research, 17(116). <u>https://doi.org/10.1186/s12913-017-2046-1</u>
- Virgo Planning. (2018). *Improving access and coordination of mental health and addiction services: A provincial strategy for all Manitobans*. <u>https://www.gov.mb.ca/health/mha/docs/mha_strategic_plan.pdf</u>
- Virgo Planning. (2018b). *Improving access and coordination of mental health and addiction services: A provincial strategy for all Manitobans, Appendices*. <u>https://www.gov.mb.ca/health/mha/docs/mha_strategic_plan_appendices.pdf</u>
- World Health Organization. (2007). Social determinants and Indigenous health: The international experience and its policy implications. https://www.who.int/social_determinants/resources/indigenous_health_adelaide_report_07.pdf
- World Health Organization. (2020). About social determinants of health. <u>https://www.who.int/social_determinants/sdh_definition/en/</u>

