

The Slow Disappearance of Matthew
A Family's Fight for Youth Mental Health Care
in the Wake of Bullying and Mental Illness

TRIGGER WARNING

This report includes discussions of bullying, mental illnesses, addiction, and death by suicide. In telling Matthew's story, we have carefully considered each detail included in this final version and consulted closely with his family. Still, be advised 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 www.ReasonToLive.ca

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Printed in Canada.

ISBN- 978-1-9995410-4-0

Suggested Citation

Manitoba Advocate for Children and Youth. (2020). *The slow disappearance of Matthew: A family's fight for youth mental health care in the wake of bullying and mental illness*. Winnipeg: MB. Manitoba Advocate for Children and Youth.

Who We Are

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* and 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.

Manitoba Advocate

STAND UP for children & youth

A Special Report published after an Investigation in accordance with Part 4 and Part 5 of
The Advocate for Children and Youth Act

Dedicated to Honour the Memory of

MATTHEW

NOVEMBER 2000 – NOVEMBER 2017



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Acknowledgements

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 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.

A Thank You to Matthew's Family

Our entire team extends its gratitude to Matthew's family who helped us understand who Matthew was and how he should be remembered. Participation by a family is always optional in our investigations and special reports, but as advocates for children and youth, we know that our work is incredibly strengthened when families agree to participate. Working with a family assists us to tell the story of their loved one beyond the service files and interviews that we have access to through our legislation. Matthew's mother and brother met with us, and Matthew's mother, in particular, helped us immeasurably by meeting with us many times to share stories of her family, provide the photos that appear in this report, and to talk about her family's experiences with provincial public services. As we neared the conclusion of the process, our team met again with Matthew's mother, auntie, and a family friend to review the entire report, its findings, and the areas in which the Manitoba Advocate is making recommendations. We are grateful for the courage we have seen by Matthew's entire family, especially his mother and her ongoing commitment to Matthew. To the family, thank you for helping us come to know Matthew and for encouraging us to use his name and his image so other families who are facing similar circumstances can see themselves in these pages and so we can all work in concert to demand improvements to systems where young people are being lost to their pain.

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Executive Summary



Matthew's story is one of a family desperate to save their son. His early years could be characterized as happy, where the family spent lots of time together: camping as a large group in the summer, and then travelling to warm destinations to escape the cold, Manitoba winters. Many Manitobans who read this story may see themselves in its pages. While his early years were happy, Matthew experienced profound levels of bullying in junior high, trauma that appeared to trigger and then exacerbate

mental illnesses. He lived through near-daily torment at his school and Matthew and his family felt as though they were left to deal with the effects of the bullying on their own. As his mental illnesses worsened over time, Matthew's level of functioning deteriorated and eventually, he was mostly housebound, unable to leave home to attend school or therapy appointments intended to help him manage his mental illnesses. His parents grew even more desperate, and with his home situation at a critical point, child and family services became involved. Over time, the family watched Matthew disappear slowly, consumed by an overwhelming hopelessness and persistent suicidal thoughts. Matthew's story is one that illuminates the many cracks in Manitoba's youth mental health and addictions system, which is a central focus of this special report. And yet, if it were not for Matthew's brief involvement with child and family services before his death, I would not be able to share his story with you today due to legislative restrictions.

As my office has learned while investigating Matthew's death – and as you will read in the pages to come – Matthew was a bright, inquisitive child. Growing up, he enjoyed drawing, reading, building with Lego and learning about bugs, dinosaurs, and rocks. As a teen, he was passionate about science, current affairs, and politics. Matthew had a good sense of humour and was an energetic debater. His great loves in life included his cats, his family, and the outdoors.

Matthew was born in Winnipeg and grew up in the city with his mother, father, and younger brother. He had some physical challenges and was emotionally sensitive. He struggled to connect with his peer group and although his mother reassured him that his natural qualities would help him grow into a wonderful adult, Matthew felt frustrated that he was socially isolated by his peers.

Matthew attended three local schools and experienced bullying by fellow students, starting in Grade 7. Matthew told his family and other adults in his life that he felt unsafe at school and that students were verbally and physically harassing him on an almost daily basis. At the age of 12, Matthew was prescribed

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an antidepressant to help address his persistent feelings of sadness. When he was 13 years old, he told his therapist that 9 or 10 children had told Matthew he should kill himself. Matthew attended therapy appointments aimed at reducing his anxiety and bolstering his self-confidence. Matthew was diagnosed with generalized anxiety and major depression just before his 14th birthday and these illnesses would amplify in relation to his experiences with school.

At times, Matthew tried relating to his peers – attempting to high-five his bullies, as reported by one former teacher, or consuming cannabis while trying to fit in with other students at his school. The bullying intensified, spilling out into the community beyond the school, and continuing online. On a number of occasions, frustrated with the ongoing abuse, Matthew lashed out in self-defense and received both in-school and out-of-school suspensions, whether for verbalizing threats towards other students, for being in possession of drug paraphernalia, or for arming himself with a weapon (a box cutter) on school grounds. Over the years, Matthew withdrew more and more from school and lost all passion for science and math studies, which had previously inspired him. By Grade 11, Matthew's mental illnesses made him unable to continue to attend school and when his parents or service providers raised school re-entry, those conversations would frequently trigger a mental health crisis resulting in emergency personnel and mobile crisis teams being called to the house.

Matthew's six-year struggle with depression, anxiety, substance use, and persistent thoughts of suicide consumed the family. Over time, his mother lived with the terror that something would happen if she was not able to provide round-the-clock supervision and support to Matthew. It was clear to the family that the patchwork of mental health interventions being offered were not well-coordinated and were not actually helping her son to recover. Matthew had many contacts with community supports, including school-based and community-based psychologists, psychiatrists, public and private therapists, occupational therapists, doctors (his pediatrician, as well as during in-patient treatment and emergency crises), police officers, paramedics, mobile crisis teams, and CFS staff. Still, Matthew's family had no success in getting him long-term help.

Matthew repeatedly told adults in his life he wanted to die and he attempted suicide at least twice. He increasingly isolated himself, he left school, and frequently his mental illnesses prevented him from being able to leave home to attend therapy appointments. His mother considered options outside the country for long-term residential mental health treatment, as there are no such services for youth in Manitoba, and what options did exist wait-listed Matthew as his condition worsened— an experience that's all too relatable for many Manitobans.

The one service that remained consistent in Matthew's life – as it was legally obligated to do so – was child and family services (CFS). A family support worker from CFS became involved with Matthew in February 2016 and started regular visits to Matthew's home, which created a meaningful relationship for

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Matthew during the final 18 months of his life. During the time that CFS was working hard to engage Matthew, all other support services backed out and closed their files. At the end, Matthew was supported only by his family and CFS. Matthew died by suicide in November 2017 – nine days before his 17th birthday.

Sadly, Matthew's manner of death is horrifically common among Manitoba youth. According to data compiled by my office, suicide has been the leading manner of death for Manitoba youth between ages 10 and 17 over the past five years. Seventy-nine Manitoba youth in that age bracket died by suicide since 2014.

Matthew's story shares similarities with those of many other children and youth in our province. That is why Matthew's family has encouraged my office to share his story and that is why I am recommending substantial changes to Manitoba's youth mental health and addictions system, building on the important work laid out in the Virgo Report, which was released in 2018.

Since the mandate of the Manitoba Advocate for Children and Youth (MACY) was expanded in March 2018, we have been flooded with calls for help accessing youth mental health and addictions treatment. In the 2018-2019 fiscal year, 53 per cent of young people calling our office wanted assistance navigating the province's mental health and addictions system (Manitoba Advocate, 2019a).

While the Virgo Report is a comprehensive strategy for mental health and addictions system transformation as laid out by its authors, the Manitoba government has been slow to move on the changes that are needed for Manitoba children and youth. Matthew's story illustrates many of the problems described in the Virgo Report and many families, like Matthew's, continue to bounce around from service to service, desperately chasing mental health and addictions services that can meet the critical needs of their children.

Our province needs to eliminate all barriers preventing children and youth from accessing health services. We also need the government to address Manitoba youth suicide rates – and immediate work needs to happen to reverse that trend. This is a children's rights issue. Young people in Manitoba have the right to the highest quality of health care and to services that prioritize the needs of *people* over the needs of *the system*. We have skilled clinicians and incredible expertise here in our province, which need to be supported by government to collectively pivot towards a child-centred delivery ethic.

While the provincial government has begun making announcements about system improvements on a rolling basis – including a series of encouraging funding announcements made last fall, these announcements appear as patchwork investments, disconnected from an overall articulated plan. Today, I am recommending Manitoba's Department of Health, Seniors, and Active Living publicly release their

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framework for youth mental health and addiction system transformation. This is important so all families can understand how the announcements the government has made and will make during the provincial health transformation fit into an overall plan for system improvement – a plan recommended in the Virgo Report.

I am also recommending that the Department of Health, Seniors, and Active Living improve access to treatment for all Manitoba youth experiencing mental health crises. Currently, all pathways to help in Winnipeg start at Health Sciences Centre's children's emergency department. Based on Matthew's experiences and consultation with experts in the system, I am calling for a group of system experts in child and adolescent psychiatry, emergency health care, and system administrators evaluate practices at HSC children's emergency so child-and youth-centred responses can be activated when young people arrive at emergency in crisis and needing mental health supports.

Matthew's mental illnesses consumed every aspect of his life. Matthew's parents advocated and accessed numerous mental health services available in Winnipeg. In their attempts to navigate the mental health system, they lived through a repeated cycle of **utilizing the same services, in the same way, with the same recommendations, the same outcomes, and no sustained improvement for Matthew.**

To change this familiar cycle for other families, I am also recommending that well-trained mental health workers, or *Navigators*, be assigned as case managers to help children and youth – and their families – as they are accessing mental health and/or addiction services. Many are struggling now to navigate these systems on their own, which creates inefficiencies and overall ineffectiveness of the system. Mental health Navigators should be assigned to help families when they are accessing the upper tiers of the youth mental health and addictions system. They would help children, youth, and their loved ones move within the system, enacting recommended plans, helping families know where to go and how to access supports. These Navigators should also ensure care plans are evaluated regularly so services are tailored as the needs of the young person change. Similar work is happening in places like Ontario and I am recommending similar supports be enacted here in Manitoba.

Today, I am also recommending that Manitoba Health establish a long-term residential facility for youth mental health treatment. No such facility exists in our province, despite the many youth who require it. It was on the morning when Matthew's mother was seeking information about such a facility in the United States that she returned home to find Matthew's body. As a province we cannot allow another parent to experience the heart-breaking desperation of witnessing their child slowly disappear before their eyes and knowing there is nothing available here in our province that can help them.

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My recommendations also include three recommendations to improve the education system for children and youth. First, I am calling on the Department of Education to work with Manitoba school divisions to promote and highlight the provincial learning objectives that focus on mental health literacy and mental well-being skills for all classrooms from K-12. In addition, I am calling on the Department and divisions to ensure training opportunities are available for educators. Some good work in this regard is already underway across our province so this recommendation builds on that momentum.

Secondly, I am repeating recommendations I made in two previous special reports that suspensions and expulsions should be phased out, except in cases of safety risks to students or staff. Evidence is clear that excluding children from the school community increases their risk and does not improve any outcomes in their lives.

Thirdly, I am recommending that the Department of Education promote safe and caring schools. To that end, I am highlighting the valuable tool created by the Department, *Safe and Caring Schools: A Whole School Approach to Planning and Safety* and I am encouraging the Department to continue promoting this example of best practice throughout Manitoba. When enacted, the approach and strategies in that document will improve the school – and life – experiences of young people and give educators more tools to support young people in the school community.

As mentioned earlier, if it were not for Matthew's brief involvement with CFS, I would not be able to share his story today, or – hopefully – start an important public discussion about the prevalence of suicide among Manitoba youth. In the weeks to come, I will be releasing an additional aggregated special report on the suicide deaths of 22 Manitoba girls. This is a conversation our province needs to have in an open and caring way because we are losing so many young people to their pain. We each have a role to play – as community members, as service providers, and as policymakers who have the power to enact real changes that can save young lives.

In the final pages of this report, I will explain why the continued limitations placed on my office by the government get in the way of accountability and improved child safety. Although *The Advocate for Children and Youth Act* was passed unanimously by the legislative assembly in 2018, parts of our new legislation – Phases 2 and 3 – have still not been proclaimed.

The current limited rollout of the act means a number of child death notifications my office receives fall out of scope for investigation, including some deaths by suicide, homicides, and accidental deaths. Last year, 19 of 32 youth and young adult deaths by suicide in Manitoba were out of scope for our investigation, as were three of six homicides and 19 of 26 accidental deaths.

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My last recommendation stemming from Matthew's investigation is for the government to set a proclamation date for the outstanding portions of the act immediately. That is the only way it will be possible to ensure that in the future, if a child like Matthew is experiencing repeated admissions for emergency mental health care or in response to suicide attempts, my office will be notified and we will be able to investigate serious injuries of children and youth in an effort to improve child safety and reduce child deaths. We – collectively – must do all we can to understand the experiences of young people, and the government must take action to address system gaps through the comprehensive investigating and analysis that an office like mine is designed to deliver.

Matthew's family – and his mother in particular – were extremely supportive of our investigation and we thank them profoundly for their help. They continue to advocate in Matthew's memory for improved mental health care in our province, an issue many Manitobans are concerned about. We hope this special report can help in their fight.

Every Manitoban has a moral and ethical obligation to do what we can to keep our children safe and healthy. As laid out in Article 24 of the *United Nations Convention on the Rights of the Child* – to which Canada is a signatory and under which Manitoba has obligations – each young person has the right to the highest quality health care and to live in a safe environment. Matthew's experience underscores why Manitoba needs to provide a fully-developed tiered model of mental health and addictions services for children and youth, rather than a patchwork of supports delivered in siloes. The provincial government has slowly begun expanding youth mental health and addiction services in the past year and I encourage them to do more and to educate the public about their overall plan.

As with all of our special reports, the release of this report also triggers a process by my office of public monitoring and accountability. Last fall I began to publish on my website analysis and updates on what actions the government is taking in response to my recommendations and I will continue to post progress updates every six months on our website. I invite each of you to follow that progress at <https://manitobaadvocate.ca/recommendation-tracking/>.

Suicide is preventable, if trauma is identified early and if tailored supports are activated to wrap securely around the child or youth who is in pain. Manitoba has a clear need for radical system transformation and stories like Matthew's show us why aggressive investments and innovative solutions are of vital importance. We need to ensure that our public systems can support the needs of all of Manitoba's children and youth.



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

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Methodology

The Manitoba Advocate for Children and Youth (“the Manitoba Advocate”) is notified by the Chief Medical Examiner of all deaths of children, youth, and young adults up to age 21 in Manitoba. The Manitoba Advocate 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 their family.¹

The Office of the Children’s Advocate (now the Manitoba Advocate for Children and Youth), was notified by the Office of the Chief Medical Examiner of Matthew’s death on November 10, 2017. It was determined that Matthew’s death was in scope for review as the family had an open file with a child welfare agency at the time of his death. As such, formal notification of the Manitoba Advocate’s intent to conduct an investigation of services was sent to the agency involved, and the General Child and Family Services Authority (“the General Authority”). The investigation was assigned internally to an Investigator, and a review was initiated under this office’s former legislated mandate.

On March 15, 2018, *The Advocate for Children and Youth Act (ACYA)* was proclaimed and the scope of the investigation was broadened under the Manitoba Advocate’s new mandate. Additional notifications were sent about the ongoing investigation and the Manitoba Advocate’s intention to make this special report public.

The Investigator who completed this review requested, received, and subsequently reviewed many sources of information to create a complete picture of the public services received by Matthew and his family prior to his death. The services reviewed for this investigation include those provided by:

- A CFS agency, which is an agency of the General Authority, which, in turn, receives its mandate from Manitoba Families;
- A CFS “designated intake agency”
- Matthew’s school, under the authority of a provincial school division, which receives its mandate from Manitoba Education Addictions Foundation of Manitoba, which is accountable through Manitoba Health, Seniors and Active Living
- Manitoba Adolescent Treatment Centre, which falls under the responsibility of Winnipeg Regional Health, and which, in turn, receives its mandate from Manitoba Health Seniors and Active Living
- The Youth Crisis Stabilization System in Winnipeg, which is managed by Macdonald Youth Services

¹See Appendix B, which provides further information about *The Advocate for Children and Youth Act (ACYA)*, including which deaths meet the legislative criteria for review and investigation. 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).

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Additionally, supplemental files reviewed included, *The Report of the Medical Examiner and Autopsy*; Winnipeg Police Services; Health Sciences Centre Records; and child psychology private practice.

In addition to reviewing files, one or more interviews were conducted with service providers from the mental health, child welfare and education systems. Those interviewed were representatives from:

- Child and Adolescent Psychiatry, Health Sciences Centre
- Manitoba Adolescent Treatment Services, including Rural and Northern Telehealth Service
- Child Health, Health Sciences Centre
- Children's Emergency Department, Health Sciences Centre
- A community health organization
- The student services department, School division
- A child and family services agency, General Child and Family Services Authority
- A family support program at the child and family services agency

Throughout the investigation process, Matthew's mother met with the investigator on numerous occasions to discuss the services that were utilized by her family, and how they experienced, navigated, and were impacted by these services. In addition, Matthew's mother, Matthew's brother, Matthew's auntie, and a family friend met with the Manitoba Advocate and members of her office to discuss the investigation, the final report, and details for the public release of Matthew's story. At that time, Matthew's mother provided formal consent for the use of Matthew's name and the photos that appear in this report. Matthew's mother hopes that by sharing his story with the public, change will be facilitated within the youth mental health system in Manitoba.

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Matthew's Story

Matthew was born in Winnipeg, Manitoba, on November 18, 2000. His mother and father were excited to be parents and Matthew was the first grandchild on both sides of the family. There was significant involvement of the extended family and family gatherings and activities were common. His younger brother was born two years later and the two brothers spent a lot of time together. They were good friends. They had the same sense of humour and shared interests in shows and games.

As a family, the four of them were close. Recognizing their boys loved being outdoors, Matthew's parents bought a camper and travelled throughout Manitoba, enjoying the outdoors with other family friends. Road trips were a common holiday for the family and they would often venture to hot destinations during spring break. Each of their sons participated in different activities and this would allow each parent separate time with the boys, which was a positive structure for their family of four.

Matthew was described as a bright and inquisitive child. As a baby, he was also described to us as 'hot tempered.' Despite being a relatively healthy baby, Matthew was diagnosed with gastrointestinal reflux when he was three months old. He would suffer from heartburn throughout his life. He said his first word, "cat" at the age of 5-and-a-half months and he was drawing legible pictures by 11 months of age. Always an independent child, Matthew kept himself busy. He loved to draw, read, and build Lego®. As a toddler, he loved bugs, dinosaurs, rocks, and minerals, and the family came to call him their "Little Professor." As Matthew got older, his passion for science grew. He studied astronomy and chemistry. Matthew loved a good debate and was passionate about current affairs and politics; he thrived on learning. He was intelligent, kind, and wore his emotions on his sleeve. Spending time outdoors and with animals, especially his two cats, were great loves for him.

Matthew was also a child who struggled with his mental health. In nursery and elementary school, Matthew's exceptional intelligence was quickly noted; however, his parents also noticed that his social skills were limited. He did not engage with his peers and his teachers observed that Matthew was regularly by himself. They noticed that Matthew would get easily annoyed at his peers and would challenge them, without recognizing the potential social implications. Matthew's mother stated that he always thought differently from his peers and "how he saw the world wasn't always the way it actually was." Even though Matthew was unaware that he was different than his peers, Matthew's mother recalled witnessing other children's negative reactions towards Matthew, which was hurtful for her to see. He would regularly come home from school upset that his peers did not think and behave the same way as he did. During this period, Matthew's mother would attempt to facilitate friendships for Matthew by organizing play dates with other children that she thought would be a good match for Matthew.

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When Matthew was in junior high, he experienced persistent and severe bullying, which he reported to the adults and service providers in his life. The bullying included social isolation, threats of violence, and physical assaults. Matthew told a number of service providers and his parents of his perception that the school was mostly leaving him to navigate the bullying on his own. As a result, Matthew had aggressive and violent outbursts and he was caught carrying a weapon at school, which he claimed was for his own physical protection, but which resulted in a number of suspensions.

Matthew was diagnosed with Major Depressive Disorder and Generalized Anxiety Disorder. In addition, he suffered from persistent suicide ideation. His parents continuously sought out myriad professional supports for their son, which are summarized in this report. The bullying grew so significant that he no longer felt safe at school and he was regularly absent from classes. Matthew was transferred to a new school in grade 10, but significant damage had already been done to his mental wellbeing. As his depression and anxiety disorders continued to escalate, he attended less and less school, emergency and mobile crisis services were called to the family home more frequently. Matthew finally withdrew completely from school, from therapy, and eventually, he rarely left the house.

Matthew's mental illness diagnoses affected the way he thought, navigated, and controlled his world. According to the Ontario Centre of Excellence for Child and Youth Mental Health (2016), it is important to understand that mental health and mental illness are not simply at opposite ends of a scale, that young people diagnosed with a mental illness can still have high levels of general mental well-being and that youth without a diagnosed mental illness can exhibit low levels of mental well-being.

Matthew's family were active in supporting him and relentless in their search for mental health services that could help him reclaim himself. Sadly, despite significant efforts by many services and from his family, Matthew's condition continued to deteriorate and service providers were unsuccessful in engaging Matthew in their services. Matthew died by suicide ten days before his 17th birthday.

“Mental health is different from the absence of mental illness, and is integral to our overall health. Mental health is a state of well-being in which the individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her own community.”

The Mental Health Commission of Canada

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A Timeline of Risk Factors and Service Interventions

Grade 7 - 2012/2013 (age 11-12)

Risk Factors	Interventions
<ul style="list-style-type: none"> • Matthew struggles socially • Aware that peers find him different 	<ul style="list-style-type: none"> • Prescribed antidepressant for anxiety

Grade 8 - 2013/2014 (age 12-13)

Risk Factors	Interventions
<ul style="list-style-type: none"> • Lower grades • School absences • Social isolation and bullying 	<ul style="list-style-type: none"> • Therapy with private therapist

Grade 9 – 2014/2015 (age 13-14)

Risk Factors	Interventions
<ul style="list-style-type: none"> • Cannabis/alcohol/pill use • School absences • Bullying • 4 school suspensions • Suicide ideation • Suicide attempt 	<ul style="list-style-type: none"> • Winnipeg Police Service attends the home • Psychological assessment • Diagnoses of anxiety & depression • School division psychology interventions • Addictions Foundation of Manitoba counsellor • Manitoba Adolescent Treatment Centre (MATC) • Youth Crisis Stabilization System

Grade 10 – 2015/2016 (age 14-15)

Risk Factors	Interventions
<ul style="list-style-type: none"> • Multi-substance use • Persistent suicide ideation • Suicide attempt • Aggressive behavior • School absences increase significantly 	<ul style="list-style-type: none"> • Eight sessions with school psychologist • 15 sessions with MATC clinician • 12 calls to Youth Crisis Stabilization System • Five home visits from Mobile Crisis Team • Second psychological assessment • Six Health Sciences Centre Children's Emergency visits • Four admissions to Child and Adolescent Psychiatric Inpatient Services (PY1) • Three calls to Winnipeg Police Service • One child welfare contact

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Grade 11 – 2016/2017 (age 15-16)

Risk Factors	Interventions
<ul style="list-style-type: none"> • Zero school attendance • MATC therapy discontinued • Multi-substance use • Persistent suicide ideation • Insomnia/poor hygiene • Medication use is inconsistent 	<ul style="list-style-type: none"> • 80 CFS family support worker sessions • Two calls to Youth Crisis Stabilization System • One home visit from Mobile Crisis Team • Two calls to Winnipeg Police Services • Three sessions with MATC clinical psychologist • One emergency room visit • Distance learning arranged • Ongoing CFS agency involvement

Grade 12 – 2017 (age 16)

Risk Factors	Interventions
<ul style="list-style-type: none"> • Zero school attendance • No mental health services active • Increased cannabis use • Persistent suicide ideation • Insomnia/poor hygiene • Medication use is inconsistent • Increasingly house-bound • Despondent and verbalizing his lost hope 	<ul style="list-style-type: none"> • CFS family support worker sessions • Ongoing CFS agency involvement



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A Curious Child who Loved Bugs and Dinosaurs

Matthew's Early Years, Kindergarten to Grade 6: 2005-2012

Matthew was an inquisitive and bright child, who had an endless curiosity (Obituary for Matthew, *Winnipeg Free Press*, November 15, 2017). According to early school records, Matthew was friendly and eager. One teacher noted:

Matthew is self-confident and understands [and] follows directions. He listens attentively and interacts cooperatively. Matthew accepts responsibility for his own behaviour and consistently follows school rules. Matthew eagerly participates in all classroom activities and shows an understanding of concepts [and] thoughts. Matthew shows a commitment to learning and will have no trouble adjusting to Grade 1 next year (Year-end report, Matthew's elementary school, June 2006).

These positive comments continue to appear in Matthew's school files as his teachers saw a child who was curious and who especially enjoyed science and learning about how the world worked. During this investigation, our team saw that Matthew's social progress in his early years was generally positive. One teacher wrote: "Matthew demonstrates academic and social maturity that is common in older children. He includes others willingly in activities and establishes positive peer relationships" (Teacher file recording, Matthew's elementary school, March 2006). In Grade 6, Matthew (age 10) continued to be seen as a child who participated easily and his teachers noted some struggles with him staying focused. They noted that he would often be asked to redirect his attention from socializing with friends to his school work. For the start of Grade 7, Matthew moved into a new school.

The Bullying Begins

Grade 7: 2012-2013 (Age 11-12)

Like most children, Grade 7 was a year of transition for Matthew. He was 11 years old and enrolled in a French immersion program in Winnipeg. Despite his earlier years where he seemed relatively well-connected in school and with peers, this was the year that Matthew became aware that his peers were noticing that he was different. During this investigation, Matthew's mother shared with us that Matthew had a growing understanding of where he "fit on the social scale" and his social status bothered him. At school, he was starting to experience bullying and social isolation, concerns he would regularly discuss with his mother. Her approach was to guide and support Matthew as he navigated these new feelings. She told us that she would try to reassure Matthew and say: "All the qualities that you hate as a child, will make you a wonderful adult." Matthew's father used a more corrective approach and would express more frustration at Matthew's behaviors, telling him to stop acting certain ways. At school, Matthew was the "peripheral friend" and never part of a core group. Student support services were not involved with Matthew during this school year.

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Predisposed by a family history of depression and understanding the accompanying symptoms, in May 2013, Matthew's parents took him to a pediatrician as a result of his feelings of sadness. Matthew was prescribed an antidepressant.

As the Bullying Intensifies, Matthew's Grades Drop

Grade 8 - 2013/2014 (age 12-13)

In Grade 8, Matthew was still enrolled in French Immersion. He had always been a bright student with above average marks; however, this year, his grades were consistently lower and his school absenteeism increased. In addition, Matthew's health records indicated he was dealing with some physical health issues, including spinal curvature, postural concerns, and persistent heartburn. He was referred for physiotherapy and some medical testing. An assessment later that year would also note, among several other issues, that Matthew appeared awkward when running and that he struggled with his body image (Therapist, Clinical case notes, June 27, 2014).

Matthew continued to experience social isolation and bullying at his school, which led to his motivation decreasing and his grades declining. This change got the attention of the school; however, they were not concerned. His mother realized that she needed to start communicating with the school when she found completed work hidden in Matthew's bedroom that was never handed in. The school staff indicated they were not concerned, beyond noting that Matthew's school work was messier than usual; however, Matthew's mother was concerned. During the course of this investigation, Matthew's mother told us:

That's when I knew something else was going on. He shrugged his shoulders a lot. It was probably scary for him, it probably didn't make any sense. That's when we started to notice his room, binder, back pack started getting messier and messier. It probably reflected how his brain felt inside (Matthew's mother, Interview, August 28, 2019).

While working part-time outside their home, Matthew's mother was also the parent who took the lead on managing and responding to Matthew's support needs, including being the key contact for external services. Coordinating support services, responding to Matthew's growing mental health needs, and being the lead organizer and support for the entire family was difficult. The responsibilities took a toll on Matthew's mother's own mental wellness and she started experiencing panic attacks when she was at her part-time job. Matthew's parents gave him a phone. This resulted in a pattern of behaviour where Matthew would send repeated and unrelenting text messages to her all day, bombarding her with complaints. Matthew's mother shared with us that she felt exhausted and worried as a parent. In retrospect, Matthew's mother noted: "That was the start of isolating our family a bit. I kept a lot of things to myself. I saw the whole picture and it didn't look good" (Matthew's mother, Interview, December 10, 2019).

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In May 2014, Matthew's parents took him to a private therapist to help Matthew with his anxiety, depressive issues, self-esteem, and social skills. They were aware of the peer bullying and social isolation that Matthew had been experiencing. At their initial meeting with the therapist, Matthew's parents shared significant information about what Matthew was facing in his daily life. They noted that physically, Matthew had stomach aches, headaches, heartburn, that he struggled with appropriate boundaries, was not physically coordinated and moved awkwardly. They noted that Matthew verbalized that he was depressed, that he did not have friends, he was being bullied, and that, "9 or 10 kids had told Matthew that he should kill himself" (Therapist, Clinical case notes, June 27, 2014).

Matthew attended three sessions. The focus of the sessions was to work on techniques to help Matthew relax his mind and body, help Matthew build confidence to verbalize his feelings, and help him develop a voice at home and school. In his first session, on July 23, 2014, Matthew told the clinician that he had been bullied every school day, multiple times per day and he felt the teachers were aware and were not intervening when they witnessed the bullying. Matthew explained that the bullying had begun when he was at McDonald's one day and a boy had wanted to borrow money from Matthew for a burger and Matthew had refused. Since that time, the boy had been targeting Matthew every day at school. Matthew noted he did not want to return to school in the fall.

Matthew also described his growing struggles in his relationships with his parents. He shared with the therapist that he felt his dad was often angry and Matthew had to carefully navigate those interactions. Matthew said he felt his mother frequently accused Matthew of lying to her, which would often spark conflict between his mother and him. He articulated to the therapist that he wanted his parents to realize he was growing up and needed to be treated less like a child. The therapist reflected in their notes that Matthew appeared to be repressing many of his emotions and that Matthew was limiting his disclosures to his parents. The therapist wrote:

Matthew seems angry because he has experienced multiple episodes of bullying at school, does not see anything changing and then returns home to be criticized by one or both of his parents. Helping Matthew develop a voice at home and school will be imperative moving into the fall (Therapist, Clinical case notes, June 23, 2014).

As a result of the relentless bullying, Matthew experienced a low level of mental well-being to the point that his normal, daily activity was severely compromised.

The First Suicide Attempt

Grade 9: 2014-2015 (Age 13-14)

Matthew's struggles at home and school intensified during his Grade 9 year. His parents continued exploring and accessing community resources in an effort to get Matthew the support that he needed. These were

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Matthew's first points of contact with many public services related to mental health and addictions, including:

- Child and adolescent psychiatry;
- The Manitoba Adolescent Treatment Centre (MATC);
- Addictions Foundation of Manitoba (AFM);
- School division psychology;
- Winnipeg Police Service; and
- The youth crisis stabilization system.

Navigating these services were unfamiliar to Matthew's parents and in order to get the services and supports that Matthew appeared to be needing, they had to swiftly learn how to communicate, coordinate, and advocate through a complex system without a knowledgeable system navigator. Matthew's mother shared with us: "It's impossible to figure out the minefield of what's available. All I ever wanted was someone to say, 'This is what you should do. This is what is available'" (Matthew's mother, Interview, August 28, 2019).

The family dynamic changed. Things became tense. "It was a deterioration of everything we had worked so hard to create" (Matthew's mother, Interview, December 10, 2019). Matthew saw the changes, too. In a session with his therapist just prior to the start of the school year, he described some of the dynamics at home, sharing that he felt his parents were always yelling. His therapist documented:

We further explored the yelling that goes on in their house and Matthew noted that is one of his biggest concerns. Because there is constant yelling, his parents are rarely listening to what he needs or wants. We brought mom into the session so she could better understand what Matthew needed to work on in between sessions (Therapist, Clinical case notes, August 6, 2014).

Matthew's parents also worried about Matthew's younger brother and the affect that Matthew's mental illness had on him. Matthew's mother was no longer working outside the home, and she was now at home, trying to organize life around Matthew's needs. They aimed to create stability in a home environment that was otherwise described to us as tense, exhausting, and all consuming.

In September 2014, Matthew's parents took him to Concordia Hospital and subsequently to the Health Sciences Centre (HSC) Children's Emergency after they found him wandering around their home in the middle of the night, incoherent and confused. Matthew (13) denied drug use; however, he tested positive for amphetamines and benzodiazepines. He was discharged after stabilizing, with a plan for his mother to follow up with Matthew's pediatrician. In the hours and days that followed, it became clear that this had been an intentional event, and Matthew's first known suicide attempt. His pediatrician saw Matthew two weeks later, on October 14, 2014. The pediatrician documented that Matthew offered no explanation about why he had wanted to hurt himself. The pediatrician documented that Matthew had always struggled

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socially and had no good friends. Further, that from “May-June he was crying – was throwing up every morning-mom was not able some mornings to get him to school” (Pediatrician, Referral form, October 14, 2014). Matthew’s pediatrician made a referral for a psychiatric assessment with the Winnipeg Regional Health Authority’s Child and Adolescent Mental Health Program.

The next day, Matthew had his third meeting with the private therapist he had started seeing earlier that summer. Matthew spoke about his suicide attempt and that he had felt so overwhelmed with life that day in September that he had swallowed a package of Benadryl pills. Matthew described in that session that he was feeling very angry with his parents because they were not allowing him any privacy. The therapist explored these feelings with Matthew and they spoke about techniques Matthew could use to establish more assertiveness in a number of areas of his life, from his communication with his parents, to better systems of organizing his school work, an issue about which he was experiencing growing anxiety. A note on file indicated that Matthew’s mother would call to schedule a follow up meeting as needed; however, no further visits to this therapist were documented.

The psychiatric assessment requested by Matthew’s pediatrician occurred on November 13, 2014. Matthew described a one year history of sadness and depression, which had interfered with his functioning and resulted in the suicide attempt. Matthew described having low energy, decreased appetite, insomnia, and decreased concentration. He shared that he had experienced bullying and social isolation and disclosed having suicidal thoughts for one year. Matthew told the psychiatrist that he had used cannabis and alcohol previously. The psychiatrist documented that Matthew was predisposed to family histories including depression, anxiety, and possible bipolar affective disorder and that Matthew’s own depression and anxiety were significantly interfering in his life. “It seems evident that one of the predisposing factors for his anxiety and depression has been some bullying and teasing in school, as well as some physical issues” (Psychiatrist, Clinical notes, November 13, 2014). Matthew was diagnosed with major depressive disorder and generalized anxiety disorder. It was recommended that Matthew receive ongoing services at the Manitoba Adolescent Treatment Centre (MATC) to address mood and anxiety symptoms, start a new medication, and implement the recommended sleep hygiene techniques that were discussed during the assessment.

‘Does Not Care About School Anymore’

The next day, on November 14, 2014, when Matthew (13) returned to school, he was involved in an incident with another student. According to school documentation, Matthew was in the yard at school and had dropped his phone. Another student had called Matthew “an idiot” and Matthew had punched the other student twice. Matthew received a one-day, in-school suspension (Matthew’s junior high school, Student discipline record, November 14, 2014).

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On November 26, 2014, concerned that Matthew was now misusing substances, Matthew's mother called the Addictions Foundation of Manitoba (AFM) for help. She described that Matthew was not taking his prescribed medication, which resulted in him being unregulated for sleeping and that Matthew was dealing with long-term depression. Matthew's mother shared that she had found drug-related paraphernalia in his bedroom and that she knew Matthew had tried alcohol. A one-on-one session with AFM Youth Services was set for December. Matthew's parents had an open conversation about the risks of substance use with Matthew and in December 2014, he had one session with an AFM counsellor where he disclosed he had used cannabis on four occasions.

MATC's Brief Community Child & Adolescent Treatment Service (B-CCATS) became involved with Matthew in December 2014. B-CATTTS offers brief intervention services to youth who are experiencing emotional, behavioural, or psychiatric difficulties. As part of his involvement, Matthew had four sessions with a mental health clinician. The focus of the sessions was to assess Matthew's mental health status and observe and discuss family functioning. His parents and younger brother also attended a session. They focused on appropriate and consistent parenting approaches. This approach was frustrating for Matthew's mother, who shared with us that she felt:

...like they [BCATTTS] were focusing on the wrong thing, focusing on parenting. It was not helpful to focus on parenting, it was maddening. We were good parents and we needed coping skills to tell us what to do, not questioning us and our ability (Matthew's mother, Interview, August 28, 2019).

Still, both Matthew and his parents agreed to further services and a referral was made for ongoing services through MATC's Community Child & Adolescent Treatment Services (CCATS).

AFM Youth Services also started to provide services to Matthew in December 2014. The AFM file noted that Matthew's parents had shared Matthew received a suspension from school on December 8, 2014, for making threats against another student.² It was not clear from the record whether this was one of the students who had been bullying Matthew on an ongoing basis. When Matthew met with the AFM youth counsellor on December 9, 2014, the counsellor described Matthew as "clearly upset today" (Youth counsellor, AFM case notes, December 9, 2014). In the counselling session, Matthew described that he was taking a full caseload at his school and particularly liked his math class. He also shared that he spent his time playing video games, baseball, and fishing, and that he liked camping in the summer. He admitted to the AFM counsellor that because his closest friend did not use cannabis, that Matthew was seeking out and spending time with other peers where he was able to use cannabis more easily. The AFM counsellor committed to following up with Matthew and his mother later that month to enquire about scheduling ongoing appointments. Follow up from AFM occurred on December 29, 2014, in a phone call to Matthew's

²School records note that the incident actually occurred on December 9, 2019.

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mother; a voicemail was left requesting a call back. AFM records note that no return call was made to AFM and therefore, AFM closed their file regarding Matthew on March 2, 2015 with a note to reassess Matthew for service, if the family called again. When we met with Matthew's family, his mother explained that she did not return the call because Matthew had told her that he would not attend the meetings (Matthew's mother, Interview, February 21, 2020).

On December 10, 2014, the day after Matthew's first AFM appointment, Matthew received a three-day out of school suspension for being in possession of a box cutter at school. School files describe that the school interviewed a number of students who were involved in what appeared to be a situation, which stretched over a number of days. According to school files, over the previous weekend, Matthew had made a number of threats against another student, including that he would throw a "Molotov cocktail" through the other student's window and attack the student with a knife. School personnel reviewed transcripts from the social media exchange and confirmed the accusation about Matthew's online behaviour. In response to the threats, Matthew reported that a group of students had been following him and attempted to engage him in an altercation. Matthew said he feared for his safety, which had prompted him to arm himself with the box cutter at school. Matthew was searched, the box cutter was located and his mother was called to come pick him up. The school recorded that re-entry to the school would require a board office re-entry meeting and that the school would also be referring Matthew to the psychological services department (Matthew's school, Student discipline record, December 10, 2014). Our office was unable to locate any minutes regarding the required re-entry meeting, although a note was placed on Matthew's file that the re-entry meeting was scheduled for December 15, 2014.

Another thing our office was unable to determine during this investigation was whether the school took any action to address not only this incident, but the larger issue of the pervasive bullying that, by this point, had been ongoing for about two years in the school. When we met with school personnel during the investigation, they stated they had been working to address the bullying with the other students involved (School personnel, Interview, January 31, 2020). When we met with Matthew's mother, she informed us that she met with the administration twice. She told us that as part of those meetings she requested a meeting with the parents of the other students involved in the bullying, but that this had never been arranged (Matthew's mother, Interview, February 21, 2020).

On December 16, 2014, Matthew and his mother attended the first meeting with the clinician from the MATC B-CATTS program. They reviewed the medication Matthew was taking at that time to treat his depression and anxiety. Matthew's mother expressed that a key concern for her was Matthew's use of cannabis. She told the clinician that she no longer trusted Matthew and that she would conduct daily bedroom and backpack checks until he earned her trust again (MATC B-CATTS, Integrated progress notes, December 16, 2014).

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When school resumed in January 2015, a school division psychologist opened a file in order to provide services to Matthew. On January 12, 2015, the newly assigned psychologist spoke with Matthew's mother over the phone to gather initial information about Matthew. Matthew's mother provided information about other services being accessed (MATC, AFM), current medication, and social information, including that Matthew felt unsupported by the school regarding the ongoing bullying to which he had been subjected over a long time. Matthew's mother told the psychologist that the incident with the box cutter was connected to the bullying, that Matthew felt afraid at school, and that while he used to be a good student who enjoyed school, that had evaporated and he did not care about school anymore (School division psychologist, Case notes, January 12, 2015). A meeting for Matthew to meet with the school division psychologist was set for February 10, 2015.

The school division psychologist established a positive rapport with Matthew and they had four one-on-one sessions. The psychologist consulted with Matthew's mother, the school staff, liaised with the MATC clinician, and facilitated transition planning as Matthew would be attending a new school for grade 10. The anxiety and depression that Matthew experienced significantly impacted his ability to engage in school. Due to the bullying, Matthew reported that he sometimes did not feel safe at school. On Matthew's insistence, he did not want school staff implementing a safety plan. It was therefore decided that the safety plan would include the school staff monitoring Matthew's interactions with peers and observe for any bullying. The psychologist provided bullying resource information to Matthew's educators.

Ongoing bullying occurred for Matthew during the school year. On three separate occasions, suspensions were handed out to students who bullied him. Examples included: physical intimidation, threats, and a physical assault against Matthew. Matthew also received further suspensions that year. On January 28, 2015, the school received a report that some students, including Matthew, had been smoking cannabis during the lunch hour the previous day. Matthew was interviewed and searched by school personnel and was found to have a quantity of cannabis, a pipe, and two lighters in his possession. Matthew was suspended out of school for five days. The school referred Matthew for drug counselling through AFM. In total, Matthew received one in-school suspension and three out-of-school suspensions during this school year. He missed 13 days of school as a result of his out-of-school suspensions.

Matthew shared with the school division psychologist that he was "...very worried about students calling him a snitch, calling him gay, physically intimidating him...He cannot focus at school because of these problems" (School division psychologist, Continuous recording report, March 12, 2015). When students would call him names, Matthew sometimes tried to use humour to turn these situations around. "I love you anyway!" he called out to one bully who was harassing him (Matthew's mother, Interview, February 21, 2020).

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The school psychologist met with Matthew's teachers on March 20, 2015, to discuss some of the concerns Matthew had raised. The teachers indicated they had noticed a change in Matthew the previous October when he stopped completing all of his school work and was observed to be acting strangely. The psychologist shared some examples of bullying reported by Matthew and the teachers indicated they had never seen Matthew being bullied. One of the teachers added that during the previous week, they had observed Matthew attempting to high-five the students he was claiming were bullying him (School division psychologist, Case notes, March 20, 2015).

Matthew's father called Winnipeg Police Service (WPS) on February 14, 2015, due to Matthew threatening suicide. WPS responded to deescalate the situation and further WPS intervention was not required.

Matthew had a session with the MATC B-CATTS mental health clinician on February 19, 2015, where he acknowledged previous suicidal ideation and noted that his school suspensions contributed to his unhappiness. The plan was to continue meeting with Matthew and his family. Matthew remained on the wait list for MATC's Community Child & Adolescent Treatment Service (CCATS). Matthew shared with the clinician that he had been suspended from school again from February 13-20, 2015, after two other students had showed the school principal photos of Matthew holding a cannabis cigarette. Matthew and his parents had denied the veracity of the cellphone images when shown. The school had again searched Matthew and discovered Visine eye drops, a lighter, and a rolling paper and issued a five-day out-of-school suspension. In his session with the mental health clinician, Matthew noted he was looking forward to changing schools for September 2015.

The AFM school-based youth counsellor met with Matthew on four separate occasions starting in February 2015. During the initial assessment, Matthew reported his own perceived benefits of cannabis use, including that it helped him feel "happy," "gives him a break," and that it "helps to deal with depression." Conversely, he identified that the consequences of his cannabis use caused him ongoing problems at school and home. Matthew shared with his AFM counsellor a number of incidents of bullying he had experienced, which involved a small number of specific students. Matthew indicated that he had reported the bullying and that his parents had been involved, but that little had changed to improve the situation he was experiencing. Matthew described his suicide attempt in September 2014 as an "...awful experience, I would never do that again." An assessment was conducted with Matthew, which documented his protective factors as:

- Having a strong relationship with his mother;
- A lot of family support; and
- That school was important to Matthew.

His risk factors included, that he:

- Was easily influenced by peers;
- Had a history of being bullied; and

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- Struggled with anger management.

Matthew indicated he was interested in abstaining from using cannabis and committed to that plan, but the counsellor wrote that while Matthew engaged easily in the session, he had been very clear that, in his opinion, counselling was not helpful. Education materials specific to cannabis use were provided, Matthew and the AFM counsellor agreed that counselling could be concluded and the file was closed on April 13, 2015. The AFM counsellor followed up with Matthew's mother on March 12, March 25, and April 16, 2015, to discuss the assessment results. The AFM counsellor invited Matthew's mother to an upcoming AFM Parent Intervention Program. This program offers parents and caregivers further information and support regarding their young person's alcohol, drug, or gambling use. Matthew's mother said that although she was familiar with much of the material presented in the information session, this was a required pre-requisite to being able to access AFM counselling for her son (Matthew's mother, Interview, February 21, 2020).

In April 2015, Matthew was slapped by another student hard enough that it left a mark on Matthew's skin. Although a school meeting with Matthew and his mother was suggested to develop safety plans, Matthew's mother declined the offer of a meeting, saying it would be unnecessary because Matthew had lost trust in the school.

The following week, on April 10, 2015, Matthew met with the school division psychologist and disclosed that he was being physically threatened on social media by two students who attended the school. According to Matthew, the students were threatening that they would get a gang after Matthew and made a comment about "finding themselves a body" (School division psychologist, Case notes, April 10, 2015). While the psychologist noted that an offer was made to Matthew to create a safety plan, he declined the offer with concerns that he did not want to be further singled out in the school. There was no documentation that the psychologist reported the disclosure of physical threats to anyone else.

On April 29, 2015, Matthew's mother spoke with the psychologist over the phone. Matthew's mother shared that there had been another incident over the weekend:

Matthew was called by a friend to meet him at the park. Once he arrived, a student who has been bullying him was there. The student tried to burn a hole in Matthew's bike tire and pushed him off his bike causing minor injuries. Matthew felt very hurt by this "set up" and embarrassed. He thought these boys were his friends (School division psychologist, Case notes, April 29, 2015).

A case note from the school division psychologist, dated May 5, 2015, indicates that one of Matthew's teachers was observing that Matthew continued to be seeking out the students who were bullying him in apparent attempts to make friends with them. The teacher reported that Matthew's interactions involved him behaving in ways that made it even less likely for a successful peer connection. On June 4, 2015, the school division psychologist was informed by one of the teachers that Matthew had been physically

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assaulted (i.e. slapped) by another student, resulting in the other student receiving a suspension from school. In a subsequent phone call with Matthew's mother, it was noted by his mother that Matthew "...cannot complete academic work because he is feeling anxious, depressed, worried, and annoyed by the students who have been bullying him" (School division psychologist, Case notes, June 4, 2015).

Matthew remained at this time on the waitlist for ongoing counselling services from MATC.

The school division psychologist received a report from one of Matthew's teachers that another incident had occurred at the school. This time, on June 10, 2015, a knife had been discovered in a desk and it was unclear whose knife it was, but Matthew and a few other students had been questioned about it. The psychologist noted that the finding of the knife might heighten Matthew's anxiety as he had shared that he was worried about a student who had returned to the school and the school wondered if Matthew was feeling the need to

Adapted Education Plans

Manitoba Education has identified a range of instructional supports for addressing student diversity, including differentiated instruction, adaptation, modification, and individualized programming. Adaptation means a change made in the teaching process, resources, assignments, or pupil products to help a pupil achieve the expected learning outcomes. Adaptation addresses identified student-specific needs.

Source: www.edu.gov.mb.ca

protect himself. The teacher noted that Matthew appeared to have quite a bit of knowledge about the knife when questioned about it. Two school staff indicated they would be conducting a search of Matthew's bag the following day (School division psychologist, Case notes, June 10, 2015). Files indicate the school did conduct the bag search on June 12, 2015; no details were included regarding anything that may have been found in the search.

In June, the school division psychologist from the junior high school spoke with the guidance counsellor for the new high school where Matthew would be attending. The purpose of the contact was to provide some context and history, with Matthew having given his permission, about the bullying, including the names of the students who had been bullying Matthew. The new school invited Matthew for a pre-school year meeting to help him make the transition. It was noted that the high school was open to speaking with Matthew about the class list for his upcoming year (School division psychologist, Case notes, June 11 and 12, 2015).

The school service plan for the next year, at his new high school, would be for psychology supports to remain open; for Matthew to establish a strong rapport with one staff member at his new school; and for Matthew to stay engaged in counselling to address traumatic experiences that occurred for him in the past regarding peer conflict. Matthew passed all of his courses and was issued eight credits. The psychologist recommended that a brief, adapted education plan be developed and transferred to Matthew's new high school. The students who had been bullying Matthew were not expected to be attending the new school

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and the hope was that this would have a positive effect on some of his anxiety. When we met with his family, Matthew’s mother told us that she had not been informed that the school was considering an adapted education plan for her son (Matthew’s mother, Interview, February 21, 2020).

In summary, as noted in the table below, Matthew’s Grade 9 year had seen a startling drop in his academic achievements from earlier years, where he was known to enjoy school, especially science and math classes.

CLASS DESCRIPTION	DAYS ABSENT (out of 197 total instructional days)	DAYS LATE	FINAL GRADE
ELA Immersion	94	7	53%
French	87	0	52%
Sciences Humanities	78	2	54%
Math	80	4	60%
Science	97	3	54%
Physical Education	82	3	87%
Drama	78	3	59%
Food and Nutrition	18	0	79%
Electricity/Electronics Technology	9	1	66%

The Youth Crisis Stabilization System was first utilized by the family in July 2015. Matthew’s father called the 24-hour crisis line as Matthew was under the influence of an unknown substance and threatening to harm his father. Support was provided over the phone and the incident stabilized.

Youth Crisis Stabilization System

The Youth Crisis Stabilization System offers a range of supports & services to help stabilize youth & families in times of crisis. A variety of youth crisis services are operated by four non-profit Winnipeg based agencies. Services include:

- Family Support Services
- Crisis Stabilization Units
- Mobile Crisis Teams
- Home-Based Crisis Intervention
- Youth Education Services
- Brief Therapy Teams
- 24 Hour Crisis Line

Source: <https://www.mys.ca/services/youth-crisis-services>

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Matthew Enters a New School

Grade 10: 2015-2016 (Age 14-15)

Grade 10 was a very difficult year for Matthew. His parents quickly learned how to navigate multiple systems to help address Matthew's mental illness, and accessed these services repeatedly. During this time, Matthew's mother had to be at home to monitor Matthew for safety. Matthew's brother could not have friends over, so he spent time outside the home. During the course of this investigation, Matthew's mother told us, "We were always on guard. Matthew's [bedroom] door was taken off. I felt horrible. I was a prisoner. [Matthew's brother] was scared for himself and Matthew" (Matthew's mother, Interview, August 28, 2019).

The school division psychologists at Matthew's new high school made contact with Matthew and his mother early in the school year to ensure they knew psychology support services were available to help Matthew transition to his new school. Their first meeting occurred on September 29, 2015, and involved the psychologist, Matthew, and his mother. Matthew reported a good start to the year and that he was not experiencing any bullying from peers. Later in the session, as he began to open up with the new clinician, Matthew admitted that he was feeling anxiety building with growing expectations related to school. Matthew agreed to attend counselling and another appointment was set for two weeks later (School division psychologist, Case notes, September 29, 2015).

Matthew started seeing the AFM Youth counsellor again in the school, with his first AFM contact of the year at the beginning of October. Counselling sessions were set to begin that month and would also involve some discussions with the school support staff. Matthew shared with both the AFM counsellor and the psychologist – separately – that he continued to use cannabis regularly.

Matthew's ability to function on a day-to-day basis deteriorated further. He was inconsistent with taking his prescribed medication, experienced persistent suicidal thoughts, a decreased appetite, a chronic lack of sleep, his panic attacks could last the full day, and he was not managing well in the school environment due to his anxiety. There was ongoing contact with Winnipeg Police Service; Youth Crisis Stabilization System; MATC services; and visits to the HSC Children's Emergency. This year would be the family's first contact with Child and Adolescent Psychiatric Inpatient Services (PY1) at the hospital, as well as the beginning of child welfare involvement.

Attending a new high school in grade 10, Matthew was involved with the school counsellor, school division psychology, and the school-based AFM worker. Matthew shared with the school division psychologist that he was depressed and anxious, and he attributed his difficulties to ongoing cannabis use. He attended nine individual sessions with the AFM school-based counsellor and continued his sessions with the school division psychologist to address his anxiety. And while he had been enrolled in French immersion programming since

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kindergarten, due to school stressors, he switched to English classes. It was documented that he started the school year successfully, made positive connections with teachers, and made some new friendships. However, eight weeks into Grade 10, Matthew experienced high levels of stress that resulted in persistent suicidal ideation, and which impacted his ability to attend school.

On October 14, 2015, after seeing the school division psychologist during the day, Matthew went home and struggled that evening. At 8:45pm, Matthew's mother called the mobile crisis team for help as Matthew was suicidal. After the initial assessment over the phone, the crisis team was dispatched to assess Matthew in person. Matthew verbalized to his parents and the crisis team that he was sad, depressed, and had a plan to die by suicide. He spoke about the impact that the bullying had on him in the previous school year and that it had been the reason for switching schools this fall. Case notes indicated that Matthew continued to be on the waitlist at MATC for long-term therapy. The mobile crisis team files indicated that Matthew's mother had contacted MATC earlier in the day and had left a message requesting therapy. The mobile crisis team noted that the plan for now would include:

- Matthew to remain at home for the night
- Matthew's room door to be left open tonight and mom to monitor Matthew throughout the night
- Matthew to continue with AFM therapy at school
- Parent to take Matthew to the hospital if suicidal thoughts reoccur (Mobile crisis team, Contact notes, October 14, 2015).

Matthew's progress continued to be unstable, with some days much better than others. On October 27, 2015, Matthew's mother emailed the school division psychologist requesting an appointment for Matthew, noting that while he had appeared to be a bit improved for a time, he had disclosed feeling suicidal again that morning. The psychologist set an appointment for a month later, on November 29, 2015.

The next day, on October 28, 2015, MATC moved Matthew from its waitlist and initiated program admission for the C-CATS long-term therapy supports. The assigned therapist phoned Matthew's mother and a first appointment was set for November 2, 2015, which would involve Matthew and both of his parents (MATC, Integrated progress notes, October 28, 2015). In separate appointments with the school psychologist, the AFM counsellor, and the MATC C-CATS therapist, Matthew spoke about the difficulties he was having with school work: feeling anxious about assignments, perseverating on decisions, and struggling with French immersion programming. He was described as having low self-esteem and very self-conscious. In the evening after his first MATC therapy appointment, Matthew's mother transported him to HSC Children's Emergency as he was expressing suicidal ideation. They informed medical personnel that Matthew was attempting to study for a chemistry test, could not focus and wanted to die (HSC Children's Emergency, Medical records, November 2, 2015).

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The next day, Matthew and his mother met with the school division psychologist and the school resource teacher to discuss academic and other therapeutic supports that could be put in place. The option of transferring from French immersion to English programming was discussed again. That transition began that fall with a small number of classes, with a plan to transition fully to English programming for the new semester. Matthew continued to see the AFM counsellor, the school psychologist, and the MATC therapist.

On December 10, 2015, Winnipeg Police Service was called to the home after Matthew had consumed alcohol and prescription pills. He had become violent and his father had to hold him down until police arrived. Matthew was initially restrained in the police car and then transported to HSC Children's Emergency for medical care. The attending psychiatrist met with Matthew and also faxed a message to Matthew's therapist at MATC to advise of the "unintentional overdose" that evening.

During January 2016, Matthew continued to see the school psychologist, AFM counsellor, and the MATC therapist. In addition, a psychiatric assessment was conducted on January 25, 2015, with a goal of exploring whether a diagnosis for Autism Spectrum Disorder was warranted. That assessment also included information collected from the school, the AFM counsellor, Matthew's parents, and Matthew himself. Ultimately, a diagnosis for autism was not supported by the results, although the psychiatrist noted significant conflict between the parents and in their relationships with Matthew. The psychiatrist gave diagnoses of:

- Generalized anxiety disorder – continue current meds
- Depressive disorder (not otherwise specified) – continue meds
- ODD – may consider atypical antipsychotic trial to reduce ODD behaviours³
- Substance use – continue AFM
- Parent child relational problem – family therapy work through MATC (MATC-CCATS, Psychiatric assessment notes, January 25, 2016).

School is a Trauma Trigger

The mobile crisis unit was called and dispatched to the family home on the morning of January 27, 2016, because Matthew was expressing suicidal ideation. According to case notes, Matthew's dad had stated it was the third day in a row that Matthew was unable to get out of bed, noting that school pressures were amplifying his levels of anxiety as exams were approaching. A referral was made to the Youth Education Services (YES), which is another support service coordinated through the Youth Crisis Stabilization System in Winnipeg. The goal for YES involvement was to help Matthew attend school more consistently and to provide his parents with strategies to support that plan.

³When we met with Matthew's mother to review the full report, she told us that she had never known that Matthew had been diagnosed with ODD, as is reflected in the MATC file (Matthew's mother, Interview, February 21, 2020).

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The next day, Matthew had returned to school and his AFM counsellor tracked him down in the library, where he was catching up on his school work in advance of exams, which were starting this week and would carry into the following week. The counsellor offered Matthew a time to talk later that day, but Matthew declined, saying he wanted to finish his work and go directly home. The counsellor noted that Matthew seemed “glassy-eyed” and anxious (AFM counsellor, Case notes, February 28, 2016).

When exam week began, Matthew again became overwhelmed and suicidal. On February 2, 2016, his mother called MATC asking for an appointment for Matthew due to his suicidality; a session was arranged for the following day. On February 4, 2016, Matthew's mother called the youth crisis intake as Matthew was talking about suicide and was articulating a plan. She reported that while he had been at school the previous day, he was not wanting to return to school and was in crisis. The mobile crisis team was dispatched to the family home. While there, Matthew's mother requested that he be taken to HSC to be formally assessed as she was feeling unable to keep him safe and felt she had no other options. According to file reports, things in the home were spiraling out of control again:

This morning mom admitted to slapping [Matthew] out of frustration. Father stated [Matthew] elbowed his mom in the face, put a whole [sic] in the wall and was trying to pull the banister apart (Mobile crisis team, Dispatch report, February 4, 2016).

Matthew was taken to HSC Children's Emergency and the mobile crisis team sent a referral to child and family services regarding the report of violence in the home. After an initial psychiatric assessment, Matthew was admitted to the Child and Adolescent Psychiatric Inpatient Services (known as “PY1”) at HSC, where he remained from February 4-10, 2016.

On February 8, 2016, the report to CFS was assigned to a worker and a home visit was conducted on February 12, 2016. Matthew had been discharged from PY1 two days prior to the CFS home visit. CFS assessed the home and spoke with the parents and the children, noting no protection concerns. A Probability of Future Harm Assessment was completed and a score of Moderate was documented. CFS gathered details about the several therapeutic supports that were active in the life of the family and the file was closed at the intake level (Agency file, Intake notes, March 11, 2016).

In the second semester, Matthew, age 15, attended only two days in February and two days in March. The Youth Education Service (YES) program was utilized, although it was ultimately unsuccessful in getting Matthew back to school. The school division psychologist reached out to Matthew to offer support, but there was no response. Matthew did not attend school for the remainder of the year. An additional complication was that due to Matthew leaving French immersion programming, education policy required him to switch schools to a new high school in his catchment area, beginning in the fall of 2016.

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Significant life events impacted Matthew this year. First, the family cat, to which Matthew had a close bond, died on February 15, 2016. Matthew had struggled with regular school attendance prior to this event, but as he seemed to perceive school pressure to increase, his ability to cope significantly deteriorated. During the spring of 2016, Matthew experienced repeated mental health crises and the Youth Crisis Stabilization System was called and utilized February 17, February 18, March 3, March 5, March 6, and April 20, 2016. A number of these crisis events coincided with scheduled meetings at school or when a return to school was discussed with Matthew. Throughout these weeks and months, file notes from various sources reflect the high stress inside the family home and the desperation the family was feeling about responding to Matthew's needs and their abilities to keep him safe and alive.

The second significant life event that happened in the family was that on April 24, 2016, Matthew's father died of heart failure at the family home. According to various file notes in the days and weeks that followed, Matthew had been home and watching television with his father when his dad experienced a heart attack. Matthew witnessed the event, attempted cardiopulmonary resuscitation (CPR) on his dad while 911 was called. The CPR was unsuccessful. The death of Matthew's father pulled the family even further into an unstable situation. In a call to the Youth Crisis Stabilization System by Matthew's mother on May 1, 2016, she reported that the funeral had happened the day prior and since then, Matthew had been laying on the couch and had not yet cried for the loss of his dad and his witnessing of the death.

Matthew attempted suicide by consuming an unknown substance on May 3, 2016. When he woke his mother up during the night he was crying and unable to agree to keep himself safe, prompting his mother to call the Youth Crisis Stabilization System for help. They advised her to call 911 for immediate assistance. Matthew was transported to hospital and admitted to PY1 for the second time from May 4-11, 2016. While in hospital, Matthew was seen by occupational therapy staff in addition to daily psychiatric supports. The plan upon discharge was for him to continue to attend the Community Child & Adolescent Treatment (C-CATS) Program at the Manitoba Adolescent Treatment Centre (MATC) (Psychiatrist, Discharge summary, February 11, 2016). During this investigation, Matthew's mother shared that while she had requested an assessment for Autism Spectrum Disorder for Matthew at this time, she had been informed that due to the recent death of his father and its acute effect on his current mental health, Matthew would not be assessed at that time. Matthew's mother said that the assessment that did eventually happen, which concluded in August 2016, only occurred because she "called and called and called. I got him into that appointment" (Matthew's mother, Interview, February 21, 2020).

During the course of this investigation, Matthew's mother recalled Matthew and his brother supporting each other after their father's death. She also knew that the brothers felt responsible for her. Matthew's mother told us that he started hiding "weapons" throughout the house, believing he would protect his family if needed. Matthew's mother also started reaching out to extended family and friends for support.

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Now that it was a one-parent household, Matthew's mother felt as though she had to be confined to the home in order to be able to constantly watch over Matthew.

Winnipeg Police Service was called by Matthew's mother on June 4, 2016, because Matthew was intoxicated, had armed himself with a knife and was threatening suicide. Upon their arrival, officers verbally detained Matthew under *The Mental Health Act*, transported him to HSC Children's Emergency, and Matthew was admitted to PY1 for a third time. Matthew remained in PY1 from June 4 – June 13, 2016. While in hospital, occupational therapy services conducted an assessment. They noted that Matthew had minimal motivation, irregular sleeping patterns, decreased appetite and self-hygiene, and had not participated in extracurricular activities for the past two years. A schedule was created with Matthew, which he could use when returning home. Occupational therapists noted that Matthew's main goals were to increase his engagement in all activities, such as chores, attending school, exercising, and engaging with his friends. The PY1 discharge summary noted that Matthew "...has no plans to return to school and does feel hopeless about his future" (Psychiatrist, PY1 discharge summary, June 13, 2016). Matthew was discharged on June 13, 2016, with the following recommendations:

- Follow up with MATC for therapy;
- Follow up with family doctor; and
- Follow up with addictions counselling
- Stay busy and leave the house at least once a day

The child and family services designated intake agency (DIA) for Winnipeg was contacted by a community member on June 21, 2016. Matthew's mother had disclosed that she had slapped Matthew in the face after he swore at her and called her names, although no marks or injuries were noted. Further information provided noted Matthew's mental illness diagnoses and the loss and grief the family was experiencing after the death of Matthew's father. As the DIA was preparing to follow up on this matter, they were notified on June 26, 2016, that Matthew was taken to HSC Children's Emergency by his mother due to suicidal ideation and that she was refusing to take him home. In a later conversation, it was clarified that Matthew's mother had actually been insisting on a psychiatric assessment prior to taking Matthew home as she felt unable to manage his needs during the crisis. Matthew's mother knew that Matthew needed inpatient services to address his intensified symptoms related to his mental illnesses. While the hospital staff were prepared to discharge him without a psychiatric assessment, Matthew's mother insisted that one be completed before she took him home. She recalled that, "we were dealing with the most difficult things with the least amount of help" (Matthew's mother, Interview, August 28, 2019).

Matthew was subsequently assessed and admitted to PY1 for the fourth time from June 27 to July 5, 2016. His mother reflected:

It would be around this time, it really scared me, Matthew would say, 'Mom I don't want to have those thoughts in my head but I can't stop them.' Knowing something is wrong with you but not

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having someone to help, he became despondent. He didn't care anymore, he didn't care about his own life (Matthew's mother, Interview, August 28, 2019).

The child and family services DIA intake worker conducted a home visit on July 8, 2016, and met with Matthew's mother to discuss the concern of inappropriate discipline; the boys were interviewed separately. A safety assessment was completed and the children were deemed to be safe in their mother's care. Further resources were discussed with the family and safety planning was completed. The Probability of Future Harm Assessment was completed and resulted in a score of High for reasons including: the prior reports to CFS, Matthew's mother justifying slapping Matthew, and for mental health concerns. CFS intake determined that additional service would be required and the file was transferred to for ongoing services to a CFS agency under The General Child and Family Services Authority.

Matthew had a scheduled session with the mental health clinician on July 21, 2016. He was struggling to engage with therapy and the mental health clinician decided to have their session outdoors. This approach seemed to engage Matthew more. Their next appointment was scheduled for July 27, 2016, which Matthew would not attend. It was rescheduled for the following day, but due to his deteriorating mental health and his growing inability to leave the house, Matthew did not attend the rescheduled appointment. The mental health clinician attended Matthew's home for the next and final session in August 2016. Matthew had a total of 15 sessions with this mental health clinician.

On August 3, 2016, the psychological consultation report was concluded. The clinical psychologist determined that a diagnosis of Autism Spectrum Disorder would "...neither serve Matthew well, nor really contribute to our understanding of his current struggles...he is not demonstrating sufficient adaptive impairment to warrant a diagnosis" (Psychologist, Psychological consultation report, August 3, 2016). The psychologist was able to successfully engage Matthew during the consultation, noting, "Matthew is an insightful historian about his struggles over the years with social difficulties" (ibid.). The report indicated that Matthew's depressive symptoms were persistent and proved to be resistant to treatment. Both Matthew and his mother feared that it would be difficult for Matthew to attend yet another new school in the fall, due to his many areas of struggle. It was determined that the therapist visits at MATC were not effective for Matthew, and the consulting psychologist suggested cognitive-behavior therapy (CBT) as an option, given Matthew's natural analytical abilities. Matthew and his mother agreed to the therapy change. The final report of the psychologist noted:

Matthew is describing anhedonia (inability to feel pleasure) and significant difficulties with motivation, increasingly spending the majority of his time alone...Matthew acknowledged that he is struggling with feelings of grief but that he "won't allow" himself to feel these feelings of loss as they are too painful. He understands that his attempts to "repress" these feelings is taking its toll on his mental health and likely contributing to his overall depressive state (Psychologist, Psychological consultation report, August 3, 2016).

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The CFS agency opened their protection file on August 9, 2016. The CFS worker conducted a home visit on August 16, 2016. During the home visit, Matthew, his mother, and his brother were present. According to the CFS case summary, Matthew's mother shared that Matthew (age 15) was "super smart, enjoys science, pyrotechnics, [and] computer games." She wished he could make even "one really good friend" although his mental health issues and his refusal to leave the house were key barriers to his healing. The CFS worker noted that in the meeting they spoke about the looming change in schools for Matthew the next month, and that this was causing extreme anxiety, leading to angry outbursts from Matthew. Matthew's mother shared that Matthew:

- Refused to attend school,
- Was very anxious, shut down, and angry,
- Displayed aggressive behavior,
- Was misusing prescription drugs,
- Was apathetic, and
- Displayed persistent suicidal ideation (CFS agency, Case summary, August 16, 2016).

Matthew's use of drugs and alcohol was reported to be a self-imposed effort to cope with his mental health challenges; he was refusing to talk about his father's death. Matthew appeared desperate to not feel the way he was feeling. At the same time, the family felt they had accessed every possible mental health service for Matthew and believed that the strategies recommended by the mental health professionals were not benefitting Matthew. During this investigation, his mother described to our office that:

Matthew hated it. He started to see the toll it was taking on his brother and I, and he felt terrible about it. It even lowered his self-esteem to where he would say "I'm ruining everything." He would say "I'm ruining your house" (Matthew's mother, Interview, December 10, 2019).

The CFS worker offered a family support worker (FSW) as one-to-one support for Matthew, and this service was accepted. The CFS worker observed a strong and healthy bond between the brothers and their mother; they were open and transparent about their lives. No protection concerns were evident. Matthew spoke about his thoughts of suicide and stated that he did not know where these suicidal thoughts came from. Matthew agreed to work one-on-one with the FSW two times per week. The focus would be on engaging Matthew, and to support the family during their time of loss and grief. According to CFS file recordings:

Matthew's mother felt like her family was "given up on" by many agencies and institutions that were supposed to support them. She felt a sense of hope after meeting the family support worker, that she had not felt that way in a long time (Child and family services, File recording, October 26, 2016).

Near Total Disengagement

Grade 11: 2016-2017 (Age 15-16)

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Matthew's final 14 months of his life were marked by a further, significant decline. Matthew did not attend school, rarely left the house, and he said that he found it hard to think about the future. He spent significant time sleeping and was losing weight, due to not eating. As Matthew disengaged completely from school, division supports, and MATC services, the CFS-assigned FSW was actively involved with Matthew and his family. Providing long-term services was the family support worker goal, as long as it benefited the family.

As Matthew prepared to attend the new school, due to his switch from French immersion to English programming, Matthew's mother was notified of the student support services available to Matthew at his new school. These supports included an AFM school-based counsellor, school division psychology, and an in-school anxiety support group. She was informed that the school division social work department would also offer support to Matthew and his family, regardless of whether he attended school. Matthew and his mother looked into whether Matthew could enroll in distance education so he could work on his courses from home. From September 2016, until February, Matthew's school records reflect that he was absent 73 days, was parentally excused 3 days, and attended only on two days. When we met with Matthew's mother, she stated that the school record here is incorrect. She said Matthew never attended any classes at the new school and the two times he was present at the school included an introductory meeting during the summer and one occasion where he had a tour of the school building (Matthew's mother, Interview, February 21, 2020). His mother explained: "There was no way I was going to get that kid to go to a brand new school. It would have been beneficial for him to continue at [his previous high school]" (Matthew's mother, Interview, August 28, 2019).

Cognitive behavioral therapy (CBT) at MATC started for Matthew in September 2016. The plan was for him to undergo weekly individual sessions with the clinical psychologist, while Matthew's mother would remain involved with the MATC mental health clinician. When we met with Matthew's mother to review this information, she said it was surprising to hear it described as though MATC was offering her support as well. She shook her head and informed us: "I would just sit in the hall while he had his appointments" (Matthew's mother, Interview, February 21, 2020). At his October 18, 2016, session with the MATC therapist, Matthew spoke about his experiences of being bullied and his perception that he felt the school had left him to deal with that largely on his own (MATC-CCAT, Integrated progress notes, October 18, 2016).

On October 26, 2016, the CFS worker met with Matthew and his mother at the family home. The meeting had been arranged as a check in and also to introduce Matthew to the new CFS family support worker (FSW), who had been assigned to work one-on-one with Matthew. Matthew was having a hard day, having not slept well after reportedly being suicidal the night before, which his mother reported had not happened for some time. The CFS worker asked what had triggered the feelings of suicide and Matthew, laying on the couch, wrapped in a blanket and with his face covered with his hands, was unable to articulate what may have been the trigger for him. The CFS worker documented that:

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Matthew minimized the issues of the previous night, and stated that it is not a big deal. [Matthew's mother] spoke to Matthew very appropriately and stated that it is a big deal and that she takes those statements very seriously.

The CFS worker further noted:

Matthew spoke openly about his struggles with anxiety and his fear of returning to school one day. [Matthew's mother] continued to point out the positives to Matthew, in that he may not be going to school but he also hasn't been to the hospital in several months and his medication seems to be making a difference in his overall demeanor. Matthew agreed that there have been improvements in the last few months. This worker inquired as to what is done in the moments where Matthew's depression becomes unmanageable for him. [Matthew's mother] stated that they have a close relationship, where they can talk things through, but she knows if it gets to certain point she has to take him to the hospital. Matthew nodded (CFS worker, Case summary, October 26, 2016).

The FSW arrived at the home and joined the family meeting. They described what they did, that their role was to build a relationship with Matthew and the family in order to support the youth and help to reintegrate the youth to school. The FSW acknowledged that the anxiety had caused Matthew to disengage from school and that a goal would be to help Matthew overcome the anxiety in order to return to school.

The next morning, Matthew was in crisis. Winnipeg Police Service, and the mobile crisis team were contacted by Matthew's mother in the morning of October 27, 2016. Matthew had taken an unknown substance and required medical attention. His mother reported to attending personnel that she thought Matthew may have drunk a bottle of rubbing alcohol and swallowed Lorazepam; Matthew admitted to having broken into the locked medicine cabinet. Matthew appeared intoxicated, was unable to walk on his own, was uncooperative, verbally abusive, and was threatening suicide. He was transported to HSC Children's Emergency via ambulance and released the same day. Matthew's mother spoke with the clinical psychologist about the series of events and her concern for Matthew's safety. Safety planning was discussed with Matthew's mother, which included limiting Matthew's access to medication and other chemicals, utilizing emergency services, and observing Matthew for any concerning changes. A follow-up appointment with the clinical psychologist was scheduled.

Between September and December 2016, Matthew attended three sessions with the clinical psychologist. Though his motivation to attend these sessions was low, Matthew reported to the psychologist that the sessions were helpful as he was able to talk about his thoughts, rather than "internalizing a bunch of stuff" (Psychologist, Integrated progress notes, November 1, 2016). Eventually he refused to attend and informed the clinical psychologist that he only went due to his mother's insistence.

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A suicide risk assessment was conducted by the clinical psychologist during the November 1, 2016 session, with the risk factors listed as:

- Ongoing suicidal ideation for the past four months;
- A history of severe “unipolar depression” (extremely low mood);
- Feelings of purposelessness and apathy;
- Socially withdrawn; and
- Impulsive behavior, including substance misuse (Psychologist, Integrated case notes, November 1, 2016).

The psychologist documented that Matthew's protective factors at this point were minimal. Matthew did understand that death was final; he had some attachments to life and he denied suicidal intent. The treatment plan included monitoring Matthew's suicidal ideation, improving his depressive symptoms, and developing realistic and adaptive thinking patterns surrounding suicidality.

On December 2, 2016, at Matthew's mother request, the CFS-assigned FSW, Matthew, and his mother attended what would be the final session with the clinical psychologist. Matthew first met alone with the psychologist, who would later write that Matthew and the psychologist had made a “mutual decision” to discontinue treatment, with the documented reason being Matthew's unwillingness to attend sessions. Case notes from the session do not describe what specifically was discussed, how the decision to end treatment was made, whether sessions at the family home were an option or what role Matthew's debilitating anxiety about leaving his house may have played in his presentation in the discussion. However, the family support worker, who had attended this final session wrote that when Matthew emerged from the room, he “...looked visibly agitated and possibly angry” (Family support worker, Daily contact notes, December 2, 2016). The MATC closing summary noted:

Matthew became emotional to the point of tears in a few instances during the final interview. He reported that he had not experienced such feelings in over three months. In his assessment, [the HSC psychiatrist] indicated that Matthew self-reported 'repress(ing)' his feelings of grief and emotional pain. At this time, however, Matthew is not prepared to willingly address these feelings through therapy, despite the impact they appear to be having on his current mental health. It was suggested to [Matthew's mother] and their assigned Family Services Worker to gently encourage his motivation for therapy while supporting his autonomy. [Matthew's mother] and Matthew are aware of the resources available in case of crisis or emergency. File to be closed to CCATS with understanding that if further support needed family may contact the clinicians within the next year or they may contact Centralized Intake thereafter (Psychologist, MATC-CCATS closing summary, February 28, 2017).

CFS: The Only Service that Remains Active

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During Matthew's final year of life, the FSW met with Matthew and his family on 80 separate occasions. Over time, a professional relationship between the FSW, Matthew, and his family developed and was strengthened. The FSW quickly identified Matthew's strengths and realized that, "if Matthew didn't see purpose in something, he didn't do it" (Family support worker, Interview, August 27, 2019). The FSW noted that Matthew had a hard time trusting and opening up to people, describing Matthew as stubborn, strong willed, and intelligent. The FSW believed that if Matthew would apply himself academically, he would find school easy and this would open up any future path he wished to follow. The FSW also saw that Matthew was both loving and caring; they bonded over talking about world issues and internet memes. On occasion, when Matthew would not engage with the family support worker, the FSW remained committed and patient as a consistent presence in the family home. Matthew progressed from calling the FSW his "mandatory acquaintance" to calling the FSW by their name. The skillful and meaningful approach taken by the FSW allowed for a respectful and reciprocal relationship, and opened the door to address the daily challenges that Matthew faced.

The relationship between Matthew and his assigned FSW was a bright point for his mother. During the course of this investigation, she shared that:

The discussions Matthew and [the family support worker] had were so philosophical. [The family support worker] was the one consistency...Just the consistency of [the FSW] coming, whether Matthew wanted [them] to or not took the pressure off Matthew. I think if it had not been for [the FSW] things would have ended sooner for Matthew...At least I knew I had someone who knew and understood my kid and how awesome he was, which no one else got (Matthew's mother, Interview, August 28, 2019).

And she continued:

...[The family support worker] came into our home environment without judgement or preconceived ideas. [They were] the only one that got the real picture of what our life was like. There was no ulterior motive to it, it was the one dependable thing. I knew [the FSW] was coming twice a week and at what time. That was the only schedule in my life (Matthew's mother, Interview, December 10, 2019).

Matthew's mother felt that the FSW had the best chance of making a positive impact on Matthew's life. On the days where Matthew was resistant, the FSW would stay at the house and check in and plan with Matthew's mother and brother. Matthew's mother felt pressure to stay at home if she felt that Matthew was not making progress. She and the FSW would talk about her own mental wellness and how she needed to care for herself as well under the circumstances. Since the existing mental health services in Manitoba were not helping Matthew, his mother started exploring other treatment options for Matthew that would entail him leaving the country.

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Matthew continued to struggle with poor hygiene, not eating, not conversing, staying in bed, having a quick temper, refusing to leave the house, being verbally abusive, and refusing medication. And yet, in other moments, Matthew and the FSW would talk for long hours. The family would share stories about the memories of their father and of their travel adventures. Good moments for Matthew included Matthew opening the front door to welcome the FSW, engaging in difficult conversation, eating, attending family dinners, venturing outside the house, and confiding in the FSW.

"No professional would tell me what to do. It was a terrible feeling. Even [the family support worker] would do research and call around and there really was nothing."
- Matthew's mother, Interview, August 28, 2019

Since Matthew was not attending school, distance learning became his educational plan. At the school's encouragement in January 2017 to apply for funding approval, Matthew's mother provided a physician's note to the school division identifying Matthew's need for distance learning. Despite their knowledge of Matthew's unique mental health barriers to attending school, the school division did not approve the funding and Matthew's mother had to pay for the course work. In a meeting with the FSW, Matthew's mother was noted to have shared that the school division told her that despite the doctor's note saying Matthew could not attend the school due to anxiety and depression, the school would not cover the costs of him completing coursework from home. The FSW wrote:

Divisions typically believe that they can offer the courses through the school and an alternative delivery format, and therefore the student does not qualify or not being physically able to attend. [Matthew's mother] expressed her frustration with that, saying that the school didn't do anything to help her with Matthew and provide options. She said they don't seem to care that Matthew isn't attending and haven't offered anything to support (Family support worker, Daily contact notes, March 1, 2017).

The CFS agency worker conducted regular home visits and assessed that in spite of Matthew's mental health challenges, the family dynamics were healthy and functional. Matthew's mother was a strong advocate for her children, had a supportive extended family, and worked hard to meet their needs; child protection issues were never noted as a concern by the agency. Matthew's mother felt the child and family agency worker was supportive and understood her family. According to her:

[The CFS agency worker] was really great, very helpful, understanding, felt for Matthew but also for me and [Matthew's brother]. [The CFS worker] always asked if [they] could do anything. [The CFS agency] service was wonderful. It was supportive, it wasn't punishment. (Matthew's mother, Interview, August 28, 2019).

By February 2017, Matthew had decided he would not be going back to school until the fall. Over that spring and summer, contacts with Matthew described him increasingly withdrawn from everyone around him. He

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spent significant time sleeping, rarely left the home, and refused to discuss topics like school or future planning. He was not receiving any therapy.

The distance education materials arrived in April 2017. In a conversation with the FSW, Matthew's mother expressed her growing desperation with the family's situation, noting, "I can't keep living like this, with him bullying [mom], threatening to harm himself, trying to numb himself with drug and alcohol, refusing to seek help, and not being able to leave him at home alone" (FSW, Daily contact notes, April 5, 2017).

Matthew's mother called the MATC psychologist on June 28, 2017, requesting help for Matthew. According to the psychologist:

She said he has not attended school for over a year and spends the majority of his time reading on the internet or sleeping. He has no plan for his future according to [Matthew's mother]. He is ambivalent about getting any help or seeing a therapist. He takes Wellbutrin and Celexa but the medication doesn't seem to be helping. He has intermittent suicidal ideation and [mom] has taken Matthew to HSC Children's Emergency for suicidal ideation (Psychologist, MATC integrated case notes, June 28, 2017).

A clinical appointment was offered for July 12, 2017, with the psychologist also discussing an emergency session, if Matthew was expressing suicidal ideation. The July 12, 2017, appointment was rescheduled to July 17, 2017, due to Matthew refusing to attend. On July 17, 2017, Matthew's mother called the psychologist to cancel that appointment as well as Matthew was refusing to attend. According to the FSW case notes, Matthew "...refused to go to the second appointment and said he was not fixable and they wouldn't be able to help anyways" (Family support worker, Daily contact notes, July 19, 2017).

Matthew's mental health continued to deteriorate and by late August, his mother told the FSW that Matthew had been off his medication for at least two weeks. Matthew's mother told the FSW that "...Matthew is only wearing his dad's t-shirts now, he no longer wears his" (FSW, Daily contact notes, August 23, 2017).

Through September, Matthew had a few good days. His mother knew he was using cannabis and spoke about being able to accept that, if it helped his mental health, even as she spoke about knowing the risks associated with growing brains and cannabis use. She indicated she planned to speak to Matthew's pediatrician about this. By October, Matthew's mental health was declining again, and in a text to the FSW, Matthew's mother stated, "things weren't good lately. Matthew's been really down. Was talking about wanting to be dead again. I'm at a loss" (Family support worker, Daily contact notes, October 4, 2017).

Events Prior to the Death of Matthew

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The FSW's last visit with Matthew, occurred on November 3, 2017, and according to contact notes from the appointment, Matthew was very adversarial towards the worker. Matthew questioned the FSW's motives for spending time with him, and stated that he did not want anyone in his life. Matthew's behaviour towards the FSW was noted as unusual for him and the FSW felt that perhaps Matthew's outburst was an indication that Matthew felt more comfortable with him. The worker shared with us:

My last time seeing Matthew was difficult. He had been refusing to take his meds, sleeping a lot...He was very mean to me...No matter what I said, he came at me full force...I took it as one step closer to connecting with him (Family support worker, Interview, August 27, 2019).

Matthew's mother stated that things seemed normal for her family in the days prior to Matthew's suicide death. Matthew's mother recalled that the day before Matthew's suicide, she listened to her sons "giggling like kids." Matthew and his brother had been sitting in the living room looking at memes on the internet together. Later that evening, Matthew's maternal grandparents came over to their home for a visit. Matthew's maternal grandfather spent a lot of time talking with Matthew, as Matthew was expressing that he did not want to live anymore.

The morning of November 8, 2017, Matthew came into his mother's bed to spend time with her. They spent time talking and Matthew showed his mother funny things on his computer to make her laugh. Matthew knew that his mother had a meeting that day with the family support worker. She got ready, and left the home at 2:00 p.m. When she returned, approximately 90 minutes later, she found Matthew hanging in the house. She cut him down and called 911. Matthew was transported to HSC Children's Emergency, where he was put on life support in the Paediatric Intensive Care Unit. Matthew had suffered major brain damage. His life support was eventually discontinued and he died on November 9, 2017, with his family by his side. Matthew was 16 years old.

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A Mother's Call to Action

The following was written by Matthew's mother and posted on social media, January 31, 2018, two months after Matthew's death. It is reprinted here with her permission.

It's time to get real when discussing mental health today. Awareness is great. Talking about it is great. These are all positive steps towards ending the stigma of what is essentially a disease of the mind. What's not so great is the lack of mental health services available once you have decided to be brave and say "Let's Talk".

Matthew was clinically diagnosed with Major Depressive Disorder and Generalized Anxiety Disorder in 2014. In the next three and a half years we frantically tried everything to help our dear boy battle the destructive thoughts his struggling mind was dealing with. Constant meetings and encounters with school administration, teachers, psychologists, psychiatrists, counsellors, addictions support, doctor visits, mobile crisis teams, Winnipeg Police Service, CFS, social workers, family support workers, at least 6 visits to Children's Hospital ER (many by ambulance), and 4 Psychiatric hospital admissions when his invasive suicidal thoughts got to be too much for his diseased brain to handle. We tried 5 different antidepressant medications and combinations thereof to no avail. They just weren't working on his growing brain.

We watched his health decline, we saw him isolate himself, act out at school and at home, seek out the temporary fix of marijuana, pills and alcohol to numb and escape his feelings of despair. Eventually he wasn't able to attend school at all and required what basically amounted to round the clock supervision. We felt helpless, angry, confused, afraid, panicked, trapped, alone, and yes...ashamed. We weren't the kind of family that this was supposed to happen to; Matthew wasn't the kind of kid that this was supposed to happen to. Bit by bit we watched our happy, ever-so-clever, inquisitive, hilarious, bright-eyed boy disappear right before our eyes. It was every parent's worst nightmare.

Despite all our efforts, what Matthew truly needed was in-patient care to deal with his depression, anxiety, history of bullying, PTSD, grief, substance abuse and invasive suicidal thoughts. He needed round the clock care to ensure he ate, drank, got out of bed, interacted with people, went to appointments, showered, took his medications, and most importantly, didn't harm himself.

Now here's the unbelievable part. We live in Canada, which has one of the best health care systems in the world, right? Talking about mental health no longer carried the stigma it once did, right? We are encouraged to talk about it and seek help. We did everything we were supposed to do. So what do we do when everything else fails? What if this disease of the brain is so severe that the person suffering with a mental health problem runs out of hope and refuses all treatment? The answer should be simple, he needed in-patient care. **THERE WAS NO IN-PATIENT CARE AVAILABLE ANYWHERE IN CANADA TO DEAL WITH PATIENTS LIKE MATTHEW.** None, not anywhere. No one could tell me what to do to help Matthew long term. There was nothing...just nothing...

I am sharing Matthew's story today because I don't want his death to be the end of his journey. In his memory, I am motivated to make people aware of and fix the giant holes in our mental care system. Holes that are big enough to end lives and shatter families...My fight for mental health care is far from over...

Findings, Themes, and Recommendations

Bullying had a profound impact on Matthew

FINDING: Matthew experienced profound bullying throughout junior high that severely impacted his ability to attend, participate, and feel safe at school.

During our investigation, the arc of Matthew's story became clear. He had been a bright and curious young child, noted to sometimes over-socialize in class, but he was a happy child who loved science. In his later elementary years, his medical file noted that he had physical health problems, for example, a curvature in his spine and that he was awkward in his movements. His parents wondered if Matthew might have been on the spectrum for Autism and asked doctors to formally assess him; he was described as someone who did not interpret social cues in the same ways as many of his peers.

Social isolation and bullying began, in earnest, when Matthew (age 11) changed schools and entered Grade 7. We are unable to identify what specifically may have made Matthew such a target for his peers, but it is not hard to imagine that a child managing things that may have made him appear different from other students could have set him apart and created social barriers to him easily merging into a new peer group. Matthew shared with a therapist on July 23, 2014, that the bullying had been a daily occurrence and had been ongoing since he refused to give money to another student for a burger at McDonald's. Matthew believed his school was aware he was being targeted, but had not intervened in a way to make the bullying stop. Matthew was prescribed an antidepressant for his anxiety beginning in Grade 7, but things continued to worsen over the years.

From Grade 7 and through Grade 9, Matthew lived through a heartbreaking level of torment from what appeared to be a small group of peers most often, but also involved others at times. Matthew told a therapist after his Grade 8 year that, "9 or 10 kids had told [him] that he should kill himself" (Therapist, Clinical case notes, June 27, 2014). The bullying continued to get worse. Matthew felt unsafe at school and in the community and told many adults about what was happening. While several adults in his life documented the abuse he was facing, interventions seemed focused on Matthew: offering him more counselling, offering safety plans, and offering to walk him off school grounds at the end of the day. What was missing in the documentation, in our review of numerous files, was any description of what the school may have been doing to decisively address the bullying. We found no evidence that the group of bullies and Matthew were assembled to participate in any group dialogue; we saw no evidence that parents were called together to help stop what was happening among the children. During this investigation, our team met with personnel from the education system who had known Matthew during junior high and the time when the bullying was most severe. They informed us that although the details would not appear in Matthew's files, the school had been working with Matthew's bullies in an effort to intervene in the situation (School personnel, Interview, January 31, 2020).

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Over time, and while informing people that he did not feel safe at school, Matthew began to fight back. He spoke in threatening ways to other students at school and online. He armed himself with a box cutter at school. These negative choices resulted in suspensions for Matthew. In his final month in Grade 9, another knife was discovered hidden in a classroom, and school staff wondered if it was Matthew's; mention was made that one of his bullies had recently returned to school after having been suspended. School staff thought Matthew might have felt the need to protect himself. By this time, Matthew had been formally diagnosed with Generalized Anxiety Disorder and Major Depressive Disorder. Matthew had also begun to use alcohol and cannabis to self-medicate. As well, files indicate he engaged in cannabis use to try to fit in with his peers. Our office saw a number of incidents where Matthew's behaviour could be logically explained as a child who felt like an outsider trying to be accepted by his peers. One such example was witnessed by school staff in spring of 2015, when they saw Matthew "...attempting to high-five" his bullies (School division psychology, Case notes, March 20, 2015). At the end of Grade 9, the plan was for Matthew to change schools and knowing that he continued to be a target for other students, his junior high and senior high schools worked together and spoke about class lists to ensure Matthew would not have to share a class with his bullies.

In grade 10, although the bullying seemed to be over now that Matthew was in a different school, his sense of self and security was already severely damaged. He was disengaged, often absent from class, and his anxiety became debilitating. Often refusing to leave his house, his suicidality became more persistent, and the mobile crisis team along with other emergency response personnel were frequently called to assist and help keep Matthew safe. Although Matthew's death occurred two years after he finished junior high, his story reflects ample evidence that the bullying he experienced there and his feelings of being left to manage those dynamics alone certainly altered the trajectory of his life and eventual death.

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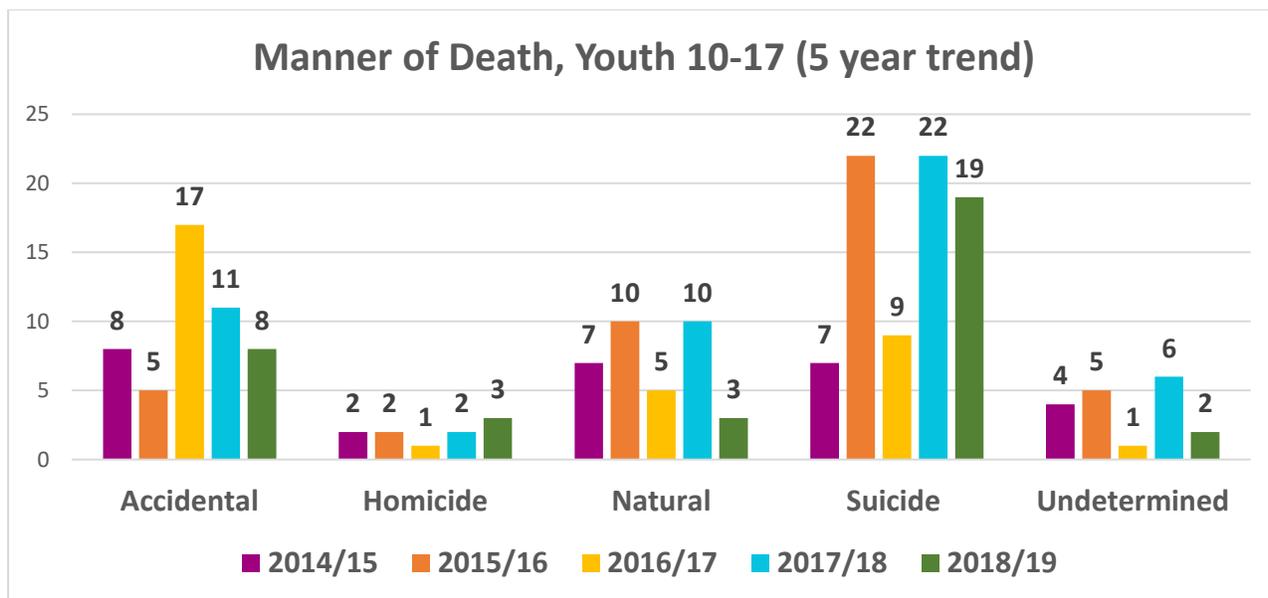
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Manitoba schools have an important role in combating bullying

FINDING: The education system provided student support services to Matthew as a response to his mental health and substance use concerns. These interventions did not address the bullying or create the necessary conditions for Matthew to feel a sense of safety and belonging in his school environment.

According to data collected by the Manitoba Centre for Health Policy (2016), 14 percent of children in Manitoba have been diagnosed with at least one mental disorder, with 8.3 percent of children being diagnosed with behavioural disorders including addictions and 7.3 percent of children being diagnosed with mood and anxiety disorders.

The Manitoba Advocate for Children and Youth has held the responsibility for investigating the deaths of children since 2008. As such, for more than a decade, our office has collected robust data on the deaths of young people in our province. **Of concern, our data show that suicide is the leading manner of death for youth aged 10-17 in Manitoba.** In the previous five years alone, 79 youth have been lost to suicide death in our province, as shown in the chart below. In response to these concerning numbers and the knowledge that each suicide represents wide impact on the youth's family, peer group, and community, our office launched *Phase Four* of our ongoing suicide study. The Manitoba Advocate opened individual investigations on 22 girls who died by suicide in our province and the aggregated report examining those 22 deaths will be released publicly by the Manitoba Advocate in the coming weeks.



These data suggest that many children are in significant distress and increased support is needed to promote mental health and wellness in young people. Given that children and youth ideally spend

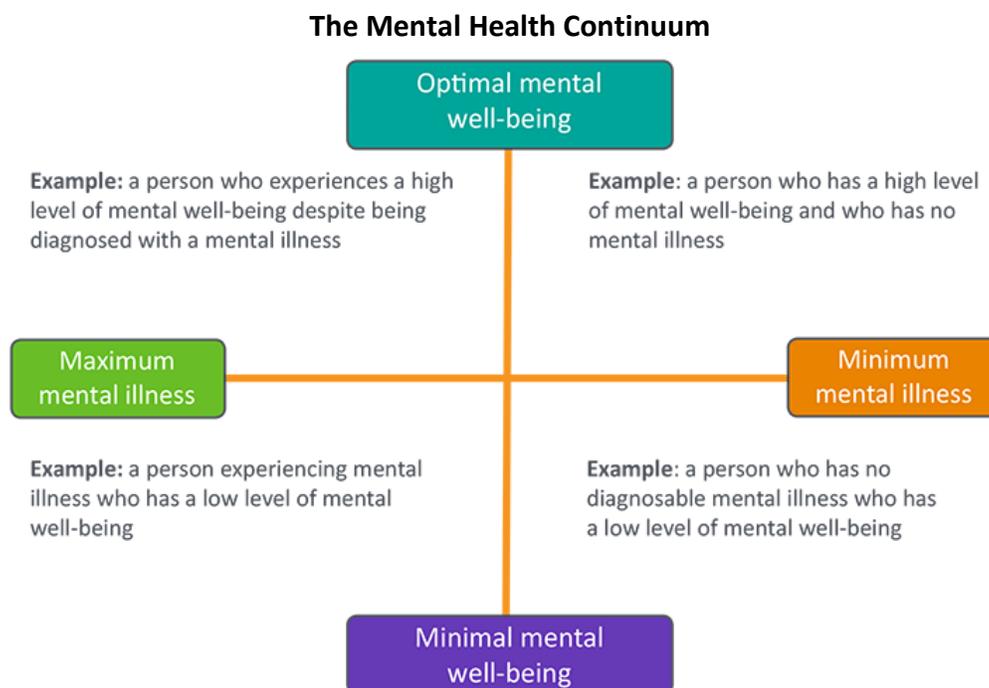
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significant portions of their days in educational programs and schools, wise investments can be made into the education systems to embed mental health and wellness into the lives of young people.

Mental health and mental illness are not simply at opposite ends of a single spectrum. Children and youth diagnosed with a mental illness can still have ideal levels of mental well-being, while those without a diagnosed mental illness can show nominal levels of mental well-being. Mental health is best understood on a continuum, where people can move among states of mental well-being regardless of mental illness. They can thrive or deteriorate, depending on individual functioning, social well-being and mental health issues. The concept highlights that mental health is not simply the absence of mental illness and it is possible to have optimal mental well-being while living with mental illness.



Source: www.togethertolive.ca/mental-health-continuum

It is known that children and youth who struggle with maintaining optimal mental wellness and those who live with mental illness are more likely to have difficulty forming and maintaining relationships with others. They also are more likely to struggle in their school environment. The school setting has an important role to play in promoting mental health and wellness from an early age. As noted by Healthy Child Manitoba (n.d.):

Schools are an ideal setting in which to promote mental health for children and youth, providing an opportunity to reach large groups of children during their formative years of cognitive, emotional and behavioural development (p. 2).

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It is also important that the service providers within this setting receive adequate education and training in order to recognize when a student is struggling with their mental health and, in turn, have the capacity to intervene in a positive and effective manner.

From an early age, Matthew struggled in school. Although he was academically proficient, he struggled with his social skills. He recognized that he was different from other students and had difficulty connecting with staff and peers. For young people who struggle with thoughts of suicide, connection to school and supportive adults has been identified as an important protective factor against suicide (B.C. Coroners Service Death Review Panel Report, 2019). In Grade 8, Matthew began to show signs of disengagement. As his absences increased, he was not submitting all of his assignments and his grades began to decline. According to Matthew's mother, the junior high school did not appear to recognize Matthew's struggles as worrisome. She shared with our office that she felt there were other students with higher needs and that was where the school focused their attention, even though Matthew was chronically bullied, did not have many friends, did not fit in and was socially isolated (Matthew's mother, Interview, August 28, 2019). Matthew's education records suggest that one objective of their involving the school division psychology was to reach out to Matthew's mother to address "some strained relationships b/w school – mom" (Psychology, Continuous recording report, January 12, 2015). The school had an important opportunity to recognize that Matthew was at a low level of mental wellness and then intervened with appropriate school supports to facilitate him feeling safe and connected to his school.

As Matthew moved from junior high to high school, this lack of connection intensified and led to increased disengagement with the school community overall. In Grade 9, Matthew (13) did get the school's attention, due to inappropriate conduct and Matthew received his first in-school suspension after he punched a student who had made fun of him for dropping his phone. According to school division policy, suspensions are utilized when other disciplinary measures have proven ineffective or when a student's behaviour disrupts or endangers others (Matthew's school division, Policy on student suspensions and expulsions, April 17, 2018). The policy noted that in-school suspensions offer a structured, supervised educational environment "with restricted contact with their peers" (Matthew's school division, Policy on student suspensions and expulsions, April 17, 2018, p. 4). This response is contrary to what is known about restorative work and promoting a positive school environment. The Manitoba Education *Provincial Code of Conduct* (2017) comments on schools utilizing restorative practices to develop a sense of community and to manage conflict "by repairing harm and building relationships." Alternatives to suspension are also noted in the provincial *Code of Conduct*, including: informal discussions, behavioural contracts, meeting with a school counsellor or involving student services. While Matthew's behaviour towards the other student was unacceptable within or outside the school setting, there was no documentation of the school utilizing alternative measures to maintain Matthew at school and support him in reconnecting with his peers and the school community.

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A few weeks later, Matthew was involved in another incident with a group of peers. It was determined by the school that Matthew and these peers had exchanged messages over social media and that Matthew had made threats online. That week at school, Matthew went to the school office to report that he was being followed by a group of students and they were attempting to engage him in an altercation. School staff interviewed the other students and it came to light that Matthew had made threats of fire-bombing one of the students and attacking that student with a knife, according to online communication that was shown to school staff by the other students. As a result, Matthew was searched and a weapon was found in his possession. Matthew was an intelligent individual and would have understood that bringing a weapon to school would be against the rules. His decision to bring a weapon to school speaks to how unsafe and insecure he was feeling at the time. As a result of this incident, Matthew received his first out-of-school suspension. Research has suggested that punitive discipline strategies such as out-of-school suspensions are not associated with increased school safety, a reduction in bullying, or a decrease in violence (Bullying and School Climate, no date). This research also suggested that suspensions and expulsions “engender feelings of mistrust and a negative school climate” (Bullying and School Climate, nd). The Joint Consortium for School Health, of which both Manitoba Education and Manitoba Health, Seniors, and Active Living are members, issued a report (Joint Consortium, 2010), which noted that suspensions and expulsions do not tend to create safer school settings, and that students tended to demonstrate the same or more severe behaviours upon return from suspensions.⁴ This was the case with Matthew, who received two additional out-of-school suspensions over the next two months due to incidents involving substance possession and use. This punitive approach did not help Matthew connect with his school community or address the pervasive bullying that continued to escalate.

As highlighted in the Manitoba Advocate for Children and Youth's report, *Documenting the Decline: The Dangerous Space Between Good Intentions and Meaningful Interventions* (2018), out-of-school suspensions have been identified as risk factors for other negative outcomes, including poor academic achievement and school dropout. We highlighted this issue again in *A Place Where it Feels Like Home: The Story of Tina Fontaine* (2019b). In both special reports, the Manitoba Advocate issued formal recommendations to the government to examine their school suspension and expulsion policies and to create a strategy to limit, restrict, and phase-out exclusionary practices, except in situations of imminent safety risk to students and staff. In January 2019, Manitoba Education announced a comprehensive review of its K-12 system and received as part of its mandate instruction to meet with our office to discuss the recommendations which had been issued to the government on the issues of suspensions

⁴“The Pan-Canadian Joint Consortium for School Health (JCSH) was established by provincial, territorial, and federal governments in 2005 as a means of bringing together two large systems – Education and Health – across the country in order to combine strengths for the wellness and achievement of children and youth in the school setting” For more information on the JCSH, see: <https://www.jcsh-cces.ca/about-us/>

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and expulsions. The K-12 education commission requested a meeting with the Manitoba Advocate, the first of which occurred in June 2019. At that initial meeting, our office presented extensive research and other materials that focused on themes of:

- The rights of children to equitable and inclusive education
- Previous special reports from our office and their education-specific recommendations
- Chronic and severe absenteeism
- Suspensions and school drop-out rates
- Education access for children with disabilities and behaviour concerns
- Barriers to school enrollment
- The importance of meaningful youth consultation in the commission's work

Following this initial meeting with our office, the K-12 education commission accepted our offer to arrange a meeting for them to hear directly from the Manitoba Advocate's Youth Ambassador Advisory Squad (YAAS!). The members of the commission attended a focus group with members of YAAS! in July 2019, and were provided with direct accounts of what the youth feel needs to improve within schools and more broadly within the system of education. Among several issues raised by YAAS! were those of youth needing more support at school when things in their lives are difficult. YAAS! members emphasized that when a young person is struggling with regular attendance, what can sometimes help them get back to school is knowing that someone there cares about them. They highlighted the importance of supportive staff-student relationships and that adults in schools do not always know how to identify the students who are struggling with their mental health or their feelings of belonging.⁵

This was identified as an important issue for Matthew. He would eventually be referred to the school division psychologist; however, by the time the psychologist was involved with Matthew, he had lost all trust in the school's ability to keep him safe. Matthew attended one-on-one sessions with the psychologist to discuss his thoughts and feelings towards the school; however, any attempts to reengage Matthew with his school community was met with resistance and negative responses. In April 2015, Matthew was slapped by another student hard enough that it left a mark on Matthew's skin. Although a school meeting with Matthew and his mother was suggested to develop safety plans, Matthew's mother declined the offer of a meeting, saying it would be unnecessary because Matthew had lost trust in the school. The following week, Matthew disclosed to the school division psychologist that a group of students had issued physical threats against him, including comments to Matthew about "finding themselves a body" (School division psychology, Case notes, April 10, 2015). Even in response to situations like this, we were unable to find evidence of an elevated intervention by the school or division.

⁵To read the Manitoba Advocate's formal submission to the Manitoba Commission on Kindergarten to Grade 12 Education, please see this link: [https://manitobaadvocate.ca/wp-content/uploads/2019-06-18-_MACY-Submission to K-12 MB Education Commission.pdf](https://manitobaadvocate.ca/wp-content/uploads/2019-06-18-_MACY-Submission%20to%20K-12%20MB%20Education%20Commission.pdf)

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Manitoba schools have access to comprehensive school health materials, which acknowledge that schools have “the potential to contribute positively to students’ positive mental health” (Joint Consortium for School Health, 2010). This supporting document, *Safe and Caring Schools: A Whole School Approach to Planning for Safety and Belonging* (Manitoba Education, 2017) describes that promoting students’ safety and well-being at school includes providing school-based mental health services and suicide prevention and intervention services (Manitoba Education, 2017). One important pillar of this document considers the importance of healthy school policies, including discipline policies that are designed to connect with youth and address issues in more holistic ways. Such positive discipline strategies were identified as an increased focus on developing rapport and strong working relationships with students, using restorative approaches to keep students engaged with the school, developing behaviour contracts, and using solution-focused or motivational interview to identify issues and plan for resolution (Joint Consortium for School Health, 2010). The pathway for addressing Matthew’s school struggles did not demonstrate an understanding that he was a victim of school-based violence (read: bullying) that was building insurmountable obstacles for his ability to function in school. Instead, the interventions from the education system reflected a punitive and reactionary approach. This approach did not facilitate a positive connection to school with supportive adults, and as a result, Matthew’s right to an education in a safe and supportive environment was not met.

During this investigation we asked Manitoba Education about the support document titled *Safe and Caring Schools: A Whole-School Approach to Planning for Safety and Belonging* (Manitoba Education, 2017). “This support document is based on current research and evidence-based practice in planning for and sustaining positive, health, and safe schools, and has been developed to:

- Apply a whole-school approach in planning for safety and response
- Provide steps to develop a safe and caring school plan
- Share tools, research, and resource links
- Support existing school and/or school division planning, initiatives, and expertise” (Manitoba Education, 2017, page 4).

Department representatives informed us that this document is an update from previous work in the area of anti-bullying and is widely distributed throughout provincial school divisions. In addition, the department has hosted regional training sessions to school divisions as well as professional learning sessions. Summer sessions have also been provided as part of its continuing professional development for educators. The Department of Education informed us that the framework is well-received province-wide and there have been requests outside of Manitoba from other jurisdictions which hope to use it. The department also noted that while it is well-received and provincially-supported, it is a support document that is not mandatory for use (Department representative, Interview, February 12, 2020).

In November 2019, during the course of this investigation, we met with Matthew’s school division and asked them about current efforts toward mental health and wellness of their students. School division

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representatives explained that the approach includes efforts to reduce the stigma of mental health challenges or mental illness. They shared with us that under the umbrella of the division, each school uses universal, targeted, and individualized programming to promote prevention and provide good intervention with respect to good mental health. Staff further informed us that mental health promotion information is embedded in health classes, and that some of the programs and approaches used include the *Zones of Regulation* and *Project 11*. At a division level, they described an active mental health committee, which consults and plans for student and staff wellness (School division representatives, Interview, November 7, 2019).

RECOMMENDATION ONE: Promote mental health in all K-12 classrooms

The Manitoba Advocate for Children and Youth recommends that Manitoba Education, in conjunction with Manitoba school divisions, highlight and promote the provincial learning objectives that focus on mental health literacy and mental well-being coping skills for all students from Grades K-12. Secondly, Manitoba Education and Manitoba school divisions should ensure that training is available to all teachers that will support and facilitate their classroom skills in mental health promotion.

RECOMMENDATION TWO: Stop suspending and expelling when safety is not an issue

The Manitoba Advocate for Children and Youth recommends that the Department of Education, with participation from all school divisions, develop a province-wide policy to limit, reduce, and phase-out exclusionary practices, except in situations of imminent safety risk to students and staff. This policy should provide evidence-informed disciplinary alternatives that are in line with the best interests of the child and respect the right of children and youth to education.

RECOMMENDATION THREE: Create and promote safe and caring schools

Safe and Caring Schools: A Whole School Approach to Planning for Safety and Belonging is a valuable tool created by the Department of Education and is an example of best practices for creating positive school environments. The Manitoba Advocate recommends that Manitoba Education continue its work to promote these supporting documents with Manitoba school divisions because all schools in Manitoba should be implementing the optional tools in the *Safe and Caring Schools* supporting documents.

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Suicide risk factors are important in determining the level of support a youth needs

FINDING: Matthew exhibited eight known risk factors for suicide.

As noted above, suicide is the leading manner of death for Manitoba youth. Suicide is a complex issue. Many different situations and experiences can lead someone to consider suicide. While we often think of suicide in relation to depression, anxiety, and substance use problems, there are many factors that may increase a person's risk of suicide, including factors that are not related to any mental illness (Mental Health Commission of Canada, 2019). If trauma and pain are addressed early, suicide is preventable. As such, it is important to understand what factors in a person's life may increase their risk, and what factors may serve as protective in preventing death by suicide.

Suicide Research at MACY

Suicide is an issue that the Manitoba Advocate for Children and Youth (MACY) has studied and spoken publicly about for many years. Our intent, as always, is to provide data and analysis about suicide in Manitoba so that our evidence and recommendations may be used to enhance service delivery in and prevent the suicide deaths of young people. MACY, formerly known as the Office of the Children's Advocate, has released several reports concerning youth suicide. Such reports include *The Changing Face of Suicide and the Narrow Window for Intervention: Phase One* (2015) and the subsequent *Phase Two* reports (2016). These are part of a multi-year suicide study that remains ongoing at MACY and from which we will be releasing *Phase Four* in early 2020. In *Phase One*, we examined the lives of 50 youth who died by suicide in Manitoba between 2009 and 2013, looking at established risk factors. In *Phase Two*, we compared the original cohort of 50 to a control group of 100 of their peers to study the factors that were common or different between the groups.⁶ *Phase Three* is a unique aspect of the study in that we took the data and lessons from the first two phases, collaborated with the Canadian Mental Health Association (Manitoba and Winnipeg office) to create Thrival Kits™, a mental health promotion project for Grade 4-6 students, which is currently being delivered to more than 4,000 students in elementary schools across Manitoba.⁷ *Phase Four* of the ongoing study, which the Manitoba Advocate will release in the coming weeks, examines the deaths of 22 girls who died by suicide who were in need of, or who were seeking mental health services at the times of their deaths. In *Phases One, Two, and Four*, our team investigated files and other source material for the presence of 20 established risk factors for suicide in the lives of the youth, including:

1. Physical abuse
2. Sexual abuse
3. Sexual exploitation

⁶See the Phase One report here: https://manitobaadvocate.ca/wp-content/uploads/The-Changing-Face-of-Youth-Suicide-in-Manitoba_FINAL_web-2.pdf, and the Phase Two report here: https://manitobaadvocate.ca/wp-content/uploads/The-Changing-Face-of-Youth-Suicide_P2_web-1.pdf

⁷For more information on the Thrival Kits™ project, see here: <https://thrivalkits.ca>

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4. Youth substance use
5. Parental substance misuse
6. Violence in the home
7. Bullying
8. Poor school attendance
9. School behavioural problems
10. History of hospitalization for suspicious injuries or mental health admissions
11. Youth criminal justice involvement
12. Placement changes, housing instability
13. Self-harm
14. Suicidal ideation
15. Previous known suicide attempts
16. Suicidality of family or friends (attempts or ideation)
17. Suicide death of family member and/or friends
18. Recent conflict
19. Alcohol use at time of death
20. Drug use at time of death

Matthew exhibited eight of these risk factors for suicide as outline below.

Youth substance use

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

Marijuana is the most commonly used illicit drug within the Manitoba youth population. "Overall, 13% of students reported using marijuana/hashish one or more times in the past month, and 19% of students reported using it in the past year" (Partners in Planning, 2014, p. 46).

Out of the 100 youth included in the control group in MACY's *Phase Two* study, forty-one (41) were documented to have used alcohol and/or illicit drugs. Of the youth who died by suicide and profiled in MACY's *Phase One* study, 74 percent were documented to have used alcohol and/or illicit drugs.

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Matthew's first known substance use was when he was 13 years old and he admitted to using cannabis on four occasions. He would continue to intermittently use cannabis up until his death. He also identified that the consequences of his cannabis use caused him ongoing problems at school and home. Matthew decided to quit using cannabis for a time in 2015 and he shared with a number of adults that this was because he saw his memory and stress levels being significantly impaired from the amount he had been using and that the deficits he felt had scared him. His abstinence was short-lived; however, and he returned to more regular use.

Matthew also used alcohol on a number of occasions. In those moments, he would get angry and, at times, he became verbally and physically aggressive towards his parents; Winnipeg Police Service was called as a result. Further, in October 2016, he was hospitalized after consuming a homebrew he had made, along with Lorazepam, and a quantity of isopropyl alcohol ("rubbing alcohol").

Bullying

Since he was 12 years of age, Matthew was a victim of ongoing and severe bullying at school. The bullying was a targeted campaign by a small number of other students against him, and although Matthew disclosed the trauma to many adults and service providers in his life, he largely felt he was left to manage the bullying on his own while he was at school and in the community. After the first year of bullying, he was prescribed an anti-depressant and he was eventually diagnosed with generalized anxiety disorder as well as major depressive disorder. Over the years, his mental wellness deteriorated and he felt hopeless and lost faith in the ability of anyone to help him heal from the trauma the bullying had inflicted on his spirit. Four months prior to his suicide death, Matthew's low level of mental well-being made him unable to attend a series of therapy appointments. He told his CFS-assigned family support worker that, "...he was not fixable and they wouldn't be able to help anyways" (Family support worker, Daily contact notes, July 19, 2017).

Poor School Attendance

Matthew's ability or desire to attend school consistently was severely impacted by the bullying he experienced in junior high as well as his mental illnesses, including the anxiety he experienced about school. Still, Matthew was intelligent and had an affinity for science, politics, and current events, which we saw throughout his life. In Matthew's report card from June 2013, the end of his Grade 7 year, the school noted that his attendance had been good during the year. He had been absent only 9.5 days and late one time over the school year. Poor school attendance started occurring for Matthew in Grade 8, and his summary report from June 2014 noted his absences had increased to 30.5 days and that he had been late to class seven times. The end of his Grade 9 year showed a staggering decline in Matthew's attendance and grades. According to his annual summary report:

- In ELA – Immersion 10F Matthew received a grade of 53 percent, he was absent from class 94 times throughout the year and late seven.

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- In French 10F Matthew received a grade of 52 percent, he was absent from class 87 times throughout the year and late zero times.
- In Sciences Humanities 10 F Matthew received a grade of 54 percent, he was absent from class 78 times throughout the year and late twice.
- In Math 10F Matthew received a grade of 60 percent, he was absent from class 80 times throughout the year and late four times.
- In Science 10F Matthew received a grade of 54 percent, he was absent from class 97 times throughout the year and late three times.
- In Physical Education 10F Matthew received a grade of 87 percent, he was absent from class 82 times throughout the year and late three times.
- In Drama 10F Matthew received a grade of 59 percent, he was absent from class 78 times throughout the year and late three times.
- In Food and Nutrition 15G Matthew received a grade of 79 percent, he was absent 18 times and late zero.
- In Electricity/ Electronics Technology 15G Matthew received a grade of 66 percent, he was absent nine times and late once (Matthew's school, Annual summary report, June 11, 2015).

Following his years in junior high, Matthew transferred to a new school and although bullying did not appear to be an issue for him at his new high school, Matthew expressed extreme anxiety about attending school. In a final effort to reconnect him to his education, Matthew's mother arranged for him to complete distance education from their home, but although the materials arrived, Matthew never completed the work. Eventually, he was unable to attend altogether and would emotionally shut down or become angry whenever school was raised as a topic by the adults in his life.

School Behavioural Problems

School behavioural problems surfaced for Matthew as he got older. His mental illnesses became more debilitating and the ongoing bullying he faced in junior high created situations in which Matthew, feeling unsafe and unprotected by the school, began to lash out in what could be understood as efforts of self-protection. He made negative choices at times, including bringing a box cutter to school and issuing threats to his bullies. These events resulted in Matthew being labelled as having behavioural problems at school. He was suspended once in-school and three times out-of-school in his grade 9 year from 2014-2015 for drug possession and physical aggression towards other students.

History of hospitalization for suspicious injuries or mental health admissions

When we examined hospitalizations in our *Phase One* and *Two* suicide studies, we looked specifically for incidents where medical attention was sought for reasons that might have been self-inflicted or inflicted by another person (i.e. physical assaults). We also included admissions to hospital for mental health issues (e.g. suicide attempts, ideation, depression, psychiatric evaluation). We omitted incidents where a

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youth sought treatment for a sprained ankle, for example, if the injury was reasonably explained in medical charts. Sixty-six (66) percent of the youth included in *Phase One* (Manitoba Advocate, 2015) of this study had a history of hospitalization.

Zambon, Laflamme, Spolaore, Visentin, & Hasselberg (2011), conducted a study investigating the extent to which previous hospitalization for injury of any intent and the risk of subsequent suicide. The authors found that hospitalization for both intentional (i.e. self-harm) and unintentional (i.e. falls, motor vehicle accidents) injuries “were highly associated with the risk of future youth suicide, regardless of sociodemographic factors in the family” (p.178). The study noted that the risk of suicide was 40 times higher among subjects previously hospitalized for self-inflicted injuries, when compared to subjects without previous hospitalization. The study further found that “...previous hospitalization for assaults and unintentional injuries – such as falls or road traffic crashes – increases the risk of suicide among young people by 9 and 3 times, respectively, compared with young people without history of injury” (p.180).

Matthew’s mother called emergency responders and the mobile crisis team multiple times due to Matthew’s behaviours, mental health crises, and emergency medical needs resulting from substance misuse. Matthew also had seven visits to the HSC Children’s Emergency for mental health crises challenges by the time he was 16 years old. He also had four admissions to the Child and Adolescent Psychiatric Inpatient Services (PY1).

Suicidal Ideation

Suicidal ideation is the preoccupation with suicide and may include thoughts of suicide or verbally expressing suicidal thoughts or the wish to die. Twenty-six percent of the 100 youth included in MACY’s *Phase Two* (Manitoba Advocate, 2016) suicide study had a documented history of suicidal ideation. Previously, in the *Phase One* report (Manitoba Advocate, 2015), there was nearly a three-fold increase of documented suicidal ideation within that population, with 64 percent of the youth who died by suicide having previously expressed their wish or intent to do so.

Fraser, Geoffroy, Chachamovich, and Kirmayer (2014) note that “suicide ideation and attempts are part of a continuum of suicidal behaviors and are among the strongest predictors of death by suicide” (para. 2). Suicidal ideation not only increases a “youth’s risk of suicide attempts and of death by suicide, it is an important marker for an array of significant mental health needs, sexual risk behavior, substance use, and delinquent behavior” (Thompson, Connelly, Thomas-Jones, & Eggert, 2013, p.2).

Matthew had persistent suicide ideation throughout his teenage life. Starting at about age 12 or 13, Matthew disclosed having suicidal thoughts. Sometimes he told people that these thoughts emerged and he knew to turn to his family or service provider for help and support. Other times, Matthew seemed

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wholly overwhelmed with persistent suicidal thoughts and expressed feelings of utter hopelessness. When Matthew was 13 years old, he was diagnosed with major depression and generalized anxiety disorder.

Previous Suicide Attempts

Research has consistently noted that a previous suicide attempt is the single best predictor of suicide. In their 2009 study, ten Have et al. (2009) noted that “attempted suicide is one of the strongest risk factors for death by suicide, and 60% of planned first attempts occur within the first year of ideation onset” (p.825). Forty-eight percent of youth in the *Phase One* study (Manitoba Advocate, 2015) were documented to have had prior suicide attempts, although, due to data limitations, it is likely that this was an underreporting. This is because in order for our office to find notations of previous suicide attempts certain conditions had to be true, including that the youth had to have disclosed the attempt to a service provider or the incident had to have been correctly interpreted as a suicide attempt (i.e. overdose), and then the service provider had to have assessed that the information was important enough to document on file.

Matthew's first known suicide attempt was in Grade 9 when he was 13 years old, and although he would later tell his addictions worker that it was an “awful experience, I will never do that again” (AFM worker, Student referral form, February 4, 2015), it would not be his last attempt. The second known attempt was in Grade 10, although he was plagued by persistent thoughts of ending his life.

Suicidality of family or friends (attempts or ideation)

Consistent evidence indicates that children and youth who are already vulnerable to suicidal behavior are at greater risk of suicide if they are exposed to suicide or suicidal behavior (Velting & Gould, 1997). Research shows that children and youth are often more susceptible to the suicidal behavior of family and peers than are adults (de Leo & Heller, 2008).

In MACY's ongoing study on suicide, 68 percent of youth who died by suicide had family members or friends known by Child and Family Services to have expressed suicidal ideation or who had attempted or died by suicide in the past (Manitoba Advocate, 2015). Exposure to suicidality was found in 39 percent of the youth in our control group (Manitoba Advocate, 2016). When youth grow up in an environment hearing siblings, parents, and extended family members expressing their wish to die or attempting suicide when faced with adversity, they themselves may come to view suicide as a viable option when they are struggling. This maladaptive coping style can then become the norm for these youth.

While Matthew's family history did not include significant exposure to suicidality, files indicate that Matthew did have an extended family member who “had suicidal attempts” (Physician, Referral form to adolescent psychiatry, October 14, 2014).

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While risk factors are not wholly predictive in terms of knowing which individuals will attempt or die by suicide, it is important to understand risk factors, and for professionals and service providers to screen for them. When service providers have contact points with youth, it can represent an important opportunity for assessment and adjustment of care plans. Suicide is rarely an individual's first response to trauma or sadness. In Manitoba, the child death investigations our office has conducted over the last decade show that most often, suicide is the final decision made by an individual who has sustained sometimes long years of unaddressed pain. In many cases, our investigations after a suicide piece together stories of young people who have significant trauma in their early years, their trauma remains unhealed, their support systems fade and they feel as though there is no other alternative they can imagine to end the pain they carry. The message we need to promote to youth at all times is that there is always a better option, wounds can heal and pain can end. If help is offered early and consistently and when youth find spaces where they feel heard and understood, suicide can be prevented.

The World Health Organization agrees that suicide is preventable. They note that:

Suicides are preventable. There are a number of measures that can be taken at population, sub-population and individual levels to prevent suicide and suicide attempts. These include:

- reducing access to the means of suicide (e.g. pesticides, firearms, certain medications);
- reporting by media in a responsible way;
- school-based interventions;
- introducing alcohol policies to reduce the harmful use of alcohol;
- early identification, treatment and care of people with mental and substance use disorders, chronic pain and acute emotional distress;
- training of non-specialized health workers in the assessment and management of suicidal behaviour;
- follow-up care for people who attempted suicide and provision of community support.

Suicide is a complex issue and therefore suicide prevention efforts require coordination and collaboration among multiple sectors of society, including the health sector and other sectors such as education, labour, agriculture, business, justice, law, defense, politics, and the media. These efforts must be comprehensive and integrated as no single approach alone can make an impact on an issue as complex as suicide (World Health Organization, 2019, para 8-10).

While many youth display some risk factors at different points in their lives, there are key benefits of understanding risk factors and who may be at highest risk. Importantly, interventions and investments can be evidence-informed to ensure those at highest risk have greatest access to the most effective supports. While risk factors are not predictive in terms of who will die by suicide, risk factors can be instructive for service providers to know when to increase or modify services. Of course, providing risk-

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informed supports is only possible if the professionals in the mental health system know when a child or youth is experiencing elevated risk. For Matthew, although he had multiple contacts with crisis services, emergency response personnel, repeated visits to the hospital emergency department, several admissions to in-patient psychiatric care, and was widely known by professionals to be at severe and ongoing risk, Matthew had no one assigned to him from the health system who could operate as his case manager and coordinate his care needs. Instead, his family, like many families in Manitoba, were left on their own to manage his escalating mental health needs and develop their own abilities to know when he needed crisis-oriented or medical interventions. His family had to try to educate themselves on where the risks were for Matthew and what response that ought to generate.

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Children and youth need mental health and addictions system Navigators

FINDING: Matthew's family, like many others in Manitoba, were left to navigate the youth mental health and addictions system on their own. For Matthew, this resulted in a repeated cycle of crisis, emergency intervention, hospitalization, discharge, repeat – with no sustained improvement. Families need assistance in understanding where to go and what is available.

Matthew was a child diagnosed with mental illnesses and his illness consumed every aspect of his life. Matthew's parents advocated and accessed numerous mental health services available in Winnipeg. In their attempts to navigate the mental health system, it was a repeated cycle of **utilizing the same services, in the same way, with the same recommendations, the same outcomes, and no sustained improvement for Matthew**. His parents continually worried for their son's safety as Matthew's mental health deteriorated. By November 2016, his mother told the CFS worker that she was afraid to leave her house, afraid what Matthew might do to himself; she said it felt like she was on house arrest. Despite the good intentions of individuals inside the systems, and his mother's unrelenting advocacy for services that would help Matthew manage his spiraling mental health, Matthew did not receive the kind of long-term, intensive help to which he had a right. What the family encountered were crisis-oriented intervention services that would address only the immediate risk before stepping back, and various ongoing therapeutic services that did not meet Matthew's complex needs.

In Winnipeg, Health Science Centre (HSC) Children's Emergency sees approximately 3,000 mental health visits a year. Out of the 3,000 visits, approximately 50 percent of the children will be triaged to see the emergency room (ER) psychiatrist. Roughly 40 percent of those children seen by the ER psychiatrist will be admitted to the Child and Adolescent Psychiatric Inpatient Services (PY1). The remaining children seen by the ER psychiatrist will be discharged with a care plan (Psychiatrist, Interview, February 27, 2019). The following process are the steps a child and youth must undergo if they attend HSC Children's Emergency for a mental health crisis.

1. Triage nurse at ER sees the child and documents the circumstances for the emergency room visit (this is for all children entering children's emergency).
2. A mental health nurse sees the child and gets further detailed information of the crisis that they are in.
3. An ER physician then sees the child to assess whether that child needs to be seen by the attending psychiatrist. At this point in the process, 50 percent of children are discharged from the hospital with a care plan. The process up to this point commonly stretches over many hours.
4. If referred on to psychiatry, the attending psychiatrist sees the child to assess their needs and develop an appropriate care plan. Plans may include discharge and referral to the child and adolescent mental health clinic (3-5 day wait time); discharge and referral to acute assessment (multi-week wait time); discharge and continue with the family's existing plan; or, admission to PY1 (Child and Adolescent Psychiatry, Interview, February 29, 2019).

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Using children's emergency as the only access point for children with a mental health crisis is not serving children with mental health challenges in an effective manner. Wait times can be long and mental health nurses are not on site 24/7. Once the ER physician assesses that a child should be seen by the attending psychiatrist, the additional waiting period can also be lengthy. Furthermore, ER psychiatrists do not take on patients; therefore, when a child is triaged to see the attending psychiatrist, they are potentially seeing someone new each time, which can be a difficult process for the child and their family (Health professional, Interview, December 3, 2019). And further, children's emergency is also the catch-all for all children where a caregiver has determined a need to seek medical attention. Pressure at this front door of the system, as myriad situations are presented for assessment and triage can hamper the ability of ER staff to identify medical emergencies when many other children in the waiting room might be better served at an urgent care location, and sometimes, simply waiting to see a non-emergency physician the next day in a clinic.

For mental health crises, each time a child experiences a mental health crisis, they are required to go to the children's ER every time and restart at the first phase of the triage process. This repetitive practice may discourage parents from bringing their children to the ER when they are presenting with mental health challenges. Matthew was taken to children's emergency on seven occasions due to mental health crises and over time, Matthew and his family became disheartened with the process. Not only were their wait times long, but Matthew's mother also informed us, "There were times I should have taken Matthew to the hospital but I didn't because it had never changed anything and I knew the discharge process and plan was the same and [the plan] didn't do anything" (Matthew's mother, Interview, August 28, 2019).

In cases where children have been subjected to violence and attended children's ER multiple times, the hospital social work department would contact Child and Family Services (CFS). Usually, the communication between the hospital social worker and CFS ends at the CFS intake level. There is no similar mechanism within the ER process for mental health concerns to connect with the child after discharge to ensure that discharge plans made for the child are being followed through and meeting their needs. Given the breadth and complexity of the provincial health system, a knowledgeable navigator would be beneficial, who could provide follow-up and services aimed at connecting the youth and their family to the recommended or available services, or who could flag for medical staff when a discharge plan is not meeting the needs of the youth. The role of children's ER is to assess and provide a two-fold decision, which entails either admitting the child or discharging the child with a community resource plan (Health professional, Interview, December 3, 2019).

Healthy emotional and social development in early years lays the foundation for good mental health and resilience throughout the lifespan. An estimated 1.2 million children and youth in Canada are affected by mental illness (Mental Health Commission of Canada, 2020a). Only 1 out of 5 children who need mental health services receives them and less than 20 percent of the children and youth will receive appropriate

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treatment. Living in Winnipeg, Matthew had access to many community mental health services. These included:

- One psychiatric assessment for diagnosis and recommendations
- Four therapy sessions with one mental health clinician for brief service
- Fifteen therapy sessions with a second mental health clinician for ongoing service
- Six home visits from the Youth Crisis Stabilization System, mobile crisis team
- A second psychiatric assessment
- Four admissions to the Child and Adolescent Psychiatric Inpatient Services (PY1)
- Three therapy sessions with a clinical psychologist

Getting these services was not an easy task for Matthew's mother. She had to advocate for her son's mental health needs and coordinate the services through an unclear pathway. She repeatedly shared Matthew's story with multiple service providers and during this investigation, she told us that, "There was no coordination between systems" (Matthew's mother, Interview, February 21, 2019). Her observation was borne out when our office looked at the evidence. It was clear that health care services, including mental health services, were highly integrated and responsive the four times that Matthew was an inpatient at PY1. While in the hospital, he was supported by psychiatrists, psychiatric nurses, occupational therapists, and others. He received assessments, regular medication, attended group and individual therapy sessions, and more. However, his stays there were brief and when he was discharged and returned to the community, he struggled and his mental health declined further. There were long periods, especially in his final year of life, when his mental illnesses made it impossible for him to function to achieve basic daily tasks. He would often not get out of bed or leave the house, went long periods without showering or proper meals, refused his medication, experienced violent outbursts, and reported persistent suicidal thoughts.

Additionally, Matthew's mental illnesses combined with a low level of mental well-being, resulted countless times in his refusal to attend scheduled therapy sessions. A pattern emerged: Matthew's anxiety and depression would make him unable to leave the house, his mother would call to let the service provider know, the appointment would be rescheduled, and Matthew would be unable to attend the reorganized appointment as well. Instead of amplifying their efforts to engage him in treatment, multiple service providers noted his "resistance" to treatment. House calls are not always possible in all cases. It would be neither practical, nor possible to offer house calls to all people living with mental illnesses, which is why Matthew's story illustrates the need to target resources where they are needed. Matthew's illnesses became so debilitating and his family was understandably desperate to save him. What he needed was an integrated and coordinated plan built around him that met him where and when he needed it. While he did have a therapist make house calls two occasions, his inability to engage was interpreted as service refusal, and those house calls ended with a referral to a different service.

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And yet, Matthew needed help, he knew it, and he attended many sessions where he spoke about the trauma of the bullying, his mental illnesses, his persistent suicide ideation and his desire to heal. His inability to engage in therapy, particularly in the final year of his life was an opportunity to increase the intensity and variety of intervention, but instead, Matthew seemed to encounter people at his school or in the health system who reflected a position that if he really wanted help, he would make a bigger effort. What we saw when we gathered evidence and interviewed people familiar with the case was that Matthew disappeared slowly, over a very long while, eventually giving up all hope that he would ever recover. On July 12, 2017, four months before his death, Matthew was unable to attend a scheduled therapy session, so it was rescheduled for five days later. When that second date came around, Matthew's mother called the psychologist to cancel that appointment as well as Matthew was refusing to attend. According to the FSW case notes, Matthew "...refused to go to the second appointment and said he was not fixable and they wouldn't be able to help anyways" (FSW, Daily contact notes, July 19, 2017). Slowly, over time, all health care services disappeared from his life and the only service left standing was Child and Family Services, which is the one service that is not permitted to walk away when a family is in crisis. In the end, it was only Matthew's CFS family support worker, the assigned CFS social worker, his mother, and his brother.

Often, Matthew's treatment was not meaningful and child focused. For example, Matthew's mother shared with us that the sessions with the mental health clinicians tended to focus on parenting practices. "MATC was not looking at depression and anxiety with Matthew, it was a family thing. The whole time I kept saying 'I don't know why you guys are focusing on us, it's not a matter of us, it's Matthew'" (Matthew's mother, Interview, August 28, 2019).

When children and youth are discharged from children's ER or from PY1, discharge plans are provided to the child and their caregiver for ongoing support. For a child or youth who has had multiple plans, they are often repetitive in nature and the adult caregiver is left with the responsibility to facilitate and lead the recommended plan. Within a five-month period, Matthew had four admissions to the Child and Adolescent Psychiatric Inpatient Services. The mobile crisis stabilization system was accessed 14 times, he was already in sessions with a mental health clinician, and yet he still remained in a minimal mental well-being state. Despite the need for something different, the discharge plans remained the same. They included:

1. Discharge in the care of his parent(s)
2. Utilize Winnipeg's crisis intervention services
3. Utilize the services of the community mental health program
4. Continue with medications as recommended
5. Follow up with family physician

Matthew became despondent and ultimately refused to attend therapy and school. The treatment options for Matthew were not working and he needed more intensive treatment to address his

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debilitating mental illness. At this point, Matthew's mother started researching other treatment possibilities outside of Manitoba and Canada as the mental health services in Winnipeg were not adequate for his debilitating mental health needs.

Mental health care continues to suffer from it being seen as less important than physical health care. If a parent brought their child to an emergency room because of an illness and the physician prescribed antibiotics and those antibiotics were not effective, when the parent brought the child back in, alternative options would be offered. If the second course of treatment was also ineffective, when the child returned to emergency, further options would be explored, consultation and testing might occur. What would not happen would be for the physician to prescribe the same, ineffective antibiotics over and over and over again and then come to the conclusion that the child was just resistant to healing. And yet, this is how Matthew's mental health care needs were supported and viewed over the years. He had repeated contact with the mental health system, and unless he was able to physically attend office

*"When a flower doesn't bloom,
you fix the environment in which
it grows, not the flower."
- Alexander Den Heijer*

buildings and hospitals, services were limited, they increasingly saw him as "resistant" and eventually, they each closed their files. The problem was not the individual service providers or medical professionals per se, the issue is that the child and youth mental health care system is set up to serve itself, when what is needed is for the system to pivot towards children. Manitoba has an opportunity and an obligation to offer a full complement of tools and resources within a tiered model of care to ensure that children and youth receive the right care, at the right time, in the right place.

Ontario's Model: Mental Health Youth Patient Navigators

Patient Navigator programs were first introduced in the 1990s to improve health outcomes for patients receiving care from complex health systems (Freeman & Rodriguez, 2011). In Ontario, the patient navigator model was implemented to support youth mental health, and to identify and resolve youth barriers to care. The goals of patient navigator programs differ, but generally they 1) improve patient care coordination, 2) shorten wait times, 3) provide emotional support and improve community supports, and 4) connect primary care with specialized services and community-based health and social services (Valaitis et al., 2017).

Youth and families self-refer to patient navigator programs. Navigators assess the needs of patients and create individualized plans to enable the most appropriate provision of services in a timely and effective manner. Navigators also offer guidance on services and they track and evaluate the trajectory of services across different providers and outcomes. Importantly, they are qualified professionals with authority to access the right level of care, ensure continuity of care, and improve communication of health professionals.

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The responsibilities of Patient Navigators in Ontario are adapted according to the region and target population. In Halton, Ontario, Navigators provide in-school supports to children and their teachers.⁸ The Aboriginal Health Centres in Hamilton and Brantford, have an Aboriginal Youth Mental Health Patient Navigator Program that focuses on helping Indigenous youth reconnect with their communities.⁹

Manitoba has many extremely skilled clinicians who deliver services despite the pressure points in the system. Just like the pressure point of Children's Hospital ER standing as a repetitive entry point for care, here in Manitoba, we lack a fully-developed tiered model for mental health care services. Our public dollars are not adequately oriented to upstream and early years services, even though research clearly shows those broad and early supports are shown to prevent illness and reduce crisis points further downstream. Instead, like in many jurisdictions, we continue to see laser focus on downstream investments, like reducing wait times for inpatient and addictions treatment beds, increasing emergency response dollars, expanding security measures to manage people in the throes of a crisis. Certainly, and without question, these downstream measures have become of vital importance because people have a right to treatment, to crisis care, and to live and work in safe environments. However, Manitobans know that those reactive measures would be less necessary if comprehensive and proactive health care was available to all of us, across our province. A fully-developed tiered model of mental health care services would boast a range of high quality and highly-coordinated services, including:

- Early opportunities for children to form safe and healthy attachments to caregivers,
- Early years interventions to security within a healthy family circle,
- Safe and healthy school environments that embed mental health and wellness and also offer both integrated and targeted supports to students,
- A range of therapy options to address emerging issues in adolescence,
- Community-based and multi-discipline crisis responders,
- Options for short-term inpatient stays,
- Residential long-term treatment options when youth are at severe risk to themselves or others.

RECOMMENDATION FOUR: Improve access points for children and youth experiencing a mental health crisis

The Manitoba Advocate for Children and Youth recommends that Manitoba Health, Seniors, and Active Living, along with representatives from Shared Health, children's emergency staff and child and adolescent psychiatry -- in accordance with their master plan overview of Health Sciences Centre -- evaluate practices at the Health Sciences Centre – Children's Hospital Emergency Room, with the intent of developing and implementing a child and youth-centred,

⁸ https://www.haltonhealthcare.on.ca/services_/28763/t28545-mental-health/t28361-child-and-adolescent-services/t28557-navigator-service

⁹ <https://aboriginalhealthcentre.com/services/mental-health/>

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separate and specialized access point that meets the needs of children and youth who are experiencing a mental health crisis.

RECOMMENDATION FIVE: Create mental health system *Navigators* to help children and youth

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.

Manitobans deserve to understand how the mental health and addiction system is changing

FINDING: Manitoba Health has not provided the public with a framework for the redesign of the youth mental health and addictions system. The department has not informed Manitobans how recent and anticipated funding announcements and health system transformations are located within a systemic tiered framework. This lack of transparency serves to reinforce the siloed and disjointed nature of the health care system for Manitoba families who are left to navigate a perpetually confusing public system.

When the Virgo Report (Virgo Planning, 2018) was released in Manitoba, it offered the Manitoba government, specifically Manitoba Health, Seniors, and Active Living a strategy for improving access and coordination, especially for child and youth mental health services, which were identified as a strategic priority area. The Virgo Report promotes a tiered model of health care, where Manitoba citizens can access the appropriate intensity of service, based on their presenting – and changing – needs. According to the authors:

One key principle for service enhancement advanced in this review was for a population-health approach to system planning; an approach which aims to address the needs of the whole community across a full spectrum of severity and complexity. In this approach, the population is considered in sub-groups based on severity and complexity, often called “tiers”, and a corresponding set of treatment, support and other services aligned with each tier. This approach formed the basis for a conceptual framework to guide future system enhancements in the province (Virgo Planning, 2018, p. xi).

The graphic below provides a brief summary of the tiered model presented in the Virgo Report, although a far more detailed image can be found in that original document.¹⁰

¹⁰To view the detailed tier model, see the Virgo Report (2018) here, especially see p. 12: https://www.gov.mb.ca/health/mha/docs/mha_strategic_plan.pdf

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An Improved System Framework for Manitoba (summarized), Source: The Virgo Report, p. 12.

TIER 5: Highly specialized, intensive services	<ul style="list-style-type: none"> • Residential services • Intensive case management • Hospital-based acute care psychiatric treatment
TIER 4: Intensive and specialized services	<ul style="list-style-type: none"> • Home/mobile withdrawal management • Intensive case management • Day/evening treatment
TIER 3: Services targeted to moderate needs	<ul style="list-style-type: none"> • Structured, brief intervention • Specialized consultation, assessment & treatment • Case management
TIER 2: Early intervention and self-management services	<ul style="list-style-type: none"> • Self-management resources including e-mental health • Early intervention suicide prevention training (Mental Health First Aid, SafeTalk, ASIST) • Targeted prevention
TIER 1: Population-based health promotion and prevention	<ul style="list-style-type: none"> • Primary prevention • Community-level health promotion • Community capacity building, health literacy

We See Youth Like Matthew Every Day at MACY

The barriers that Matthew and his family faced within the mental health system are not unique. The Manitoba Advocate for Children and Youth office (also known as “MACY”) is mandated to provide advocacy services to children from birth to 17 years old involved in several public services, including mental health services. In the 2018-2019 fiscal year, 53 percent of young people who called our office requested assistance with the mental health and addictions system. The primary issues we are working on with these cases are quality of service and adequate service delivery. Examples range from denial of psychiatric service; long wait lists for mental health services; treatment plans that are not meeting the child’s need; and a lack of intensive treatment options. These are situations where youth are at extreme levels of risk and where they are unable to access appropriate mental health and addictions services, or where no appropriate services exist here in Manitoba that can meet their needs. As the Manitoba Advocate, I continue to raise these issues and refer specific cases to the government on a case-specific as well as on broader systemic levels.

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When the report *Improving Access and Coordination of Mental Health and Addictions Services: A Provincial Strategy for All Manitobans* (the “Virgo Report”) was released in 2018, it confirmed what many Manitobans have long felt: that mental health and addictions services in Manitoba are woefully underfunded and do not correspond to the high need for services, especially for Manitoba’s children and youth (Virgo Planning, 2018). Furthermore, “The most complex children and youth are estimated to cost the province between \$1-\$2 million per child per year and with limited positive life outcomes” (Virgo Planning, 2018, p. 41).

There were 39 recommendations made in the Virgo Report pertaining to children and youth, which were grouped in the following six strategic priorities:

1. Population health-based planning, disparity reduction and diversity response
2. Comprehensive continuum of evidence-informed services and supports
3. Seamless delivery of integrated services across sectors, systems and the life span
4. Mental wellness of Manitoba’s children and youth
5. Mental wellness of Indigenous Peoples of Manitoba
6. Healthy and competent mental health and substance use workforce

Further, the Virgo Report called for enabling supports in the following four areas, which also included specific recommendations:

- Funding and accountability for quality outcomes
- Evidence generation/translation to policy and practice
- Surveillance, monitoring and performance management
- Community engagement and change management

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 barriers that Manitoba children and youth face. From April 1, 2018 – December 20, 2019, the province made six announcements that directly relate to enhancing mental health services for children and youth in Winnipeg.

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 moderate mental illness and other health issues. Distance coaching approach to services. No wait list policy.	\$500,000
Announced October 7, 2019		
NorWest Youth Hub	Funding will be used to increase mental health and addictions counselling, as well as Indigenous cultural supports.	\$823,000

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Project 11	Provides lessons and activities designed to increase mental health awareness and positive coping strategies.	\$621,000
Thrival Kits™	Expand the distribution of Thrival Kits™, a mental health promotion project for elementary schools.	\$1.5 million
Announced October 17, 2019		
The Metis CART Pilot Project	The project will see teams that include a caseworker, family mentor, and addictions and mental health workers for families with parental substance use and child abuse or neglect problems.	\$1.9 million
Announced November 6, 2019		
Community Schools Program	Funding from the program will be given to implement five new schools (two of the five schools are in Winnipeg).	\$1.6 million
Community Helpers	Provide mental health and addiction services to families and caregivers, reducing the risk of Child and Family Services apprehension or placement breakdown.	\$525,000
Announced November 12, 2019		
Project Neecheewam	Improve access to Indigenous-led healing, care, and treatment services to sexually exploited youth.	\$3.8 million
MATC and StreetReach	Funding so MATC (Manitoba Adolescent Treatment Centre) can work collaboratively with StreetReach to provide care for youth who have multi-systems needs that require "integrated access to mental health, substance use and addictions services."	\$1.12 million
Announced November 18, 2019		
HSC's child and adolescent mental health services	Expand resources already available at HSC. Includes increasing availability of child and adolescent 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.	\$4.2 million

It is encouraging that the provincial government has begun – in the last few months – to publicly roll out investments in child and youth mental health. Given the staggering needs in Manitoba, comprehensive investments into the lives of children will benefit us all now and as we move forward. These recent investments align with the needs we are seeing at our office and in our work with children. It is what many system experts in our province have long been calling for, and the recent investments are responding in a positive way to the additional recommendations in the Virgo Report. And yet, significant investments are still needed to meet the growing child and youth mental health needs in our province. Further, we look to the provincial government to articulate an overall vision, or how these announcements may be located within the sculpting of a broader, comprehensive tiered strategy that addresses children and youth across the full continuum of their needs. Gaps in the current system must be identified and addressed, including:

- Long wait times,
- Unclear pathways to care,

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- Siloed care,
- Limited meaningful engagement of children, youth and their families
- Treatment often neither youth-friendly nor culturally appropriate
- Service cliff at age 18
- Inadequate and often inappropriate care
- Lack of measurement and evaluation to assess quality and outcomes of services (Graham Boeckh Foundation, 2019).

Comprehensive child-centered mental health services are needed across the province to meet the varied mental health needs of children and youth. Implementing community access points where children can be connected to a variety of mental health services ranging from education, to assessments, to therapy

ARTICLE 24
States recognize the right of the child to the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health.
United Nations Convention on the Rights of the Child

options, to immediate inpatient care is needed (Health professional, Interview, December 3, 2019). This standard of practice would serve myriad mental health needs that children present with at the first point of contact. This suggestion was confirmed by Matthew's mother who had been looking for more intensive and residential treatment

options on the morning Matthew died. She told us during this investigation that Matthew needed "A place where they manage his health, his medication, his diagnosis, where he is safe" (Matthew's mother, Interview, August 28, 2019).

RECOMMENDATION SIX: Long-term residential mental health treatment for youth

The Manitoba Advocate for Children and Youth recommends that the Government of Manitoba, through the Department of Health, Seniors and Active Living create a long-term, residential treatment centre for youth who are in the top tier of mental health care needs and for whom less intensive options have been ineffective.

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.

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Child and family services provided child-centred support to this family in crisis

FINDING: The child and family services agency provided exceptional services to Matthew and his family.

The services provided by the Child and Family Services (CFS) worker were comprehensive and the Provincial standards for the delivery and administration of child and family services were met. The CFS worker involved the family in each step of the case management process. Assessments were thorough and there was a clear understanding of the child and family's needs and strengths. The case plans reflected the needs of the family in a holistic manner that aimed to address Matthew's mental health challenges and strengthen the family unit.

Matthew's mother, Matthew and the CFS agreed that having a family support worker involvement would benefit Matthew. A referral was made to the program and the family support worker starting working with Matthew and the family in October 2016. The role of the family support worker is to provide a range of services that contribute to improving family functioning, parental capacity and child safety and well-being.

This family support worker has years of experience working with young people experiencing mental health challenges and quickly understood the complexities of Matthew's mental illness. After a month of working with Matthew, his mother noted, "...the [family support worker] had the best chance of making a positive impact on Matthew's life." The family support worker knew the value of working in a collaborative manner and he helped the family traverse through resources, communicated with other services, participated in family meetings with the mental health and education systems, and executed this approach in a meaningful child-centered manner.

The family support worker quickly identified Matthew's strengths and needs and recognized that in order to build a trusting relationship with Matthew, the family support worker had to be patient and consistent. Despite the fact that Matthew refused, on occasion, to engage with the family support worker, the family support worker remained committed and stayed in the home. During those times the focus would be to provide support to Matthew's mother. This approach demonstrated to Matthew that the family support worker cared and was dedicated and invested in Matthew and his family to achieve optimal mental well-being. This skilful and meaningful approach made the family support worker a valuable member of Matthew's team.

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Outstanding sections of *The Advocate for Children and Youth Act* must be proclaimed

FINDING: To improve the responsiveness and effectiveness of child-serving public services in Manitoba, the two outstanding sections of *The Advocate for Children and Youth Act* must be proclaimed.

By law, the Manitoba Advocate for Children and Youth (MACY) is notified by the Office of the Chief Medical Examiner (OCME) every time a child or youth under age 21 dies in our province. Following the child death notification, our office will determine whether the death meets the legislated criteria for formal review. Currently, our legal mandate for child death reviews remains narrow and many deaths of children, youth, and young adults fall outside of our legal scope. A formal review and investigation of government services is only triggered if the child or their family were receiving child welfare or adoption services at the time of the death, or in the 12 months that precede the date of death of the child. This means many concerning deaths come to our attention and we are prevented from reviewing government services and any important lessons that could be learned are lost to us all. We only know Matthew's story because Matthew's situation had become so desperate that child and family services was called in to provide support, and in the end, as we have shown, CFS was the only service that remained active, when all other services had stopped providing support. It is important to remember that for the first 15 years of his life, there was no CFS involvement and Matthew's family only came to the attention of the CFS system at a point of desperation when the services which ought to have been providing mental health supports to the family were consistently unsuccessful in engaging Matthew in appropriate treatment.

Many families in our province face struggles and barriers similar to those experienced by Matthew and his family. Many of those families are desperately seeking mental health and addictions services for their child and doing so in the absence of CFS involvement. When tragedies occur in Manitoba, families ought to know that an office like the Manitoba Advocate for Children and Youth is immediately activated to conduct independent reviews and investigations of the public services that were – or which should have been – provided to their child. Unfortunately, due to the current restrictions on our mandate, only families where CFS was involved prior to the death of their child will have government services formally reviewed by our office.

The final report of the *Commission of Inquiry into the Circumstances of the Death of Phoenix Sinclair* (Hughes, 2013) recommended that the Manitoba Advocate be provided a stand-alone legislation and a significantly expanded mandate to advocate for and investigate the deaths of any child who was receiving any form of government services. Commissioner Hughes, who oversaw the inquiry, noted that public accountability of government services is a vital element of a strong provincial system, and he therefore noted that any service provider accepting taxpayer funds and delivering services to children and youth ought to be reviewable by the independent office of the Manitoba Advocate for Children and Youth (formerly, the Children's Advocate). Specifically, Commissioner Hughes stated:

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Many children, youth, and families who need the services of the Children's Advocate now have no access to that office. The authority of the Office should extend beyond the child welfare system, to include services by any government department or publicly funded organization to children and youth (Hughes, 2013, p. 419).

It took four years and several draft pieces of legislation before *The Advocate for Children and Youth Act* (ACYA) was introduced to the floor of the Manitoba Legislative Assembly. The Bill progressed through readings in the chamber, committee tables, and was finally passed – unanimously – and received Royal Assent. It was a win for children and youth. The ACYA is a special piece of legislation because it received support from all three political parties in the legislature, it enshrined children's rights into provincial law, and it was a strong commitment on the part of all Manitoba legislators to increased accountability and transparency with respect to the ways in which provincial services are delivered to children, youth, young adults, and their families. The ACYA was proclaimed and came into force on March 15, 2018, but there was a problem.

Important Information from Child Deaths is Being Lost

In preparation for the coming-into-force of the ACYA, a decision was made to roll it out in phases. Phase 1 of the ACYA did come into force in March 2018, but important sections of the Act, known as Phases 2 and 3 were held back. Phase 1 was the expansion of our advocacy services from a previous focus on only CFS and adoptions, to now also including: education, disabilities, mental health, addictions, youth justice, and victim supports (including domestic violence and sexual exploitation), in addition to CFS and adoption services. Further, Phase 1 expanded our mandate so we can provide formal advocacy services to young adults up to age 21, in addition to children and youth between birth and 17. Additionally, Phase 1 established our responsibilities to conduct child-centred research, promote children's rights (per the *United Nations Convention on the Rights of the Child*) and the Manitoba Advocate is now also responsible for tracking government progress and their levels of compliance with recommendations made by the Advocate under the ACYA.¹¹

Phase 2 (*expanding child death reviews and investigations*) and Phase 3 (*investigation and reporting on serious injuries to children*) of the ACYA remain not in force. These are critical sections of the Act that, when proclaimed, hold the likelihood of helping to increase child safety and prevent future deaths of Manitoba children and youth.

¹¹ Our office recently launched a recommendations tracking tool on our website where all Manitobans are invited to learn what recommendations our office has made through our investigations and special reports, what the government is doing to implement those recommendations, our analysis of their activity, and what remains outstanding. Please find that information here: <https://manitobaadvocate.ca/recommendation-tracking/>

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Distressing statistics demonstrate why the proclamation of Phases 2 and 3 is needed urgently. Indeed, Manitoba has the largest number of children in care, the largest number of youth in correctional facilities among provinces, among the highest rates of youth suicide and homelessness in the country, and the largest number of missing and sexually exploited children and youth per capita. And as noted previously, data from our office reveal that suicide is the leading manner of death for Manitoba youth, ages 10-17.

There has never been a more important time in our province to invest in children.

The proclamation of Phase 2 – *expanding child death reviews and investigations* – will increase the types of cases considered in scope for review and/or investigation by MACY.

Phase 2 will allow MACY to review and investigate the death of a young person if they or their family had involvement with the mental health, addiction, or youth criminal justice systems within one year of their death (in addition to child welfare and adoptions, as is currently the case). The opportunity to do such reviews and investigations is crucial in light of the high rates of youth justice involvement and the large numbers of young people who are in crisis every day and who require and deserve mental health and addiction treatment.

Furthermore, the current limited rollout of the ACYA means that a number of child death notifications remain out of scope, including out of scope deaths by suicide, homicides, and accidents. In the last five years, MACY has been notified of 105 preventable deaths, which were out of scope for our office. Last year alone, 19 of the 32 youth and young adult deaths by suicide in Manitoba were out of scope. So too were three of the six homicides and 19 of the 26 accidental deaths. If we are not reviewing or investigating these deaths, lessons that may be learned from such tragic circumstances may be lost.

LESSONS LOST

Of the 104 children, youth, and young adults who died by suicide in Manitoba from April 1, 2014, to January 1, 2020, **48 of those suicide deaths fell out of scope for any review by the Manitoba Advocate because they had no child welfare involvement at the time of death or in the year prior to death.** Suicide deaths with mental health, addictions, or justice involvement (with no additional involvement by CFS) will continue to fall out of scope for a formal review until Phase 2 of the ACYA is proclaimed. Any lessons which could be learned are being lost.

Out of Scope Suicide Deaths

2014-2015	2015-2016	2016-2017	2017-2018	2018-2019*	YTD 2019-2020**
2	9	4	8	19	6

*Some of this increase in numbers of deaths by suicide is due to the new reporting requirements of our expanded mandate. Our office now receives death notifications to age 21.

**Deaths from April 1, 2019, to January 1, 2020.

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Manitoba Does Not Know How Many Children and Youth are Being Injured

Equally important is the proclamation of Phase 3 of the ACYA – *investigation and reporting on serious injuries to children*. A significant current gap in our province is that while most individual public systems are required to report critical injuries according to their own internal procedures, there is a concerning lack of analysis and systematic tracking or aggregation. This means we cannot assess the big picture in terms of how children, youth, and young adults are sustaining serious injuries. When Phase 3 is proclaimed, reviewable public services (CFS, mental health, addictions, and youth justice) will be required to report all serious injuries of children and youth to our office. MACY's analysis, reviews, and investigations into serious injuries will have the central objective of making recommendations that improve systems so that young people are safer and some deaths may be prevented.

As noted, our office was only notified of Matthew after his death. And yet, with serious injury reporting in place as described in the held-back sections of the ACYA, our office would begin receiving serious injury notifications when young people, like Matthew, attempt suicide or are hospitalized for other life-threatening injuries. In the future, when the government brings serious injury reporting into force, we will be able to review and assess the injury reports and when warranted, follow up directly with the youth or their family to ensure appropriate services are wrapping around the young person effectively.

The Advocate for Children and Youth Act defines a serious injury as one that:

- (a) is life-threatening;
- (b) requires admission to a hospital or other health care facility & is expected to cause long-term physical/ psychological impairment; or
- (c) is the result of a sexual assault that causes serious physical harm or is expected to cause long-term psychological impairment.

*Service providers will have a duty to report serious injuries of children and youth to the Manitoba Advocate

There are very real social and financial missed opportunity costs to Phases Two and Three remaining outstanding. Early prevention, detection, and intervention are critical. Reactive policies are not fiscally responsible, nor are they socially responsible to children and their families.

We know, based on the number of serious injuries reported by other provincial child advocate offices across the country, including

British Columbia, that the number of serious injuries occurring right now in Manitoba is likely very high. In their 2018-2019 annual report, the Representative for Children and Youth in British Columbia (RCYBC) reported that of the 2,735 critical injury and death reports their office received, they determined 1,146 notifications to be in scope for review by their office (Representative, 2019). Importantly, in BC, that province's health system has not yet begun to report addictions and mental health-related incidents to the RCYBC, although that is under review by the provincial health department, with a hopeful resolution soon, given that those service areas do have a duty to report to the BC Representative, as will be the

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case here in Manitoba when Phase 3 is proclaimed. For Manitoba, it is difficult to give a reliable projection of serious injuries as they are not currently tracked centrally.

Without question, Phases 2 and 3 of the Advocate's legislation are critical to our ability to continue to provide accurate data and analysis to government and the public. Recommendations MACY has made have seen real and tangible improvements to how we provide public services to Manitoba's young people.

The expansion of this work carries with it the likelihood and opportunity for more efficient services to families, and significantly better data for government to structure its delivery of services in ways that balance fiscal prudence and a strong social safety net so that all citizens may thrive. This is needed change that was passed in the Manitoba legislature because all MLAs recognized its potential to make significant and positive improvements in the lives of Manitoba's youngest citizens. MACY has remained ready to implement the full scope of the ACYA since March 2018, and we are committed to doing this work while simultaneously honouring our commitment to maximize our resources to the fullest extent possible so that we are fiscally responsible to taxpayers in this province. Since *The Advocate for Children and Youth Act* has already been proclaimed, the Manitoba government simply needs to declare a proclamation date to meet their stated commitment to this legislation and to fulfil this part of the legacy of the inquiry into the death of Phoenix Sinclair.

As we have clearly shown in Matthew's story, deaths by suicide have devastating and immeasurable impacts and leave families, friends, classmates, coworkers and communities struggling with grief. For every suicide death, there are five self-inflicted injury hospitalizations, 25 to 30 suicide attempts, and seven to 10 people affected by suicide loss, including family and friends. Young Canadians have highlighted the need for increased mental health services more than almost any other issue. Valuable lessons and critical oversight has been lost in legislative barriers to conduct reviews and more thorough investigations.

"The government has consistently talked about the need to get this right, but in waiting to enact sections of the provincial law, we're compromising the here and now. The lessons that are in these deaths and injuries that we are not investigating will be lost forever if we wait."

-Manitoba Advocate for Children and Youth, Daphne Penrose

RECOMMENDATION EIGHT: Proclaim the outstanding sections of the ACYA

The Manitoba Advocate for Children and Youth recommends that the government of Manitoba set a proclamation date for the remaining portions of *The Advocate for Children and Youth Act* in the spring of 2020.

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Appendix A: Summary of Findings and Recommendations

FINDING: Matthew experienced profound bullying throughout junior high that severely impacted his ability to attend, participate, and feel safe at school.

FINDING: The education system provided student support services to Matthew as a response to his mental health and substance use concerns. These interventions did not address the bullying or create the necessary conditions for Matthew to feel a sense of safety and belonging in his school environment.

RECOMMENDATION ONE: Promote mental health in all K-12 classrooms

The Manitoba Advocate for Children and Youth recommends that Manitoba Education, in conjunction with Manitoba school divisions, highlight and promote the provincial learning objectives that focus on mental health literacy and mental well-being coping skills for all students from Grades K-12. Secondly, Manitoba Education and Manitoba school divisions should ensure that training is available to all teachers that will support and facilitate their classroom skills in mental health promotion.

RECOMMENDATION TWO: Stop suspending and expelling when safety is not an issue

The Manitoba Advocate for Children and Youth recommends that the Department of Education, and with participation from all school divisions, develop a province-wide policy to limit, reduce, and phase-out exclusionary practices, except in situations of imminent safety risk to students and staff. This policy should provide evidence-informed disciplinary alternatives that are in line with the best interests of the child and respect the right of children and youth to education.

RECOMMENDATION THREE: Create and promote safe and caring schools

Safe and Caring Schools: A Whole School Approach to Planning for Safety and Belonging is a valuable tool created by the Department of Education and is an example of best practices for creating positive school environments. The Manitoba Advocate recommends that Manitoba Education continue its work to promote these supporting documents with Manitoba school divisions because all schools in Manitoba should be implementing the optional tools in the *Safe and Caring Schools* supporting documents.

FINDING: Matthew exhibited eight known risk factors for suicide.

FINDING: Matthew's family, like many others in Manitoba, were left to navigate the youth mental health and addictions system on their own. For Matthew, this resulted in a repeated cycle of crisis, emergency intervention, hospitalization, discharge, repeat – with no sustained improvement. Families need assistance in understanding where to go and what is available.

RECOMMENDATION FOUR: Improve access points for children and youth experiencing a mental health crisis

The Manitoba Advocate for Children and Youth recommends that Manitoba Health, Seniors, and Active Living, along with representatives from Shared Health, children's emergency staff and child and adolescent psychiatry -- in accordance with their master plan overview of Health Sciences Centre -- evaluate practices at the Health Sciences Centre – Children's Hospital Emergency Room, with the intent of developing and implementing a child and youth-centred,

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separate and specialized access point that meets the needs of children and youth who are experiencing a mental health crisis.

RECOMMENDATION FIVE: Create mental health system Navigators to help children and youth

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.

FINDING: Manitoba Health has not provided the public with a framework for the redesign of the youth mental health and addictions system. The department has not informed Manitobans how recent and anticipated funding announcements and health system transformations are located within a systemic tiered framework. This lack of transparency serves to reinforce the siloed and disjointed nature of the health care system for Manitoba families who are left to navigate a perpetually confusing public system.

RECOMMENDATION SIX: Long-term residential mental health treatment for youth

The Manitoba Advocate for Children and Youth recommends that the Government of Manitoba, through the Department of Health, Seniors and Active Living create a long-term, residential treatment centre for youth who are in the top tier of mental health care needs and for whom less intensive options have been ineffective.

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.

FINDING: The child and family services agency provided exceptional services to Matthew and his family.

FINDING: To improve the responsiveness and effectiveness of child-serving public services in Manitoba, the two outstanding sections of *The Advocate for Children and Youth Act* must be proclaimed.

RECOMMENDATION EIGHT: Proclaim the outstanding sections of the ACYA

The Manitoba Advocate for Children and Youth recommends that the government of Manitoba set a proclamation date for the remaining portions of *The Advocate for Children and Youth Act* in the spring of 2020.

Appendix B: Relevant Sections of *The Advocate for Children and Youth Act*

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.

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;

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- (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 well-being 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.

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