PROVIDING FOR THE NEEDS OF YOUTH WITH SUICIDAL BEHAVIOURS IN GOVERNMENTAL CARE

A Thesis
Submitted to the Faculty of Graduate Studies and Research
In Partial Fulfillment of the Requirements
For the Degree of

Master of Social Work

University of Regina

By
Aaron Michael Ashton
Regina, Saskatchewan
July 2019

Copyright 2019: A. Ashton
Aaron Michael Ashton, candidate for the degree of Master of Social Work, has presented a thesis titled, *Providing for the Needs of Youth With Suicidal Behaviours in Governmental Care*, in an oral examination held on July 3, 2019. The following committee members have found the thesis acceptable in form and content, and that the candidate demonstrated satisfactory knowledge of the subject material.

External Examiner: Dr. Jenn DeLugt, Educational Psychology

Supervisor: Dr. Daniel Kikulwe, Faculty of Social Work

Committee Member: Dr. Gabriela Novotna, Faculty of Social Work

Committee Member: *Dr. Christine Massing, Curriculum & Instruction

Committee Member: *Dr. Ailsa Watkinson, Faculty of Social Work

Chair of Defense: Dr. Larena Hoeber, Faculty of Kinesiology & Health Studies

*Not present at defense*
Abstract

This thesis explores the work being done by the Ministry of Social Services (MSS) with youth-in-care in the province of Saskatchewan who are displaying suicidal behaviours. It aims to answer the research questions: 1) How are youth-in-care with suicidal behaviours being supported? 2) Are these approaches successful? and 3) how do the supports and services provided by MSS align with the United Nations Convention on the Rights of Children and the Truth and Reconciliation Committee’s Calls to Action?

The goal of this research was to explore what services and supports are being provided by MSS to those youth-in-care exhibiting suicidal behaviours; determine if these supports are successful in reducing the prevalence of those behaviours and examine those supports from a human rights perspective. This study used a qualitative, multiple case study method; utilizing content analysis to review and analyze the cases of eight different youths, all of whom had been exhibiting suicidal behaviours while in the care of MSS.

This research demonstrates just how significant the issue of youth mental health is, and how intertwined it is with many other significant issues faced by today’s youth, including addictions, trauma, and historic abuse. This study analyzes the complexities of working with youth, many of whom are dealing with multiple issues concurrently, but also in partnership with other organizations who are trying to help the youths. This study demonstrates that strong and supportive treatment plans being created for youth exhibiting suicidal behaviours can be successful in reducing the prevalence of those behaviours. I conclude that by providing appropriate mental health and addictions programming, and by appropriately supporting a youth’s independence, there is potential to reduce a youth’s suicidal behaviours.
Acknowledgements

I would like to thank those individuals who gave their assistance and support as I took on this project. My wife Azure-Dee has been nothing short of amazing as I worked on this thesis. Thank you for the countless hours of proof-reading you provided over the past many years, and for the continuous encouragement you gave and continue to give. I expect to repay this support and encouragement in the near future. To Arlene, for graciously allowing me to take time away from work whenever needed while I was in classes; for the invaluable advice you provided; and the years of support in realizing this goal. To my family for always giving me the encouragement I needed to continue on and see this all through, I thank you.

I would also like to thank my committee members, Dr. Ailsa M. Watkinson, Dr. Gabriela Novotna, and Dr. Christine Massing for sharing their time and wisdom in helping me see this through to completion. I especially would like to thank Dr. Daniel Kikulwe for everything he has given to me throughout the past couple of years. You not only gave me a great deal of your time, you provided me with invaluable insight and knowledge, and you were patient with me as I worked on this project. Thank you.
# Table of Contents

Abstract.................................................................................................................i

Acknowledgements.............................................................................................ii

Table of Contents..................................................................................................iii

List of Figures.........................................................................................................v

**CHAPTER ONE: Introduction**........................................................................1
1.1 Background.....................................................................................................2
1.2 Significance of the Research.........................................................................3
1.3 Research Goals..............................................................................................4
1.4 Research Questions........................................................................................4

**CHAPTER TWO: Conceptual Framework**......................................................6

**CHAPTER THREE: Literature Review**...........................................................11
3.1 Children and Youth in Foster Care...............................................................11
3.2 Mental Health................................................................................................13
3.3 Trauma...........................................................................................................15
3.4 Addictions....................................................................................................17
3.5 Exposure to Peer Suicide.............................................................................19
3.6 Impact of Residential Schools.....................................................................20
3.7 Non-Suicidal Self-Injury, Suicidal Ideation and Suicide Attempts................22
3.8 Youth Suicide in Canada and Other Countries...........................................24
    Canada...........................................................................................................24
    Australia........................................................................................................25
    New Zealand..................................................................................................25
    United States of America..............................................................................26
3.9 Treatment for Suicidal Behaviour.................................................................27
3.10 Suicide Prevention Efforts...........................................................................29
    Canada...........................................................................................................29
    Australia........................................................................................................34
    New Zealand..................................................................................................35
    United States of America..............................................................................36

**CHAPTER FOUR: Method and Design**...........................................................39
4.1 Case Study......................................................................................................39
List of Figures

Figure 1: File location.................................................................46
Figure 2: Identified sex...............................................................46
Figure 3: Cultural status.............................................................47
Figure 4: Legal status.................................................................47
Figure 5: Placement type............................................................48
Chapter 1

Introduction

This study focuses on how the Ministry of Social Services (MSS) in Saskatchewan provides services and support to its youth-in-care who have either expressed suicidal thoughts, have been hospitalized due to suicidal behaviours, or attempted suicide on one or more occasion. Included in this study are the following key areas: objectives of the research, research question(s); current literature; an outline of the study methodology, research method and data analysis; research findings; discussion; implications for policy and considerations for future research.

Exploring the reasons behind suicidal behaviours in youth, and the supports they require is a topic for which there exists substantial literature. My research looked specifically at the follow-up case-planning and support being provided by MSS in Saskatchewan to its youth-in-care with suicidal behaviours. I am not aware of any other research having been done in this specific area. Given the uniqueness of this topic, my intention was to conduct research which was as thorough as possible. My rationale for choosing this topic was the fact that I work in the field of child welfare for MSS, and have seen the impact that youth suicide can have on families. I also chose this topic due to the rising numbers of suicidal behaviours being expressed by youth-in-care, and a desire to explore how this can be addressed by MSS.

I analyzed eight youth-in-care case files, specifically looking at case-planning, referral processes, and treatment plans for youth-in-care with suicidal behaviours. In conducting this case study research, I found that many of the issues that contribute to suicidal behaviours in youth, namely mental health problems, addictions, prior abuse, and neglect, are issues that many of MSS’ youth-in-care possess, and struggle with each day.
I found that by providing appropriate mental health and addictions programming, and by appropriately supporting a youth’s independence, there is potential to reduce a youth’s suicidal behaviours.

**Background**

The suicidal behaviours of youth in the care of the MSS in Saskatchewan is an important topic, given its increasing occurrence. MSS does have processes in place to analyze circumstances where a youth has completed suicide, however, there is no process that takes a critical look at circumstances where youth express suicidal ideation, non-suicidal self-injury (NSSI) or attempt suicide. Based on internal MSS statistics, between January 1, 2011 and December 31, 2016, there were 277 separate incidents involving youth in the care of MSS who had either inflicted a NSSI, expressed suicidal ideation or attempted suicide. Of the 277 incidents that occurred, 39 involved NSSI, 95 involved suicidal ideation, and 143 involved a suicide attempt. Single attempts and individuals repeating suicidal behaviours are all included in these numbers. It is also important to understand that these numbers account for reported incidents only, and are likely not representative of all suicidal acts being committed by youth-in-care, which makes it difficult to portray the exact picture and extent of the problem.

MSS collects data on the suicidal behaviour of its youth-in-care and has been able to provide quantitative data that gives some insight into which youth are more affected by suicidal behaviour. For example, information gathered by MSS tells us that between 2011 and 2016, those most likely to attempt suicide are Indigenous female youth, approximately 15 years of age, in care under a long term wardship order, residing in some form of group home, and that they primarily attempt suicide by way of a drug
overdose. This is valuable information for MSS in identifying who is most at risk; who
they need to pay close attention to in an effort to prevent further suicide attempts and
deaths; and which youth are most in need of supports.

Although this research focusses on youth in the care of MSS displaying suicidal
behaviours, it is important to recognize that suicide is a concern for all youth in
Saskatchewan, especially Indigenous youth. The average for all suicides in Canada was
approximately 11/100,000 in 2012, with Saskatchewan reporting a rate of 13/100,000 in
2012 (Conference Board of Canada, 2017). The Federation of Sovereign Indigenous
Nations’ (FSIN) Mental Health Technical Working Group recently released a report
indicating that the rates of youth suicide are much higher for Indigenous youth in
Saskatchewan than the Canadian average. This report shows that the rate of suicide for
Indigenous females between the age of 10 and 19 was approximately 48/100,000, with
Indigenous males of the same age having a rate of 41/100,000 (The Federation of

**Significance of the Research**

This research is designed to explore the work that is being done by MSS, to
successfully treat youth-in-care with suicidal behaviours. Though some youth suicides
may not be preventable, many of these deaths may be avoided if the right types of
support are offered, and there is an increased awareness and knowledge of who may be at
greater risk, and how best to help these youth. This research will be of value to those
youth who are currently in the care of MSS; future MSS clients; and the families
involved with MSS who have children expressing suicidal behaviours and who are still
residing in the parental home. The research will also inform child welfare social work
practice and help to determine where change is possible and desirable. This knowledge will be applicable and relevant to other Canadian jurisdictions and services to youth-in-care.

**Research Goals**

The goal of this research is to analyze the follow-up planning that occurs between MSS and the youth-in-care who have demonstrated suicidal behaviour, and to explore the strengths of that follow-up planning. Based on current research about the behaviours and characteristics of youth with suicidal behaviours, this research will explore whether or not the actions by MSS are in line with what current literature suggests youth with suicidal behaviours require in order to be appropriately supported. This research will also explore, through a human rights lens, the services and support that are being provided to these youth, and how they relate to the needs and priorities of children as identified by the United Nations Convention on the Rights of the Child. Lastly, this research will explore how the services and support provided by MSS align with the Truth and Reconciliation Committee’s Calls to Action for child welfare agencies.

**Research Questions**

The questions that this research aims to explore include the following:

1. How does MSS respond to and support its youth-in-care with suicidal behaviours?

   1a. what follow-up plans were implemented for those youth-in-care expressing suicidal behaviours?
2. Are the supports and services provided by MSS aligned with what current research suggests youth with suicidal behaviours require for appropriate treatment?

3. Are the supports and services provided by MSS aligned with the United Nations Convention on the Rights of the Child and the Truth and Reconciliation Committee’s Calls to Action?

This study sought answers to the above three questions primarily because of the goal to keep a sustained focus on children and families impacted by issues of suicide, specifically those in governmental care. The focus of this research was on how MSS in Saskatchewan provides services and support to its youth-in-care who have either expressed suicidal thoughts, have been hospitalized due to suicidal behaviours, or attempted suicide on one or more occasion. The other intention of raising these research questions was to normalize the discussion of mental health in a continued effort to recognize those who have been stigmatized, disrespected, and denied their respect and dignity because of mental illness.
Chapter 2

Conceptual Framework

As a focus for my research, I have chosen to ground my work within a human rights perspective. The United Nations Convention on the Rights of the Child (UNCRC) is a document, which very clearly outlines the rights that should be afforded to children to ensure that they are able to live safe and healthy lives. Canada became a signatory to the UNCRC in 1990 and ratified it in 1991. The UNCRC is the most widely and rapidly ratified international human rights treaty in history, and as of 2016, it has been ratified by 196 nations (Bernstein, 2016; Kikulwe & Mann, 2018). While the UNCRC speaks to 54 separate articles pertaining to the rights of children, my conceptual framework will focus primarily on Article 24 – Health and Health Services, and Article 39 – Rehabilitation of Child Victims (OHCHR, 2018). Though all of the articles outlined in the UNCRC are relevant and important in the protection of children, these two articles are especially relevant to the topic of the provision of governmental services to youth-in-care with suicidal behaviours.

Article 24 speaks to the importance of children being afforded the right to best forms of health care in order to keep them healthy (OHCHR, 2018). This article is relevant to my research topic as access to mental health services for youth experiencing suicidal behaviours is crucial, but not always available. The importance of, and access to, appropriate health services is an area that will be discussed in further detail in my literature review and discussion sections. Article 39 looks at the rehabilitation that should be provided to child victims, and is also relevant to my research topic. Article 39 speaks to children who have been the victims of abuse and neglect being afforded the
right to have whatever assistance they require in order to recover physically or psychologically (OHCHR, 2018).

Equally important, a focus on mental health is also emphasized under the Canadian Charter of Rights and Freedoms. Principle 7 reads, "Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice." Similarly, Principle 15(1) indicates that, "Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability" (Canadian Charter, 1982, s 6(2)(b)).

Many youth-in-care who are suicidal have been the victims of trauma at some point in their lives. Research states that trauma is strongly linked to suicidal behaviours at later points in the lives of many youth (Conradi & Wilson, 2010). Exploring this research topic through a human rights lens allowed me to focus on the needs and priorities that these youths should be provided, but may not be receiving.

There are two significant events that have had a devastating and long-lasting impact on the Canada’s Indigenous population. These are the introduction of the Residential School System, and the Sixties Scoop. The residential school system in Canada refers to a period of time (1870s to the mid-1990s) where more than 150,000 First Nations, Metis and Inuit children were removed from their homes by the Canadian government and church officials and placed in church-run schools. According to Wilk, Maltby and Cooke (2017), the purpose of residential schools was to “civilize and Christianize Aboriginal children” (p. 2). By being forcibly displaced, many of these
Indigenous youth experienced physical, sexual, spiritual, and psychological trauma while attending residential schools. Due to the trauma sustained from attending residential schools, many Indigenous youths have now grown up enduring health problems, substance use issues, suicidal behaviours, involvement in the criminal justice system, and a breakdown in their relationships with family and friends (Spencer, 2017; Truth and Reconciliation Canada, 2015; Wilk et al., 2017).

Bombay, Matheson and Anisman (2011) discuss that as a result of being placed in residential schools, many Indigenous people believe that the ability to transmit their culture to the next generation was disrupted, which resulted in the undermining of their parenting capacity and an ability to provide a healthy environment for their children to grow up in. For many residential school survivors, the undermining of their parenting capacity and the inability to provide a safe and healthy home environment led to their children removed from their care during the Sixties Scoop. Bombay et al. (2011) discuss how there is evidence showing that children of residential school survivors are at higher risk of developing depressive symptoms as a result of the impact that residential schools had on their parents. While residential schools are no longer in existence, the intergenerational trauma caused by them continues to pose a significant risk to children and youth, particularly those in governmental care (TRC, 2015).

Though commonly referred to as the Sixties Scoop, this event actually began in the 1950s and lasted until the 1980s. According to Spencer (2017), in 1951, with the creation of Amendment 88 of the Indian Act, provincial laws were allowed to be enforced on reservations, which permitted provincial social services agencies to apprehend and remove children from reserve communities. It is estimated that between
the 1950s and 1980s over twenty-thousand Indigenous children were removed from their parents and placed with non-Indigenous families in other provinces, countries and continents. Due to the transracial adoptions that occurred as a result of the Sixties Scoop, many Indigenous youths experienced a loss of their cultural identity (Spencer, 2017).

The Truth and Reconciliation Commission of Canada (TRC) was created in 2008 by the Government of Canada, with a mandate to create a comprehensive record detailing the policies, operations and outcomes of residential schools and the Sixties Scoop. This report was completed as a way of sharing the testimonials of survivors of residential schools, in the hopes of providing the opportunity for reconciliation and renewed relationships. As part of this report, the TRC created a list of 94 calls to action for both the provincial, territorial, federal and Indigenous governments (TRC, 2015).

The timing of this research is especially relevant as it follows the recent calls to action from the TRC, calling upon governments to recognize the needs and priorities of Indigenous peoples (TRC, 2015). Since a large percentage of Canadian youth displaying suicidal behaviours are Indigenous (FSIN Mental Health Technical Working Group, 2017), and as MSS data shows that Indigenous youth represent the majority of those residing in foster or kinship care in Saskatchewan, I wanted to include the TRC’s calls to action for child welfare agencies as a focus of my research.

There are several TRC calls to action that deal with child welfare and are relevant to my research. Those of relevance are included as part of my conceptual framework. Specifically, these are calls to action 1(v), requiring that all child-welfare decision makers consider the impact of the residential school experience on children and their caregivers; 4(ii), requiring that child-welfare agencies and courts take the residential school legacy
into account in their decision making; and 4(iii), requiring (as an important priority) that placements of Indigenous children into temporary and permanent care be culturally appropriate (TRC, 2015).
Chapter 3

Literature Review

This literature review was completed to help inform my understanding of the complex needs of youth with suicidal behaviours. To be able to understand these needs, and to be able to answer the aforementioned research questions, I completed a review of current literature on a wide variety of issues related to suicidal behaviour in youth. I reviewed literature on the different types of suicidal behaviours, most common risk factors for predicting future suicidal behaviour, as well as how these risk factors are interconnected. The literature reviewed explored resources between 1993 and 2018, and consisted of peer-reviewed journals, books, government documents and reports, and newspaper articles.

This literature review explores available research, showing strong linkages between suicidal behaviours in youth and the presence of mental health problems. Research shows the strong connection between suicidal behaviours and youth’s issues of substance use, historical abuse, neglect, and trauma, as well as the impacts of familial residential school attendance. This review also explores research showing that with the rates of suicide already being high for youth, they are even higher for Indigenous youth, and youth residing in governmental care. Lastly, this review considers how Canada and other countries similar to Canada have implemented prevention programs in an attempt to reduce the rates of suicide.

Children and Youth in Foster Care

For those children who have spent time residing in foster care, evidence is present to suggest that time in care may lead to the development of suicidal behaviours. Using
administrative records from hospitals, Taussig, Harpin and Maguire (2014) report that children and adolescents with a history of being in the foster care system are between two to six times more likely to attempt or complete suicide than those in the general population. In a review of several studies conducted in Denmark and Sweden, Taussig et al. (2014) report that emotional neglect and maltreatment (particularly sexual and physical abuse) show a strong linkage to adolescent suicidality. The same research by Taussig et al. (2014) indicates an increase of suicidality for those youth who are placed in the foster care system due to maltreatment, with incidents of suicidal ideation (reported by the youths) ranging from 7% to 27%.

Kretschmar and Flannery (2011) also discuss how family instability and displacement can have an impact on adolescent suicide rates. They explain that youth who are removed from their family homes due to neglect, abuse, or both often lack a sense of belonging, or feel as though they have become a burden to their families. Briggs (2015) argues the importance of youth having a sense of belonging as it is crucial in the development of a positive sense of emotional well-being and good mental health. As a result of family instability and displacement, youth often struggle to establish a sense of belonging or value in their new environment, which increases the risk of suicidal behaviour amongst this population (Briggs, 2015).

It is important to recognize that while the risks of suicidal ideation, suicide attempts, and suicide completion are high for those adolescents who are residing in the foster care system, the risks are even greater for youth residing in group homes. Gramkowski et al. (2009) discuss the fact that adolescents are often placed in group homes due to high risk behaviours that prevent them from being able to reside in typical
foster home or kinship care placements. Anderson (2011) further explains that for those adolescents residing in group homes, the likelihood of experiencing incidents of suicidal ideation was seven times higher than those residing in foster care or kinship care. Anderson (2011) also notes that adolescents residing in group home placements were almost five times more likely to show signs of clinically depressive symptoms, which is shown to have a significant association with suicidal ideation. In conducting a review of literature on this subject, research as to the reasons why youth in foster care (especially group homes) in Canada experience suicidal behaviours at a higher rate, is minimal. Further research on the dynamics of what youth are experiencing in out-of-home placements in Canada, and how those dynamics are impacting them and causing higher rates of suicidal behaviour is needed.

The increase in the rates of suicidal behaviours for those youth residing in group homes versus those residing in a foster care or kinship care-based placements are likely tied directly to a youth’s sense of belonging, as was previously discussed. The aforementioned research suggests that being placed in a group home with other youth who have behavioural issues likely has far more negative impacts on a youth’s sense of belonging than for youth placed in family-based foster care environment with fewer other youth.

**Mental Health**

In exploring how mental health issues impact youth displaying suicidal behaviours, it is important to emphasize the difference between mental health and mental illness. For this study, mental health refers to an individual’s emotional and psychological state, their well-being and self-perception. Having good mental health
allows an individual to develop resilience, enabling them to more effectively navigate life’s challenges and stresses. This study also adopts Magellan Health Insights’ (2018) definition of mental illness as a wide range of disorders that have the ability to affect an individual’s mood, thinking and behaviours, which in turn may lead to problems functioning in work, family and social settings.

Research shows that not only are the rates of suicidal behaviour higher for those adolescents in the foster care system, the prevalence of mental health problems adds to the complexities faced by these youth. Baidawi, Mendes and Snow (2014) explain that both international and Canadian research has shown that adolescents who are residing in the foster care system experience higher rates of mental health problems than their counterparts who are not in care. Baidawi et al. (2014) state that “mental health conditions commonly diagnosed among adolescent out-of-home care populations include depression, anxiety, post-traumatic stress disorder, conduct disorder, oppositional defiant disorder and attention deficit hyperactivity disorder” (p. 201).

In 2014, the Mental Health Commission of Canada (MHCC) stated that of the total number of individuals who died in Canada as a result of suicide, 90% had been experiencing a mental problem or disorder. While these statistics are reflective of deaths by suicide in Canada by all ages, in 2009, over one-fifth of those who died by suicide were between the ages of 10-29 (Butler & Pang, 2014). Bennett et al. (2015) cite similar findings:

Even though about 50% of youth who die by suicide are seen by a primary care provider in the 6 months prior to death, well-documented modifiable risk factors for SRB [Suicide Related Behaviour], namely, untreated or inadequately treated
mental health problems (particularly depression and substance abuse), are present at death in as many as 90% of these youth (p. 246).

Bennett et al. (2015) discuss that these statistics are an indicator that issues of depression and substance use in youth are not receiving the attention they deserve, and there is a clear need for strengthened policies and practices focused on preventing suicide related behaviours.

It is also important to recognize that the risk factors previously discussed are not mutually exclusive of each other, and many youth experience several, if not all, of these risk factors concurrently. The literature suggests that attention should be focused on supporting youth who are struggling with addictions and childhood trauma, as these factors can be, and often are a precursor to the development of mental health related problems.

**Trauma**

Another factor which research shows has a relationship to suicidal behaviours in youth is exposure to trauma. Childhood trauma can stem from many different life events, however, trauma stemming from childhood abuse and neglect presents as the most commonly seen. Understanding this is crucial to those working in the field of child welfare as a large number of those children residing in foster care or kinship care were removed from their families due to abuse or neglect. According to Liu et al. (2017), in 2012, childhood sexual abuse was as high as 10% within the general population in Canada, with general neglect reported to be as high as 32%. These findings are shared by De Araujo and Lara (2016) whose research indicates that while physical and sexual abuse are contributing factors for suicidal behaviours in youth, “childhood emotional abuse is
the most detrimental to the development of a considerable range of suicidal behaviours, including the progression from ideation to attempts” (p.18).

Along with child abuse and neglect, research suggests that youth being exposed to family violence in the home can also have an impact on youth displaying suicidal behaviours (Conradi & Wilson, 2010). There is strong evidence showing that child abuse and neglect, paired with exposure to family violence are clearly linked to negative outcomes for children and youth, including negatively impacting school performance and the development of emotional and behavioural problems (Conradi & Wilson, 2010). Conradi and Wilson (2010) state some of the most common forms of major childhood trauma come from child abuse and family violence, and that “without effective intervention, there is compelling evidence of long-term adverse consequences of untreated trauma lasting into adulthood that include substance abuse, suicidality, serious mental illness, and long-term physical health factors associated with early death” (p. 622).

On the topic of trauma, it is worth exploring the impact that the suicidal behaviours of a youth can have on their families. Children who have had a sibling die from suicide are more likely to show higher rates of new-onset depression than their peers, with those rates increasing even higher if the youth had pre-existing psychiatric disorders (Cerel, Jordan & Duberstein, 2008). For families who have experienced the suicide of a child, it is not uncommon for their feelings of loss to be compounded by difficulties in functioning. Cerel et al. (2008) report:

These difficulties included decreases in cohesion (defined as “emotional bonding that family members have toward one another”) and adaptation (defined as “the
ability of a marital or family system to change its power structure, role relationships, and relationship rules in response to situational and developmental stress”) (p.38).

This research shows clear linkages between exposure to trauma and the development of emotional and behavioural issues, and suicidal behaviours. It is because of these types of negative impacts that we need to ensure we are providing assistance to youth who have been exposed to traumatic events, and to all those affected by it, both directly and indirectly.

Addictions

Addiction is another risk factor that needs to be considered when discussing suicidal behaviours. According to King, Kerr, Passarelli, Foster and Merchant (2010), alcohol and substance use are major and common predictors for youth who attempt suicide, as well as those who complete suicide. Garnefski and Jan De Wilde (1998) discuss that suicidal ideation and attempts are often seven times more common in adolescents who are chemically-dependent than their counterparts in community samples. According to Wu et al. (2004), research has shown there to be a significant association between the use and abuse of alcohol and suicide attempts.

Addictions and substance use, specifically alcohol abuse, are risk factors for suicidal behaviour in many countries. A Finnish psychopathology study found that 26% of adolescent suicide victims between the ages of 13 and 19 had a dependence on alcohol or other substance (Rowan, 2001). The same study found that half of the participants who died as result of suicide, had alcohol in their systems at the time of suicide. It was also found that for those adolescents who had been diagnosed with some form of
depressive disorder, 33% had a diagnosis for alcohol abuse or dependence (Rowan, 2001). There are also linkages between drug use and suicidal behaviours in adolescents. In a study conducted by Wong, Zhou, Goebert and Hishinuma (2013), youth who have used heroin at least once in their lifetime had the highest odds of reporting suicidal behaviours, followed closely by those youths who had used methamphetamines. Other drugs, including cocaine, ecstasy, hallucinogens, and cannabis also showed a correlation to youth suicidal behaviour, but to a lesser degree.

Sampaio, Mesquita and Goncalves (2016) explain that when dealing with adolescent drug use, drugs are classified as either ‘soft drugs’ or ‘hard drugs’. They describe hard drugs as being those known to induce psychological or physical dependence with the ability to increase the risks to the user’s physical and mental health. Soft drugs are described as those which are typically used for recreational purposes and believed to not pose significant risks to a users’ health. Sampaio et al. (2016) describe opiates as being the prototypical example of drugs in the ‘hard drug’ category, while cannabis is the most common and generalized example of a ‘soft drug’.

Sampaio et al. (2016) explain that:

The belief in the innocuous nature of cannabis causes many youths to deny their use of the drug when asked about their drug habits in the clinical setting; to many youths, the concept of “drug use” is restricted to the so-called synthetic drugs (p. 13).

Many youths believe that cannabis is no different than other substances which cause varying degrees of psychoactive effects, such as caffeine or nicotine. This belief has contributed to cannabis becoming the most commonly used drug among adolescents
Adolescent cannabis use poses several concerns as research has shown that the use of cannabis is associated with the development of mood disorders, including major depressive disorders, as well as being associated with psychosocial maladjustment, including failure at school and future use of alcohol and illegal drugs (Sampaio et al., 2016).

Serotonin, one of the body’s chemical compounds and neurotransmitters that is responsible for regulating mood and social behaviours, is something that can be negatively affected through the use of drugs (Andrade, De Micheli, Silva, Souza-Formigoni & Oliveira Goeldner, 2016). Gipson and Kaivas (2016) explain that drugs have the ability to negatively interact with and affect the body’s use of serotonin, and that decreased levels of serotonin have been associated with impulsivity and maladaptive decision making in youth, including suicidal behaviours.

**Exposure to Peer Suicide**

The impact that peer suicide can have on youth deserves attention as research shows that it can significantly increase the risk of suicidal behaviours for exposed youth. Crepeau-Hobson and Leech (2013) conducted a critical review of literature focusing on exploring the correlation between exposure to suicidal behaviours of peers and the impacts that those behaviours can have on youth. Their review explored twenty-three articles (twenty of which were from the United States) involving studies conducted in the United States, Iceland, Hong Kong and the United Kingdom, in which 112,508 youths had participated. Of the twenty-three studies that they analyzed, twenty had results showing that there was evidence that the exposure to the suicidal behaviours of peers or acquaintances can have a significant impact on the risk of suicidal behaviours for youth.
Cox et al. (2012) suggest that one possible explanation for this relationship is that exposure to the suicidal behaviours of peers or acquaintances has the potential to exacerbate pre-existing psychiatric conditions of youth. Crepeau-Hobson and Leech (2013) suggest another possible explanation being that the peers of youth who have died by suicide, tend to exhibit higher rates of suicidal risk factors such as psychopathology, substance use and family dysfunction. Due to this, exposure may not be entirely random. It may be that the youth who exhibit these aforementioned risk factors are simply more likely to associate with others who share similar risk factors.

Similar results have also been shown by Feigelman and Gorman (2008), who report that there is evidence showing that a peer’s suicidal behaviour has a direct and immediate impact on a youth, encouraging higher levels of depression, and increased levels of suicidal thought and attempts. As a means of prevention, Feigelman and Gorman state that in the months directly following the loss of a peer to suicide, suicide risk screening should be offered to these youth as a standard procedure. This view is echoed by Crepeau-Hobson and Leech (2013) who state that it is critical that a youth’s exposure to peer suicide be included in suicidal risk assessments given how significant the impact can be.

**Impact of Residential Schools**

Research indicates that even though today’s youth did not experience Residential Schools (RS) firsthand, there are generational impacts in having one or more relatives attend. Evans et al. (2017) conducted a study which showed that those individuals who had a parent or grandparent who had attended RS had increased odds of both experiencing suicidal ideation and attempting suicide than those whose parent or
grandparent did not attend RS. Hackett, Feeny and Tompa’s (2016) completed a similar study, exploring the impacts that intergenerational RS attendance has on Indigenous peoples in five categories: self-perceived health, mental health, distress, suicidal ideation, and suicide attempts. Their research found that those individuals who had a family member who had attended RS, had a higher likelihood of negative self-perceived health and mental health. They also found that there was a higher likelihood that those individuals had self-reported experiencing mental distress, suicidal ideation, or had attempted suicide within the past 12 months.

Using data from the 2002-2003 First Nations Regional Longitudinal Health Survey (RHS), Bombay, Matherson and Anisman (2014), discuss how the distress that is often associated with having had a parent who attended RS may begin to manifest itself during adolescence for Indigenous youth. They explain that 26.3% of Indigenous youth who have had a parent attend a RS had experienced suicidal ideation compared to 18% for those Indigenous youth who did not have any familial RS attendance. Using data from the 2008-2010 RHS, their data found that 31.4% of Indigenous youth (living on reserve) who had familial RS attendance reported symptoms of depression, compared to 20.4% of those Indigenous youth with no familial RS attendance.

Bombay et al. (2014) found that Indigenous youth with familial RS attendance present are more susceptible to stressors, which is note-worthy as it highlights the impacts of structural oppression on one’s ability to develop healthy coping mechanisms to stress and trauma. Hackett et al. (2016) explain that within the Indigenous population, coping with traumatic experiences can often include the use of harmful substances such as drugs and alcohol. As the research findings will discuss, all of the youth whose cases
were reviewed within this study had experienced some form of traumatic event in their life.

It is important to recognize the impact that residential schools can play in the suicidal behaviours of Canada’s Indigenous youth. It was only in 1996 that the last residential school in Canada was closed (Union of Ontario Indians, 2013), and while today’s youth would themselves not have attended RS, there is a strong possibility that older generations within their family may have. We must recognize the connection between intergenerational exposure to RS and today’s Indigenous youth as it relates to suicidal behaviours, a problem that is often exacerbated when children are placed in governmental care. The solution to the placement of Indigenous youth and the related suicidal behaviours for these children remains distant in the face of the current overrepresentation of this population in governmental care, including in the province of Saskatchewan. According to Taylor (2018), as of December 2017, approximately 70% of the children in governmental care in the province of Saskatchewan are Indigenous.

Non-suicidal Self-injury, Suicidal Ideation and Suicide Attempts

Non-suicidal self-injury (NSSI) is described as “deliberately injuring oneself without suicidal intent. The most common form of NSSI is self-cutting, but other forms include burning, scratching, hitting, intentionally preventing wounds from healing, and other similar behaviours” (Bender, 2017). Research on suicidal behaviour among youth does not always put a lot of emphasis on NSSI as being a predictor of suicide attempts, however, a study conducted by Asarnow, Berk, Zhang, Wang and Tang (2017) suggests that it may be an important predictor. Their study looked at the probability of future suicidal behaviour over the course of 18 months involving youth who had been suicidal
emergency department patients. Asarnow et al. (2017) found that NSSI at the time of the index hospital visit ended up being a strong predictor of a future suicide attempt, with youth exhibiting NSSI being more than twice as likely to attempt suicide at some point within 12 months post-discharge.

Suicidal ideation is described as the act of having thoughts of harming, or killing oneself, or both (Evans et al., 2017; Bridge, Goldstein, & Brent, 2006). The rise in suicidal ideation, suicide attempts and completed suicide have become a major global concern (Evans et al., 2017). It is no longer just adolescents who are attempting suicide that our society needs to be concerned with, but with those who exhibit suicidal ideation as well. According to Evans et al. (2017), suicidal ideation rates are as high as 17% among adolescents, and one-third of those adolescents will attempt suicide at some point in the future. Lewinsohn, Rhode and Seeley (1998) indicate that increasing suicidal ideation is a legitimate risk factor for predicting future suicide attempts, or to rephrase, risks of potential suicide attempts will increase as suicidal ideations become stronger and last longer.

Brent et al. (1993) explains that suicidal behaviour is generally regarded as one of the most significant risk factors shared by adolescents who end up dying as a result of suicide. The risk of reoccurring suicide attempts is very high for those adolescents who have been hospitalized for a previous attempt, and/or those with frequent expressions of suicidal ideation. According to Bostwick, Pabbati, Geske and McKeen (2016), one of the strongest predictors of the eventuality of suicide are prior attempts, with a widely cited meta-analysis showing that almost 9% of individuals admitted for psychiatric care due to suicidal ideation or an attempt will likely die as a result of a completed suicide. This is
confirmed by King et al. (2010) who state that one of the primary risk factors for adolescents who have attempted suicide is whether or not they have prior suicide attempts.

**Youth Suicide in Canada and Other Countries**

**Canada.**

At a broad level, according to Health Canada (2013), suicide is the ninth leading cause of death for all Canadians, and the second leading cause of death for adolescents and adults between the ages of 15 and 34. In 2011, the suicide rates in Canada for females between the ages of 10 and 14 was 1.8 per 100,000. For females ages 15 to 19, the number jumps to 5.4 per 100,000. For males, the rate was 1.2 per 100,000 for those between the ages of 10 and 14, and 12.5 for those between the ages of 15 and 19 (Bushnik, 2016).

Both the FSIN Mental Health Technical Working Group and Health Canada state that the suicide rates for Indigenous youth are higher than that of non-Indigenous youth (The FSIN Mental Health Technical Working Group, 2017; Eggertson, 2015). As this thesis explores Saskatchewan youth-in-care with suicidal behaviours, it is important to recognize how prevalent suicide is for Indigenous peoples within the province. Eggertson (2017) explains that in Saskatchewan alone, between 2005 and 2016, nearly 500 Indigenous people have died by suicide. The high rates of suicide among youth, particularly Indigenous youth, is not a concern that exists just within Canada. The following section looks at youth suicide in Australia, New Zealand and the United States. These countries were chosen as they share similar demographics with Canada, a history
of colonization of their Indigenous population, and are dealing with similar concerns of youth suicide.

**Australia.**

Lifeline Australia (2016) reports that as of 2015, the overall suicide rate in Australia is the highest it has been in the past ten years with approximately eight deaths occurring each day as a result of suicide. Death by suicide is roughly three times higher for males than it is for females. It is also reported that for every completed suicide, there are approximately 30 suicide attempts that occur (Lifeline Australia, 2016). Similar to Canadian statistics which show that suicide is highest among Indigenous youth, statistics in Australia show that suicide rates are roughly between 4.4 and 5.9 percent higher for Indigenous and Torres Strait females (5.9%) and males (4.4%) between the ages of 15-19 than for those who are non-Indigenous and of the same ages (Australian Bureau of Statistics, 2012; Harlow, Bohanna & Clough, 2014). These statistics are similar to Canada’s, which show that the suicide rates of Indigenous youth are higher than that of their Non-Indigenous counterparts, with Indigenous females having rates higher than Indigenous males (FSIN Mental Health Technical Working Group, 2017).

**New Zealand.**

Using data collected by the New Zealand Ministry of Health, Harlow et al. (2014) found that between 2009 and 2010, suicide rates increased for all age groups, with rates of suicide for Maori youth approximately two and a half times higher than non-Maori youth. Statistics show that between 2010 and 2012, Maori males between the ages of 15-24, had an average suicide rate of 52.4/100,000 while Maori females had a rate of 29.2/100,000 (Ministry of Health: Manatu Hauora, 2018). Between 2008 and 2013,
suicide rates were highest for those between the ages of 15-24, however, as of 2014, those between the ages of 25-44 became the demographic with the highest levels of suicide (Harlow et al., 2014). There are currently no studies available to explain the change in this trend. According to the New Zealand Ministry of Health, similar to Australia, males completed suicide roughly three times more often than females (Ministry of Health: Manatu Hauora, 2016). According to data from the Ministry of Social Development, over the past 15 years, 77 children have died in New Zealand state care. Of those 77 children who died, approximately 20% were due to suicide (Collins, 2016).

**United States of America.**

According to the National Institute of Mental Health (NIMH), suicide was the tenth leading cause of death overall in the United States in 2015, claiming more than 44,000 lives. For those aged 10-14, it was the third leading cause of death, and for those aged 15-34, it was the second leading cause of death (NIMH, 2017). From 1999 to 2016, the rates of suicide for all ages have increased by approximately 28% from 10.5 to 13.4 per 100,000, with male suicides roughly four times higher than that of females (NIMH, 2017). Suicide rates were highest for American Indian or Alaska Native males (24.7 per 100,000) and females (8.7 per 100,000) (NIHM, 2017). Pilowsky and Wu (2006) confirm what others have found, namely that there are increased rates of suicidal behaviour in youth who are residing in state care. In one study looking at children residing in state care within the United States, approximately 33% of youth-in-care reported having suicidal thoughts, threatening suicide, or attempting suicide at some point while in care (Chavira, Accurso, Garland & Hough, 2010). Further to this, the
study indicated that of those who had reported attempting suicide, eight percent had attempted within the past six months.

In the United States of America, a report from the Centers for Disease Control and Prevention (2015) indicated that there are approximately 25 suicide attempts for every suicide completion within the general population. However, this estimate rises to between 100 and 200 suicide attempts for every completed suicide for those between the ages of 15 and 24. A national survey by the Centers for Disease Control and Prevention (2015) showed that in 2013, eight percent of students (grades 9-12) had attempted suicide on one or more occasions in the past 12-month period, and 17% of students had given serious thought to attempting suicide in the past 12-month period.

**Treatment for Suicidal Behaviour**

One of the most important areas of review with respect to identifying patterns of suicidal behaviour, predicting future suicidal behaviour, and preventing suicidal behaviour is the involvement that youth have with mental health services. Sobolewski, Richey, Kowatch and Grupp-Phelan (2013) discuss the fact that not a lot is known regarding youth who are released from a hospital emergency department after an admission due to suicidal behaviour or ideation. However, roughly half of the youth who are seen in a hospital emergency department for mental health problems will return within two months of that initial visit. This research by Sobolewski et al. (2013) goes on to show that those youth who attend hospital emergency departments on a repeat basis are more likely to be in foster care and are at a higher risk to exhibit harmful behaviours including non-compliance in continuing with the recommended psychiatric follow-up. Bostwick et al. (2016) also discuss the importance of psychiatric follow-up for
adolescents who have attempted suicide. They show that after a suicide attempt, there is a statistically significant reduction in the risk of death by completed suicide when the individual receives either hospital services, or psychiatric services. Their research also demonstrates that regardless of whether or not the survivors have been hospitalized after the attempt, those who attended follow-up psychiatric appointments were significantly less likely to complete suicide than those who had not attended a follow-up appointment (Bostwick et al., 2016).

Along with the research which indicates that there is a reduction in suicidal risk for those who continue with psychiatric help, there is also research indicating that follow-up help is often not utilized. Burns, Cortell and Wagner (2008) discuss how research has shown that follow-up psychiatric care is often not completed, citing one study which showed as many as 77% of the individuals who participated in the study had failed to either attend, or simply did not complete the follow-up treatment that was recommended for them after a suicide attempt. With even one follow-up treatment to deal with suicidal behaviours, the psychiatric symptoms and feelings of hopelessness are significantly reduced (Burns et al., 2008).

One such reason for why follow-up psychiatric help may not be occurring for youth with suicidal behaviours may be due to many of these youth not having access to mental health programming. The stigma attached to mental health may be another reason for youth not to complete psychiatric follow-ups (Hawton, Saunders and O’Connor, 2012). Marr et al. (2009) explain that in many northern communities in Canada it is often difficult to recruit mental health professionals. In many cases, mental health services are often brought into northern communities as a response to crisis situations, such as a wave
of youth suicides. These services are usually provided as an emergency response and are not designed to remain in place for long. In these types of situations, youth are provided the initial treatment they require but have no option for further follow-up as the services may not be readily available in their communities. Marr et al. (2009) also explain that northern communities in Canada with a high proportion of Indigenous residents, often do not welcome mental health services due to a lack of cultural specific components.

**Suicide Prevention Efforts**

**Canada.**

Canada has recognized the issue of suicide to be a growing concern, however, these growing concerns have not yet led to a national official suicide prevention strategy. *The CASP Blueprint for a Canadian National Suicide Prevention Strategy*, created by the Canadian Association for Suicide Prevention (CASP) laid the groundwork in 2004, with revisions in 2009 for all Canadian provinces and territories to create their own suicide prevention strategy (CASP, 2009). In 2012, the *2012 Federal Framework for Suicide Prevention Act* was created by the Government of Canada as a call to move forward with the development of a national suicide prevention plan. The framework is intended to encourage provincial, territorial, and federal governments to begin collaborating with non-governmental stakeholders to coordinate their suicide prevention efforts (Government of Canada, 2012). While many provinces and territories have worked hard to create prevention plans designed to address some of the issues that are contributing factors to suicide such as addictions and mental illness, to date, only some Canadian provinces and territories have used the CASP Blueprint to create prevention plans specific to suicide.
Manitoba, Nova Scotia, New Brunswick, Nunavut and Quebec have all taken the lead in the development of provincial and territorial suicide prevention plans, however, not all of these suicide prevention plans have shown themselves to be successful. While current statistics could not be located on all of the provinces that have implemented suicide prevention plans, data gathered by The Conference Board of Canada (2017) shows that the majority of the provinces that have implemented a suicide prevention plan have reported an increase in the number of provincial suicides since their plans were released and initiated.

Manitoba, one of the jurisdictions to implement its prevention plan in 2008, saw suicide rates increase from 12.9/100,000 in 2008 to 14/100,000 in 2012. New Brunswick implemented its prevention plan in 2007, and suicide rates increased from 10.5/100,000 in 2007 to 14.5/100,000 in 2012. Nunavut implemented its prevention plan in 2011, and suicide rates increased from 63.2/100,000 in 2011 to 66.4/100,000 in 2012. The two exceptions to this were Quebec, which implemented its suicide prevention plan in 1999, and Nova Scotia, which implemented a plan in 2006. Quebec has seen a steady decline in their suicide rate from 16.9/100,000 in 2000 to 12.8/100,000 in 2012, and Nova Scotia’s suicide rate has dropped slightly from 11.7/100,000 in 2006 to 11.5/100,000 in 2012 (Conference Board of Canada, 2017).

It would be beneficial for provinces and territories to explore the steps that Quebec and Nova Scotia have taken to reduce their suicide rates. Eggertson (2015) states that Quebec established suicide prevention centers in every region of the province, set up a provincial suicide hotline, and implemented more efficient mental health treatment and follow-up services for those individuals who have attempted suicide. Also, for staff at
child protection agencies, there is now access to better training to aid in their work with youth with suicidal behaviours. Even though Nova Scotia’s suicide rates have not decreased as much as Quebec, the implementation of their suicide prevention strategy has seen positive results. Nova Scotia has implemented a vast array of online training, resources and publicly available materials to those who may be contemplating suicide, those who are dealing with a suicide loss, and professionals working with individuals displaying suicidal behaviours (Provincial Strategic Framework Development Committee, 2006). Both Quebec and Nova Scotia have provided successful and tangible ideas that other provinces and territories in Canada could adopt.

Recognizing the significance of mental health issues, and the role they can play in the development of suicidal behaviours, in 2012, the Mental Health Commission of Canada (MHCC) released Canada’s first mental health strategy, entitled Changing Directions, Changing Lives (MHCC, 2012). This mental health strategy aims to address the issues of mental health problems in Canada by focusing its attention on the following six key strategies:

1. Promote mental health across the lifespan in homes, schools, and workplaces, and prevent mental illness and suicide wherever possible;
2. Foster recovery and well-being for people of all ages living with mental health problems and illnesses, and uphold their rights;
3. Provide access to the right combination of services, treatments and supports, when and where people need them;
4. Reduce disparities in risk factors and access to mental health services, and strengthen the response to the needs of diverse communities and Northerners;
5. Work with First Nations, Inuit, and Métis to address their mental health needs, acknowledging their distinct circumstances, rights and cultures; and
6. Mobilize leadership, improve knowledge, and foster collaboration at all levels.

Within these six strategies, a total of 26 priorities and 109 recommendations were generated. Work is currently underway by the MHCC to assess the progress of its strategy.

In 2014, Dr. Fern Stockdale Winder, Commissioner of Mental Health and Addictions released her report, *Working Together for Change: A 10-Year Mental Health and Addictions Action Plan for Saskatchewan*, which has been endorsed by the Government of Saskatchewan (Mental Health and Addictions Action Plan, 2014). Out of the following seven main categories of the action plan, 16 recommendations were made:

- Enhance access and capacity and support recovery in the community;
- Focus on prevention and early intervention;
- Create person and family-centred and coordinated services;
- Respond to diversities;
- Partner with First Nations and Métis Peoples;
- Reduce stigma and increase awareness; and
- Transform the system and sustain the change.

The Government of Saskatchewan has been criticized by those working in the field of mental health for its lack of response to implementing the recommendations in Dr. Winder’s 2014 report (Cowan, 2017). Recently though, the Government of Saskatchewan began taking steps towards implementing those recommendations.

Saskatchewan’s 2018-19 Budget has allocated 5% ($284M) of its total health care
spending towards mental health services and supports with a goal to increase that spending to 7%. This would make Saskatchewan’s spending in the area of mental health more in line with the national average (“Mental Health Association,” 2018). Along with the $284M currently allotted for mental health services and support, there is an additional $83M coming from other government-wide expenditures that is being allocated to address mental health concerns (Government of Saskatchewan, 2018).

Of the $284M mental health budget, $11.4M has been allocated to explore new targeted investments designed to improve mental health and addictions services for children and youth, and to enhance access to community mental health and addictions supports. Some of the ways the provincial government aims to achieve these goals is by using that money to create new child and adolescent specialist positions to reduce wait times for mental health services; implement targeted physician training programs to improve capacity to treat youth mental health problems; and by creating a multi-disciplinary community recovery teams in eight different communities aimed at providing treatment to those with complex and persistent mental illness (Government of Saskatchewan, 2018).

In 2018, the Federation of Sovereign Indigenous Nations (2018) released the Saskatchewan First Nations Suicide Prevention Strategy (SFNSPS). This suicide prevention strategy aims to address the issues of suicide in Saskatchewan by focusing its attention on the following nine key strategies:

1. Taking a focused and active approach to suicide prevention.
2. Supporting community-led action and building on cultural and community strengths.
3. Investing in the next generation by taking actions to support healthy early childhood development.

4. Better equipping children and youth with skills to cope with adverse life events and negative emotions.

5. Strengthening the continuum of culturally appropriate mental health services.

6. Strengthening the continuum of care for substance use and addictions services.

7. Developing a strategy aimed at reducing the high rates of violence and child sexual abuse.

8. Providing communication about prevention, and progress of the SFNSPS.


Youth suicide has become a global epidemic experienced by a multitude of countries. A 2014 report released by the World Health Organization (WHO) states that approximately every forty seconds someone somewhere around the world dies from suicide, and there is an even higher number of suicide attempts. Suicide occurs in all parts of the world and, similar to Canada, suicide is the second leading cause of death for those aged 15-24 (WHO, 2014). While youth suicide is an issue that is being faced on a global scale, I also looked at how the issue of youth suicide is managed in other countries. The following section explores what measures Australia, New Zealand and the United States have implemented in an attempt to reduce their rates of youth suicide. Again, these countries were explored as they share similar demographics to Canada.

**Australia.**

Having recognized that the rates of youth suicide are concerning and that something needs to be done to reduce those numbers, Australia has been implementing
strategies in an attempt to address this problem. Harlow et al. (2014) have looked at some of the suicide prevention initiatives recently introduced in Australia and found that some showed potential. Not all the strategies analyzed showed as much promise as others, but several initiatives appear to be yielding successful results.

Examples of these initiatives include the development of suicide prevention training for community members to equip them to assist in identifying and helping at risk youth. Given the impact that suicide has on youth in Australia, youth were asked to be involved in the development and evaluation of this training (Harlow et al., 2014). Another initiative demonstrating effectiveness in suicide prevention is a government program, which allows for psychological services to be provided for a period of two months for individuals who present to a general practitioner with suicide-related behaviours. This initiative supports those who have self-harmed, are experiencing suicidal ideation, and those who are at higher risk due to the impact of knowing someone who has died from suicide (Orygen, The National Centre of Excellence in Youth Mental Health, 2016).

New Zealand.

The New Zealand Government implemented a 10-year plan beginning in 2006 to address the rising rates of youth suicide; a plan focused on developing a collaborative approach to addressing the inequalities in suicide rates of different cultural groups, while reducing the overall suicide rates (Associate Minister of Health, 2006). Similar to strategies implemented by Australia, New Zealand’s strategy included thirty action items aimed at reducing the rates of youth suicide including actions based on: cultural components; community involvement; education and training for health and social
services staff; access to support services; as well as many other items (Associate Minister of Health, 2006). While the intention of New Zealand’s suicide prevention strategy was good, statistics are showing that it has not been effective in reducing the rates of suicide. The number of suicides has been steadily rising over the past several years and a plan is currently in place to revise and create a new suicide prevention strategy (Law, 2017). One explanation, held by some, as to why the strategy has not been successful, is that the focus was too heavy on suicide being a cultural issue faced by Maori people, and not by New Zealand residents as a whole. There is a belief that the issue of suicide should not have such strong focus on race, but on all people (Law, 2017).

**United States of America.**

The United States has multiple initiatives currently underway designed to help reduce and prevent suicide attempts. One of the main initiatives is the 2012 National Strategy for Suicide Prevention created by the U.S. Surgeon General and the National Action Alliance for Suicide Prevention. This strategy was created as a follow up to the National Strategy for Suicide Prevention that was released in 2001 and has been designed to look at those areas where the 2001 report fell short, as well as to build upon the areas which had been successful. The National Strategy for Suicide Prevention is comprised of thirteen goals and sixty different objectives. Some of the issues that it looked at were how mental illness is related to suicide; the effects of substance use, trauma and violence; groups who may be at an increased risk for suicide; effective types of intervention for suicide; and the importance of implementing suicide prevention in an effective manner (US Department of Health and Human Services, 2012).
An exploration of the current state of youth suicide in the aforementioned countries shows that there are similarities both in terms of their statistics on suicide deaths, as well as their suicide prevention strategies. Research shows that for each of these countries, the suicide rates for youth are high, and significantly higher for Indigenous youth compared to non-Indigenous youth. It is apparent that the epidemic of youth suicide continues to be a growing concern as all of these countries have had to build upon their previous suicide prevention strategies, expanding their scope. One area that all of these countries appear to be focusing on is the development of stronger community support in the implementation of suicide programming. Another area of improvement which is shared among these countries is the strengthening of medical services available for those individuals with suicidal behaviours. This focus is on providing better training for medical professionals, increasing capacity of services, and introducing measures such as online support services.

While these countries all share similarities in their suicide prevention strategies, there are also some significant differences that warrant discussion. All of these countries have suicide rates that are significantly higher for their Indigenous peoples, however, the suicide prevention strategy in the United States, though comprehensive, presents as general in nature, and does not provide any specific focus on its youth or Indigenous populations. New Zealand and Australia’s suicide prevention strategies both have a heavy focus on supporting their Indigenous populations, and to a slightly lesser degree, their youth populations. Both the New Zealand and Australian strategies have more of a grassroots community approach to their prevention plans, while the United States’ strategy presents as having a stronger focus on governmental involvement. All of these
countries have a history of colonization with their Indigenous populations, and all of these countries have suicide rates that are higher for their Indigenous populations. Research is clear that suicide affects Indigenous peoples at much higher rates than non-Indigenous peoples.

This literature review serves to provide an overview on the complex nature of suicidal behaviours displayed by youth. Research shows us that there are multiple factors that can contribute to suicidal behaviours in youth, and it is not uncommon for these factors to occur concurrently. Youth with pre-existing mental health problems, those who have experienced childhood abuse and neglect, and those who struggle with substance use are at an increased risk for the development of suicidal behaviours. Likewise, youth who have been removed from their homes and placed in out-of-home care, especially those who are residing in group home type placements, demonstrate suicidal behaviours at a rate higher than their counterparts.

This review also uses other countries as examples in demonstrating how the suicidal behaviours of youth are not an issue that is of concern only in Canada. The issue of youth suicide is a global concern that warrants not only the provision of adequate services to its affected youth, but also attention given to developing new and innovative methods of dealing with a growing epidemic. This literature review indicates that Canada does recognize youth suicide as an important issue and has begun taken steps to address it. However, given widespread nature of the issue, Canada will undoubtedly be dealing with the issue of youth suicide for years to come.
Chapter 4
Method and Design

Case Study

This thesis research utilizes a qualitative multiple case study method. My goal was to conduct research, which explored the complexities of providing support to youth with suicidal behaviours and the impact of that support being provided. Stake (1995) describes case study research as beneficial when the researcher wants to explore the particularities and complexities of a case. I found a qualitative multiple case study method to be appropriate for this research as it allowed me to attain the depth of information required to answer my research questions.

As the focus of my research dealt with how MSS supports youth with suicidal behaviours throughout the province of Saskatchewan, I made the decision to review multiple cases as there can exist a multitude of differing factors varying from case to case. Creswell (2013) explains that by using multiple cases within a study, the researcher shows the different perspectives that may exist on an issue. Yin (2014) states that “evidence from multiple cases is often considered more compelling, and the overall study is therefore regarded as being more robust” (p.57). By using a multiple case study method, I was able to obtain a greater depth of information than would have been achieved by using a single case.

Throughout this research, the term ‘cases’ and/or ‘files’ is often used in reference to the youth whose stories were used in this research. These terms refer to information and documents that are collected and housed for each youth-in-care. Each youth’s case and/or file is used to maintain an updated and ongoing record of their time in care. They are used to document a youth’s achievements and assess their ongoing needs. In using
this terminology, it is not my intention to treat or turn any of these youth into objects. This terminology is being used as it is the common terminology that is used in the day-to-day case management practice by those caseworkers who are working with and supporting these youths and their families. Using this terminology also provides confidentiality of the identity of those whose information was used for this research.

**Design**

Content analysis was employed in this research to systematically review existing MSS data on the services and support offered by MSS to its youth-in-care with suicidal behaviours. Content analysis is an effective means of conducting research as it is a systematic and objective means of describing and quantifying the phenomena that is to be the focus of the research (Elo et al., 2014). According to Maier (2017), benefits of using content analysis include its ability to be used in gathering data from a multitude of different sources, including books, journals, newspapers and personal communications. It is also beneficial when reviewing historical materials as it eliminates the problematic issue of participant recall or misremembering situations.

For this research, the eight cases that were chosen were my units of analysis. The main source of data that was used were the case notes that document the interventions with youth experiencing suicidal behaviours. These case notes are kept on the child’s file and primarily document the work being done directly by the caseworker with the youth. Work done indirectly with a youth, such as the completion of referrals for programming and communication with other professionals speaking to a youth’s progress in their programming, is also kept on the youth’s file. Aside from case notes, documentation that was beneficial to this research included follow-up reports by psychiatrists, psychologists,
addictions counsellors, educational facilities and group home incident reports. These sources of information all served to provide a greater depth understanding as to the interventions with these youths. According to Creswell (2013), utilizing multiple sources of information is a technique often used in case study research as it provides as much detail as possible.

Prior to commencing any data gathering, I created a specific set of questions (Appendix A) that would assist in guiding me as I researched the cases. These questions were created to assist me in recognizing and tracking important pieces of information as I came across them. Some of the questions were designed to allow me to track certain demographic data such as age, gender, or type of foster placement. Other questions were designed to gather qualitative information on items such whether the youth had been the victim of prior abuse or neglect; whether they had pre-existing mental health problems; whether they struggled with substance use issues; or the specific details of their treatment plans. The focus of my review was on examining the practices used by MSS in dealing with youth who are exhibiting suicidal behaviours, and on the follow-up case planning provided to each youth.

**Sampling Procedures**

As this research was designed to be specific to Saskatchewan, the target population was youth residing in Saskatchewan who had been placed in MSS care, and who had expressed suicidal behaviours. For the purposes of this research, the target population were youth-in-care between the ages of 11 and 17. The reason for choosing this age range was due to the fact that approximately 95% of the 277 incidents of suicidal behaviours previously discussed involved youth within that age range. This research
utilized a purposive sampling method in order to ensure that the cases chosen for this research met specific requirements. Creswell (2013) describes purposive sampling as occurring when the individual doing the research purposely chooses the sample that is to be researched. By doing so, the researcher can ensure that the cases being selected for the study meet specific criteria of the phenomenon being studied.

For the purposes of this thesis, the following criteria were used for selecting case files:

- Youth (male or female)$^1$ between the ages of 11 and 17.
- Having one of the following:
  
  (a) Two or more reported incidents of expressing suicidal ideation;
  
  (b) Two or more suicide attempts; or
  
  (c) Two or more hospitalizations due to suicidal behaviours.

- Were in the care of the MSS at the time the above-mentioned incidents occurred.
- Have not had any reported suicidal behaviours for approximately two or more years.
- Are no longer involved with MSS.

MSS provides child protective services throughout the province of Saskatchewan, with three distinct geographical areas providing services. The South Service Area provides services to Regina and surrounding communities including those as far west as the Alberta border and as far east as Manitoba border. The Centre Service Area provides services to Saskatoon, Kindersley, Rosetown, and as of June 2016, all the reservations

---

$^1$ From the larger sample that my selection of cases were chosen from, male and female were the only identified genders.
which were previously served by the Saskatoon Tribal Council. The North Service Area provides services to Prince Albert and communities as far north as Buffalo Narrows. While the South, Centre and North Service Areas each use the same policy manuals, the community-based services available to MSS staff to assist with supporting families are vastly different depending on geographical location. Stratified sampling occurs when the researcher separates a population into non-overlapping groups, and then chooses a random sample from each different group (Lemm, 2012). In order to ensure that the cases used in this research were reflective of regional differences (if any), I used a geographically stratified random sample to ensure that an equal number of cases from the South, Centre and North Service Areas in Saskatchewan were selected.

Once approval had been provided by both the Research Ethics Board of the University of Regina and by MSS, I selected my cases for review. I compiled a list of all the youth-in-care who had displayed suicidal behaviours within the past five years. From this list I eliminated all cases which did not meet the criteria outlined above. From the remaining cases, I used a guideline to randomly select eight cases for review. Creswell (2013) suggests that for case study research, no more than four to five cases need to be used for a single study as this number is usually sufficient to identify themes and to conduct cross-case theme analysis. Creswell (2013) also discusses researchers utilizing what is referred to as maximum variation sampling, choosing files with greater variations at the beginning of the study to increase the likelihood that the results will reflect differences or different perspectives. As this research aimed to explore the different limitations that may be present for child protection caseworkers throughout the different
geographical locations in Saskatchewan, a sample of eight cases was chosen to maximize the likelihood that any differences or different perspectives were present.

Choosing eight cases allowed for me to have a good representation from each of MSS’s Service Areas (South, Centre and North). As the sample size is limited to eight, and as specific criteria was required to be met before a case was chosen, it may not be possible to generalize the results of this research back to the larger population of youth expressing suicidal behaviours in Saskatchewan. However, the information gathered and analyzed as part of this thesis provides a level of in-depth information sufficient to answer the research questions.

Every youth involved with MSS has their own unique personality, and comes from a different background, which presents unique challenges for MSS to address. Not every youth will respond to a case plan in the same way, meaning every case plan must be tailored to each youth to support their specific needs. Understanding what a youth expressing suicidal behaviours needs in order to be appropriately supported is one issue, it is another to figure out how to provide that support using only the services one has available, which may not always be the services required. The factors listed above, and more, play a vital role in how MSS is able to support its youth-in-care who are expressing suicidal behaviours, and it is because of these varying factors that I utilized a multiple case study approach to examine the variety of approaches used. To my knowledge, there has been no research done on the follow-up support services being provided by MSS in Saskatchewan to its youth-in-care with suicidal behaviours. As such, my intention was to conduct research as thoroughly as possible.
The rationale for choosing cases where youth-in-care have not had any reported incidents of suicidal behaviour for approximately two or more years was based on research completed by Burns et al. (2008). In their study, they looked at the impact that different forms of treatment had on recurrent youth suicide rates over a two-year period. Their research showed that approximately 20% of the youth involved in their study had made repeat suicide attempts at some point during the two-year follow up period. Based on this research, I made the decision to choose cases where there had been no reported incidents of suicidal behaviour for approximately two or more years as I felt this would provide a sound basis for presumed success in treatment and case-planning.

Additionally, as I wanted to ensure a representative sample, I chose cases based on MSS data, which indicates that approximately 75% of all suicide related incidents involving children in the care of MSS involve female youth; approximately 60% involve youth residing in group homes; and approximately 65% involve Indigenous youth. My aim was to have a sample of cases chosen that was roughly representative in those key areas. The following is a demographic breakdown of the notable differences among the youth representing the eight files that were reviewed. The ages of these youth ranged from 14-18, with a mean age of 15.3.

Figure 1 indicates the three geographical regions representing the eight files that were reviewed for this research.
Three files were chosen from both the Centre and South Service Areas, and two were chosen from the North Service area.

Figure 2 shows that of the eight files selected, seven files involved a female youth, and one involved a male youth.

**Figure 2 – Identified Sex**

Figure 3 shows that six of the eight files reviewed involved youth who identified as Indigenous, either as a Status Indian, Non-Status Indian, or Metis, while the remaining two identified as non-Indigenous.
As shown in Figure 4, of the files reviewed, four involved youth who were in care under a long-term wardship status, two were under a permanent wardship status, one was under temporary wardship status, and one was in care under an extension of support agreement (Section 56).

Figure 4 – Legal Status

---

2 A child committed to the Minister until 18 years of age. Often considered for older children where the involvement of their family or extended family makes an adoption plan unlikely.

3 A child committed to the Minister until 18 years of age. Where parental rights are to be severed and where adoption is a viable option.

4 A child placed in the custody of the Minister for a period up to 6 months.

5 An agreement to provide assistance is available to persons who were permanent/long term care wards, upon discharge from care on their 18th birthday or any time before their 21st birthday. This agreement, referred to as a Section 56 agreement requires the youth to be actively employed, or involved in an educational program in order to continue receiving financial support from the Ministry.
As Figure 5 indicates, the following breakdown of youth-in-care placements (at time of incident) were also noted during the file review.

**Figure 5 – Placement Type**

![Placement Type Chart]

The youths’ placements at the time of each incident were reviewed. Between the eight youth, there were a total of 27 incidents of suicidal behaviours that occurred. Sixteen of those incidents occurred while youths were residing in a group home, seven while youth were residing in a foster home, three while residing in family/kinship care, and one while a youth was residing in an independent living situation.

**Data Analysis Procedures**

To assist in keeping the data organized, a spreadsheet was used to track all the recorded information regarding the questions in Appendix A. Any other pertinent information found during the research was recorded and kept in a folder specific to each youth. Once each case had been reviewed, I completed a detailed analysis of all the information that I had gathered. Initially, each file was reviewed independently from the group to look for any recurring themes or concerns that were present. I found it helpful using Appendix A as a guide as it allowed me to focus on and track specific themes; such as how often certain behaviours were displayed by the youth; how often specific supports
were being utilized; or how a youth responded to a different types of support. Once each file was reviewed independently from the group, the cases were then collectively analyzed.

Upon completion of this analysis, a summary of findings was completed, which explored the similarities and differences discovered between the cases. The analyses focused on areas where MSS services and support were provided for youth with suicidal behaviours, as well as the barriers which prevented MSS from being able to adequately support them. Lastly, based on the findings of the research, conclusions were made regarding the supports and services provided by MSS, and the impact that they had for these eight youth.

**Ethical Issues**

In preparing to conduct this research, there were certain ethical considerations that needed to be considered. One of the major considerations for this research was confidentiality, as the data that I was collecting and analyzing came from individuals who have experienced personal struggles in their lives which were significant enough for each of them to consider suicide. One of the principles of ethical research from the Canadian Association of Social Workers’ Guideline for Ethical Practice (CASW, 2005) is to ensure informed consent, anonymity and confidentiality. As part of this research project, great care and attention was given to ensuring that once all of the data had been collected, and before any analysis began, any and all identifiers were stripped from the data to ensure that confidentiality was guaranteed.

With respect to informed consent: the Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences and
Humanities Research Council of Canada’s Tri-Council Policy Statement (2014) clearly outlines criteria for conducting research without obtaining informed consent. Articles 3.7A states that if all of the following criteria is met, the Research Ethics Board (REB) may consider allowing research to proceed without the researcher obtaining informed consent:

- the research involves no more than minimal risk to the participants;
- the alteration to consent requirements is unlikely to adversely affect the welfare of participants;
- it is impossible or impracticable to carry out the research and to address the research question properly, given the research design, if the prior consent of participants is required;
- in the case of a proposed alteration, the precise nature and extent of any proposed alteration is defined; and
- the plan to provide a debriefing (if any) which may also offer participants the possibility of refusing consent and/or withdrawing data and/or human biological materials, shall be in accordance with Article 3.7B.

Regarding sections (a), (b) and (c); the data gathered was stripped of any and all identifiers to minimize the risk to those whose case information was reviewed. Secondly, the focus of this research was not on those youths whose case information was being reviewed, but rather, on MSS case practices and the supports that MSS provided to those youths. Lastly, as part of the selection criteria, only those cases involving youth who were no longer involved with MSS (due to aging out of the foster care system or being
returned home) were considered. As MSS was no longer involved with these youth, there
was minimal risk to those whose case information was reviewed.

Another consideration in proceeding with this research without seeking the
consent of those individuals whose case information was being used was the belief that
seeking their consent may have actually led to greater risk than not seeking consent. As
the focus of my research was on MSS case practices, it was my belief that locating and
contacting these youths to seek their consent to use information pertaining to their
previous suicidal ideation, NSSI, or suicide attempts posed the risk of re-traumatization.
If the youth in question was still dealing with suicidal issues, or had been able move past
these behaviours, I felt the risk of re-traumatization was greater than the risk of
conducting this research without their consent. Further to this point, as I chose cases
involving youth who were no longer involved with MSS, their current whereabouts were
unknown to me and I felt that any attempt to obtain this information and contact them
would have been a violation of their privacy.

Regarding section (d), the nature of the proposed alteration is as follows: to
proceed with this research utilizing the documentation owned by the Government of
Saskatchewan, without seeking the consent of those individuals whose information is
contained within that documentation. Section (e) speaks to providing an opportunity to
refuse consent or withdraw from the research during some form of debriefing. As no
debriefing was required or intended to be used as part of this research, this opportunity to
refuse consent or withdraw from the research was not available.

Another principle from the CASW’s Guideline for Ethical Practice is that
research should be conducted by a responsible and qualified researcher (CASW, 2005).
As an MSW student, I have completed all necessary academic requirements prior to completing this research.

One issue that needed to be recognized is the fact that I am currently employed by MSS, which is where my research data came from, and my current position requires me to work with cases similar to those that I used for this research. The benefit of this was that in conducting research using MSS data, I had the advantage of the experience and understanding of our system, knowing what to look for and where to locate such information. My goal in conducting this research was to remain as objective as possible in my exploration of the services and support provided by MSS to these youths. In an attempt to achieve this, I routinely stepped back from this research to reassess my perspective and maintain an objective view of the data being reviewed. One of the questions I would routinely ask myself when conducting my analysis was whether I was making an assessment based on knowledge I had as a result of my current position in the government, or as a result of the academic literature I had reviewed while completing this thesis. Throughout this thesis I have made a conscious effort to remain as objective as possible with my data analysis.
Chapter 5

Findings

My goal in conducting this research was to explore the MSS’ practices in managing cases involving youth-in-care displaying suicidal behaviours, and their methods of support, which led to these youth experiencing a reduction in suicidal behaviours. Based on the review of these cases, this chapter demonstrates several key findings. The key findings are based on the exploration of the impacts of the treatment plans created for these youth in response to their suicidal behaviours, specifically the medical and mental health treatment that they received. This section includes discussions of length of stay in care, youths’ struggles with histories of physical and sexual abuse, mental health problems and substance use, frequency of contact with assigned caseworkers, independence, and barriers to service.

Reasons for Apprehension

The specific details for child apprehension differed between files but there were several common factors noted between the files. Parental addiction to either alcohol, drugs, or both were documented as a contributing factor for seven of the eight youth being initially removed from parental care, and in many cases remaining in MSS care. In five of the eight cases, chronic neglect was also a contributing factor for the youth having been removed from parental care.

Neglect often takes many different forms, ranging from general neglect (involving a parent not providing the basic needs for a child such as shelter, food, clothing, medical care and other such needs), to severe neglect (abandonment, willful endangerment, and malnutrition), to physical neglect (failure to enrol in school, or ignoring a child’s
emotional needs). Chronic neglect is defined as when a child’s basic needs for necessary healthy development go unmet by a parent or caregiver and are re-occurring (Child Welfare Information Gateway, 2013; The Child Abuse Prevention Center, 2014).

Failure to address these concerns of neglect was in many cases the reason why the youth remained in care. Three of the eight cases saw youth removed from parental care due to concerns of either physical or sexual abuse. Two of those cases had insufficient evidence to verify that the abuse had in fact occurred, however, there had been other safety concerns present, which were significant enough to warrant the youth being removed from parental care. Though evidence may not have been sufficient to substantiate that physical and/or sexual abuse had occurred, these youths maintained that abuse did occur. In three of the eight cases, youth were removed from parental care due to concerns of youth being exposed to family violence in the home. Most of these cases involved multiple risk factors (addictions, abuse, neglect, family violence) as the cause of their initial and continued involvement.

**Time in Care and Placements**

All of the files that were chosen for review involved youth who had spent a significant amount of time in care before beginning to display suicidal behaviours. On the low end, one youth had spent approximately four years in care before their first recorded incident of suicidal behaviour, while on the high end another youth had spent approximately 16.5 years in care before their first recorded incident of suicidal behaviour. Multiple files showed that the youths had experienced numerous placement moves during their time in care. In one case a youth had experienced eight placement moves during
their time in the care of MSS (in care 7 years), with another having experienced as many as 41 moves (in care 16 years, 6 months).

Placement moves for youth-in-care occur for a variety of reasons, and my research found that there were several common reasons for these particular youth experiencing a move. The most common reason was due to repeatedly running away from a placement. In most files, the caregivers were initially accepting of this behaviour, but would eventually advise MSS that they were no longer willing to be a caregiver for the youth when running became a repeated pattern. Often, by the time a youth on the run was located, their placement had been relinquished and another youth-in-care was in the space. These two aforementioned scenarios occurred on multiple occasions in the cases I reviewed.

Youth often experienced a placement change due to their non-compliance to specific rules outlined by the caregiver. On many occasions, caregivers would have rules the youth were expected to adhere to, such as curfew, or chores. Most caregivers were flexible regarding a youth missing curfew on occasion or not completing all of their required chores, however, youth who were repeatedly non-compliant with a caregiver’s rules were often asked to leave or MSS were asked to find a new placement for the youth. In these situations, some caregivers allowed the youth several chances to come back and reside at the placement if they could demonstrate willingness to adhere to the rules, but often the caregiver would request that the youth be placed elsewhere.

Another common reason for youth experiencing a placement move was due to the caregiver not being able to manage the youth’s behaviours. The files reviewed in this research involved youth dealing with both mental health problems and behavioural
issues. Several examples were found where the caregivers were simply unable to manage the complex behavioural needs of the youth. In these cases, the caregivers asked for the youth to be removed and placed elsewhere as they felt they were unable to provide the required level of care and supervision.

**Culture and Family**

Of the eight cases reviewed, six youth identified as Indigenous. Of those six youth, only two advised that they were not interested in any Indigenous programming. Of the remaining four, two did express an interest in exploring their cultural heritage and attending culture-based events and programming, however, they were selective in the types of events and programming they would participate in, often declining offers for additional cultural activities. Of the remaining two youth, one was actively involved in exploring their cultural heritage and routinely participated in culture-based events that were offered to them. For the remaining youth, there was no documentation present to suggest that the topic of exploring their Indigenous heritage through culturally-based programming had been explored with them. Apart from the case lacking documentation that culturally based programming was offered to the youth, attempts were made in all other cases to offer culturally-based programming and activities to their youth.

MSS works in partnership with many Indigenous community-based organizations to provide culturally-based programming and activities to its clients. Examples of the types of programs offered are work with Elders, talking circles, counselling, youth mentorship and parent-aides. There are also activities routinely offered by the different First Nations Agencies throughout the province, including cultural camps, feasts, and sweats, which are available to Indigenous families involved with MSS.
In all eight cases, the youths had contact with their family, though this contact varied from case to case. In four of the cases reviewed, contact with the biological parent(s) was strained due to historical familial issues. In these cases, relationships had been strained either as a result of the youth’s resentment towards their parent(s), based on choices their parent(s) had made or not made in the past, or due to the youth recognizing the unhealthy influence their parent(s) had on them. For these youth, contact with their biological parent(s) was infrequent. In cases where contact with a biological parent was not safe, contact with siblings, or other family members was encouraged and facilitated when and wherever possible. In most cases, visits with siblings were facilitated by, and occurred at the group homes the youths were residing in, or at visitation centres, operated by community-based organizations. Aside from visits with parents and siblings, contact most often occurred with grandparents, aunts and uncles.

**Physical/Sexual Abuse**

In all cases reviewed, the youths disclosed that they had been either sexually abused, physically abused, or both at some point in their lives. In the majority of the disclosures, the abuse was perpetrated by a close family member. In three cases, the abuse was part of the reason the family had become involved with MSS and the youth initially placed in care. In the remaining five cases, disclosures indicated that the abuse had occurred prior to involvement with MSS, often when the youth were of a young age. In several of these cases, charges were not laid on the perpetrator due to the belief that the victim’s recollection of the event was inconsistent, rendering them an unreliable witness.

Evidence was present in five of the eight files that some form of support services were offered to the victims once the disclosures were made. On three of those five files,
counselling services were offered to the youth once the disclosures had been made. In one case, counselling had already been in place prior to MSS becoming involved, and in the remaining case, counselling services were offered to the youth, however, the youth declined those services. On the three files where there was no documentation that services had been put in place by MSS specifically regarding the historic sexual/physical abuse allegations, counselling services were later put in place, but to address different issues.

Mental Health

In seven of the eight cases, there was evidence that the youths were dealing with some form of mental health problem concern prior to exhibiting suicidal behaviours. In five of those seven cases, the youth had been diagnosed by a psychiatrist, prior to exhibiting suicidal behaviours, as having some degree of depression. Of the remaining two files, one youth was dealing with mental health concerns related to past familial trauma. The other struggled with behavioural issues such as abnormal defiance to those in authority, physical aggression towards people and animals, and Attention-Deficit/Hyperactivity Disorder. In each of the seven files where there was evidence of prior mental health concerns, evidence was present that the youths had met with at some point or were presently meeting with a psychiatrist or counselor to address these concerns.

Documentation was present to indicate that, of those youth who had been diagnosed with depression, four had been prescribed some form of anti-depressant medication. In three of those cases, the youths at some point voluntarily discontinued the use of their prescribed medications without consultation with their psychiatrist. The
remaining youth remained medically compliant up until the end of their involvement with MSS. For the three youth who discontinued their medication, all three had admitted that they stopped taking their medication as they felt that they no longer required it.

**Addictions**

Of the eight cases reviewed, six of the youths had prior and current addictions issues with either alcohol, drugs, or both. In five of those six cases, there was evidence that these youths had been exposed to parental addictions when they were younger, which in many cases had been a contributing factor for the family becoming involved with MSS, or the youth being apprehended. In each of these six cases, the youths had either been referred to an addictions counsellor for ongoing support, placed in youth detox (either by MSS or the justice system), or had been involved in some form of youth in-patient treatment program. In three of the six cases where addictions were present, the youth had been involved with both a detox/in-patient program and an addictions counsellor. MSS was not always responsible for the referrals to addictions programming for the youth,\(^6\) when addictions were present, addictions-specific programming was often part of MSS’s follow-up treatment plan for the youth.

Of the six youth who had been involved in some form of addictions programming, only three seemed to display any real commitment to the programming. For these youth, the majority of appointments with their addictions counsellors were attended, and they generally seemed in favour of receiving help with their addictions. For one of these youth, though they did commit to attending programming, they maintained that they did not have any problematic issues with alcohol or drug use. The remaining three youth

---

\(^6\) In several cases, addictions programming was a requirement of the youth’s involvement with the criminal justice system.
were less accepting of receiving help with their addictions, and were less engaged in their programming believing that they did not have any issues with drugs or alcohol. Of those three youth, one later discontinued all addictions treatment (aside from being admitted to a secure youth detox facility at one point). The remaining two did continue attending appointments with their addictions counsellors, however, in one of those cases, attending addictions treatment was a court ordered condition of the young offender program.

**Treatment Planning**

My research focused mainly on mental health and medical treatment. In all cases reviewed, some level of mental health or medical treatment was provided at some point as part of their treatment planning. Seven of the youth had been regularly seeing a counsellor, or psychiatrist, for pre-existing concerns prior to the commencement of their suicidal behaviours, while the remaining youth had not. All incidents involving suicidal behaviours captured in this study resulted in MSS either connecting the youth to some form of counselling or psychiatric services, or assisting them in maintaining the pre-existing mental health arrangements that they had.

**Mental health treatment.**

Of the eight youth whose cases were reviewed, all received counselling as part of their treatment plan. In addition to counselling, five youth also had regular contact with a psychiatrist. Though five of these youth had contact with both a psychiatrist and counsellor as part of their treatment, psychiatry appointments generally became less frequent as time went on, often becoming used on an “as needed” basis. My research found counselling to be the primary form of mental health treatment offered to these eight
youths, most often being provided through community based organizations (acting as extensions of a health region), or by school counselors.

Six of the youth had been participating in counseling prior to them beginning to display suicidal behaviours. In these cases, counselling was occurring to address concerns of historical abuse or familial relationship issues. In cases where counselling was already occurring, MSS would assist by ensuring that transportation was provided, when necessary, for the youth to attend their appointments, and by continuing to encourage them to attend their programming. In the cases where counselling did not exist prior to the youth’s beginning to display suicidal behaviours, MSS ensured that referrals were made to a counselling program for the youth as part of their treatment plan. In almost all cases, counselling was arranged as a result of the first incident of suicidal behaviour. There were two cases where counselling was not set up after the initial incident of suicidal behaviour. In one of those cases, MSS attempted to arrange services for the youth, but the youth refused all services offered. In the other, counselling was not offered to the youth after the first incident, however, regular appointments were set up with the youth’s psychiatrist.

File documentation was not always clear in indicating how long counselling occurred for with many of these youth. On most of the files, documentation would at some point indicate that counselling was occurring on a regular basis, as per the treatment plan. There would then be large periods of time where there was no indication that counselling was occurring. Documentation would later indicate that the youth was again meeting with their counsellor. In reviewing these cases, I could not determine precisely
whether counselling had been occurring on a continuous basis, or if it had stopped and resumed at a later date.

The content of the counselling was not always clearly identified within the files. As most files did not contain progress reports from the counsellors, information as to what the youth were working on with their counsellors was usually found in case notes referencing conversations between the youths’ caseworker and the counsellor, or from conversations between the youth and their caseworker. Specifics regarding the discussions occurring between the youth and their counsellors were never documented on the files, however, documentation was present to indicate that there were several key themes being addressed between these youth and their counsellors. Key issues that were addressed in counselling regarded dealing with past trauma, anxiety, feelings of depression and issues related to addictions. Recognizing suicidal thoughts and how to process them, and the development of healthy coping mechanisms were also reoccurring themes. File documentation indicated that these ‘alternative and healthier’ coping mechanisms were often to help the youth learn about things they could do to replace self-harming behaviours such as cutting.

Generally, counselling was set up on a regular schedule for the youth, ranging anywhere from weekly to ‘as required’. The majority of cases saw counselling occurring weekly or bi-weekly. Often the counselling appointments occurred during the day, requiring a youth to be absent from school for periods of time, an issue which will be discussed further in this paper. As positive progress was made by the youth in their counselling sessions, frequency usually moved from a set schedule, to occurring ‘as required’ by the youth. This was almost always the case for those youth who were
granted greater independence from MSS, something which will be discussed in greater detail within the discussion section of this thesis. Increases in counselling frequency were required periodically for several of the youth (often at the request of the youth), and were able to be accommodated in each situation. Along with general counselling, many of the youth were also receiving medical treatment from a psychiatrist, most commonly for depression, anxiety, and suicidal behaviours.

Medical treatment.

In all eight cases reviewed, the youth had some form of involvement with a psychiatrist after their suicidal behaviours occurred. There were five youths who had been meeting with a psychiatrist prior to these behaviours. For them, regular contact with a psychiatrist continued after their suicidal behaviours began. The frequency of contact with a psychiatrist differed between these five youths and was based on their presenting needs or level of crisis. In several cases, the youth’s psychiatrist felt that more frequent contact was required to ensure that medications prescribed were at the correct level, or until emotional and behavioural regulation was attained. In these cases, contact occurred as often as bi-weekly for a period. For the remainder of these cases, contact with a psychiatrist generally occurred once every two months on average. Three youths did have contact with a psychiatrist after their suicidal behaviours began, but only on an emergency basis, and always occurring at the hospital. In these three cases, the psychiatrist felt that further psychiatry involvement was not warranted, recommending that the youth work with a counsellor instead. Referrals for counselling were made in each of those cases.
Many of the cases reviewed did not contain copies of the psychiatry reports from the youth’s appointments with their psychiatrist, rather, they contained summaries of the progress or lack of progress being made with the youth, as reported to MSS by the psychiatrist. This type of case documentation generally indicated that follow-up appointments with a psychiatrist were focused on assessing the current level of risk a youth posed to themselves at that time or on the medications being prescribed to the youth.

Where psychiatry reports and hospital discharge reports were present, information was more comprehensive. These reports discussed in greater detail the youth’s account of how they were feeling and what was occurring in their lives prior to the appointment or hospitalization. Psychiatry recommendations, when present on the files, tended not to differ too much, with most being for the youth to maintain follow-up appointments to assess medications and emotional stability. Next to this, psychiatry recommendations were most often to start, or continue attending counselling or addictions programming. In almost all cases, the recommendations were adhered to.

**Additional treatment.**

Aside from having the youth connected to psychiatrists and counsellors, there was documentation of caseworkers utilizing other resources as a means of providing support to the youth. In three of the cases, youth mentors\(^7\) were arranged for the youth to provide positive support and role-modelling. Youth connected with a youth mentor responded positively to this type of support and appreciated the one-on-one interaction and

---

\(^7\) Several organizations working collectively with MSS employ staff to offer youth mentorship services to youth involved with MSS. Youth mentors are contracted by MSS to provide positive role-modelling and assistance to youth.
mentorship that they received. Contracts typically allowed for youth mentorship to occur once or twice per week, however, one case had a contract in place approving up to 30 hours of youth mentorship per week.

Specific tasks for a youth mentor differed between the three youths, but there were several themes for what was requested of them to work on with their respective youth. First and foremost was for the youth mentor to act as a positive role model for their youth, and a safe individual for the youth to seek guidance and support from. Other tasks involved working on basic problem-solving and coping skills, money management, healthy meal planning, and applying for employment. Youth mentors also helped their youth seek out and engage in available local community services or activities for additional support.

Contact

MSS’ policy manuals dictate how often youth-in-care are required to be seen by their caseworker based on factors such as their age and the type of legal authority they are in care under. These policy requirements are referred to as contact standards. Prior to recent policy revisions, which occurred in April 2017, contact standards required an in-person contact between caseworker and youth to occur at least once every six weeks for youth-in-care under a permanent legal authority such as a Long-Term Wardship\(^8\) or Permanent Wardship\(^9\) order. For youth-in-care under a non-permanent legal authority, such as a Temporary Wardship\(^10\) order, contact standards required an in-person contact

---

\(^8\) A child committed to the Minister until 18 years of age. Often considered for older children where the involvement of their family or extended family makes an adoption plan unlikely.

\(^9\) A child committed to the Minister until 18 years of age. Where parental rights are to be severed and where adoption is a viable option.

\(^10\) A child placed in the custody of the Minister for a period up to 6 months.
between caseworker and youth to occur at least once per month. Recent revisions now require contact with youth-in-care under a non-permanent legal authority to continue occurring once per month, and contact with youth-in-care under a permanent legal authority to occur twice per ninety-day period. All cases reviewed in this research involved incidents which occurred prior to the April 2017 contact standard updates.

In all cases reviewed, the amount of contact that occurred between the caseworker(s) and the youth exceeded policy requirements, the majority of which significantly exceeded policy requirements. Many of the cases had contact occurring on a weekly basis, with several cases seeing the caseworker having face-to-face contact with youth upwards of eight times per month to provide support to them, or to simply check in on how they were doing. When a youth was doing well, contact was most often comprised of the caseworker discussing with the youth how they were doing, what had been occurring in their lives, what their current needs were, their plans for the future, and what their caseworker could do to assist. When youth were struggling or facing challenges, discussions between caseworker and youth focused more on encouraging a youth to attend programming of some kind, how the youth planned to keep themselves safe, who they could contact when in crisis, and how their caseworker could assist.

It is important to note that the contact described above refers only to in-person contact occurring between the caseworker and youth. A significant amount of contact occurred over and above this via telephone and text. A great deal of time was invested in these youth by their caseworkers to ensure that these youth had someone available for them both during times of crisis, as well as their successes.
Independence

One of the interesting findings from this research had to do with the level of independence provided by MSS to several of the youth while in care. My research found that five of the eight youths involved in this research showed a reduction in suicidal behaviours once they were provided increased independence. Primarily, this independence was regarding the youth’s ability to determine where they would be residing, and the ability to manage their own finances, and to a lesser extent, their vocational choices and medical treatment.

Youth having the ability to determine their own placements appeared to have the greatest impact on the reduction of suicidal behaviours. All but one of the aforementioned five youth had been residing in some form of group home setting when they began to display suicidal behaviours. At the same time these suicidal behaviours were occurring, many of these youth were also running from their placements on a regular basis. Due to the constant running from MSS approved placements, many of the group homes would not allow the youth to return once their running became too frequent. In each case, a new placement was found for the youth. In most cases, the youth would run again before long.

My research found that youth were often running in order to stay with friends, family, or current partners. Once the decision was made by MSS to allow them to make the choice as to where they would reside, suicidal behaviours decreased, or stopped altogether. After the youth determined where they were going to be living, their caseworker provided MSS sponsored financial support to them for groceries, clothing,
and personal needs. In most cases this financial support was provided to the youth on an ‘as needed’ basis.

For several of these youth, this independence appeared to reduce their suicidal behaviours and motivate them in other aspects of their lives. Of the five youth who were provided independence, four began seeking out employment opportunities, which allowed them to be able to afford the rental of apartments or houses with their friends, or purchase items that they wanted. Many of these youth had previously attended some form of education programming prior but had been asked to discontinue due to their poor attendance or behavioural issues. This new-found independence appeared to have a positive impact on their aspirations for continued education as several of the youth made the decision to return and complete the educational requirements to obtain their grade twelve education.

Another area that appeared to see improvement for several of these youth was with respect to medical treatment. For those residing in a group home, youth often had scheduled appointments to attend with either a counsellor or psychiatrist. In several of the cases reviewed, youth advised their caseworker that they did not feel as though meeting with a counsellor or psychiatrist was benefiting them and they wanted to stop going. Despite encouragement from their caseworkers, the youth would often go on the run prior to their appointments. Although MSS continued to encourage these youths to continue attending these appointments, after being provided independence, they were allowed to make the decision as to whether or not they would continue attending these appointments. In some cases, the youth stopped going altogether, deeming themselves no
longer in need of these services, and in some cases, they chose to schedule and attend appointments at their own discretion and based on their self-perceived level of need.

For three youth, the ability to make their own decisions regarding finances, living arrangements, and educational opportunities appeared to have an impact on their substance use. Once provided with increased independence, there was a reduction and eventual discontinuation of substance use by these three youths. Though these youths never made the admission to their caseworker that increased independence was the reason for discontinuing their use of substances, they had reduced or stopped using substances soon after they were provided the increased independence.

It is important to recognize that even though the increased independence these youths were provided yielded positive results in several aspects of their lives, including a reduction in suicidal behaviours and substance use, there were other areas where several of these youth continued to struggle. Two of the youth, prior to being provided with increased independence, became involved with the youth criminal justice system. Despite being provided the opportunity to begin making their own decisions regarding their finances, living arrangements, and educational choices, their involvement with the youth criminal justice system continued.

**Barriers to Service Delivery**

In conducting this research, I found several examples where there were delays in service. The first, and least prevalent were the wait times for some of the services required. Though not a common occurrence, there were a number of incidents whereby a youth was not able to access counselling or psychiatry in a timely manner. Referrals were made soon after the incident of suicidal behaviour but could not be accommodated
in a timely manner due to a lack of available appointments. In two cases, there were waitlists of approximately two to three months for counselling, and in another two cases there were waitlists of approximately two to three months for psychiatry appointments. These instances were not specific to certain regions of the province, and occurred in the South, Centre and North service areas. It should be noted that the delay in being able to meet with a psychiatrist was for regular and scheduled psychiatrist appointments, not emergency based appointments. If a youth required an emergency room visit due to their behaviours, they were always able to see the on-call psychiatrist.

Another reason for not having access to services in a timely manner was due to the difficulty in ensuring that the youth experiencing suicidal behaviours was placed in the home most appropriate for their needs. With respect to the types of placement that are able to provide internal services to youth exhibiting behavioural, cognitive and mental health problems, demand often outweighs the supply. There were multiple occasions where a youth’s needs at a specific time may have been best managed in a placement that specialized in providing services to youth with those behaviours. This need was recognised by MSS, however, these homes were unavailable at that time. In those cases, a youth was often put on a wait list for a specific placement until a space became available.

Lastly, and most commonly, were services not provided due to the youth being on the run. For many of these youth, being on the run became a common occurrence, making it difficult to ensure that they were attending appointments or programming on a regular basis. Youth routinely being on the run was common in five of the eight cases reviewed. Having youth on the run from their placements made it difficult for both their
caseworker and the group homes to ensure that a youth was attending scheduled appointments with counsellors and psychiatrists. Despite efforts made to schedule these appointments and arrange transportation to them, it was commonplace for a youth to run from their placement a day or two before the appointment resulting in a rescheduled appointment. As a result of these behaviours, many youths were unable to see their counsellors or psychiatrists as often as they likely needed to.
Chapter 6

Discussion

The goal of this research was to answer several questions with respect to how MSS provides for the needs of youth-in-care with suicidal behaviours; how MSS in Saskatchewan responds to situations where youth-in-care exhibit suicidal behaviours; whether or not the types of services or support offered and provided are in line with what current literature and research has shown to be successful in supporting the needs of youth with suicidal behaviours; and whether or not those supports are in line with both the UNCRC, and the TRC’s Calls to Action.

Throughout this section I plan to revisit my research goals, discussing in greater detail, a number of the observations that were identified throughout the research process. I plan to discuss several key categories within this section, including mental health, health, addictions, and youth independence. I will use existing literature to expand on my findings, and I will discuss several areas where I feel there are implications for practice and policy. The strengths and limitations of this study will be examined in this section. Lastly, I will discuss some of the areas where I believe further research would be beneficial.

Mental Health and Addictions

One of the major themes of this research, was that of youth mental health. For each of the youth whose stories were part of this research, there was some form of mental health problem present, which had been identified as a contributing factor of their suicidal behaviours. The findings of my research demonstrate that the mental health problem that these youth experience are multi-faceted, often affecting multiple areas of
their lives, including substance use, educational performance and success in independence. The research demonstrates that by supporting youth and helping to facilitate positive change in their mental health, other areas in their lives can benefit.

For almost every incident where a youth exhibited suicidal behaviour, MSS responded by ensuring that the youth was connected to some form of mental health service. In some instances, this involved meeting with a psychiatrist, but in most cases it involved attending some form of counselling. My research found that there was minimal documentation present to indicate, in any significant detail, what was discussed between counsellors and the youth, and there was no indication as to what types of psychosocial interventions were used by the counsellors. Despite minimal information regarding counselling content and the types of therapies used, documentation shows that MSS was diligent in ensuring that these youths were provided access to some form of mental health programming for their suicidal behaviours. Except for the few occasions where a youth was required to be on a waitlist for mental health programming, access to these types of services was timely.

Although there was no documented verification of the types of therapies provided to the youth who were the subject of this research, existing literature shows evidence of different types of therapeutic interventions, specifically cognitive-behavioural therapy (CBT), dialectical behavioural therapy (DBT) and mentalization-based therapy (MBT) having a positive effect on lowering instances of suicidal behaviour in adolescents (Ougrin et al., 2015). CBT aims to use a social cognitive learning theory perspective to encourage a change in clients by aiding in their ability to relearn adaptive methods of relating both to themselves and others, while also developing the ability to effectively use
those skills. With DBT, the goal is to help the client recognize, synthesize, and integrate opposing ideas; essentially, helping the client learn to tolerate painful feelings while simultaneously recognizing that there is potential for change (Singer, O’Brien & Lecloux, 2017). MBT is focused on helping the client strengthen their ability to mentalize; the ability to understand the mental state of themselves or others. MBT suggests that “enhancing one's ability to mentalize is hypothesized to decrease impulsivity, improve affect regulation, and aid in establishing a coherent concept of self, thereby enhancing interpersonal relationships and reducing self-harming behaviors” (Burke, Buchanan, Amira, Yershova & Posner, 2014, p.75). According to Ougrin et al. (2015), despite evidence that therapeutic interventions such as CBT, DBT and MBT may be beneficial to those displaying self-harming behaviours, there is need for further research in this area to determine continued effectiveness.

All of the youth who had identified issues with substance use had received some form of addictions support as a part of their treatment plans. Youth generally responded well to addictions treatment, with some showing greater success than others. Some of the youth had worked with addictions counsellors while at the same time meeting separately with a mental health counsellor. Others received concurrent mental health and addictions treatment from the same counsellor. Case documentation was not explicit in documenting the reasons why some youth received mental health and addictions programming concurrently and others received it separately. Regardless of whether addictions treatment and mental health treatment were provided by the same individual, research shows that treating both concurrently has its benefits. According to Hawkins (2009) and Singer et al. (2017), treatment of mental illness and substance use is generally
done separately, but research has shown evidence of positive results providing integrated services in treatment of adolescents with co-occurring mental illness and substance use issues. Motivational enhancement treatment (MET) aims to help the client successfully progress through the stages of change, while CBT emphasizes the development of coping skills to handle high-risk situations. Hawkins (2009) explains that research has shown that when CBT and MET are combined in a comprehensive integrated treatment strategy, there is evidence of positive results in treating those with co-occurring mental illness and substance use. Health Canada (2008) also states that evidence is present to suggest that interventions designed to address mental illness and substance use issues concurrently can be effective.

For youth dealing with suicidal behaviours, or with mental health problems in general, it is important to recognize that there can be a stigma attached to youth seeking help. Hawton et al. (2012) explain that for many adolescents, there is hesitation in seeking help when dealing with mental health or suicidal issues due to concerns of confidentiality and stigma as a result of negative peer perceptions. Research suggests that youth are concerned about seeking help due to the fear that their peers may find out, or that rumours may begin to circulate within their school. Concerns of confidentiality and stigma are reflected in a study done by Huggins et al. (2016), who report that many students are hesitant to utilize school-based mental health services due to the risk of being perceived as ‘crazy’ or ‘insane’ by their peers. This issue of help-seeking and the attached stigma is being discussed here as many of these cases had youth attending counselling during the day, often requiring them to be absent from their classes. My goal in bringing up this issue is not to suggest that counselling should not occur if it requires a
youth to miss school, rather, that going forward we are mindful of the fact that there
exists stigma for youth accessing mental health services and that discussions occur with
the youth about it.

**Advocacy for Children and Youth**

Issues of youth mental health, addictions and suicidal behaviours are not unique
to Saskatchewan, they are prevalent across Canada. Many Children’s Advocate offices
have devoted time and resources conducting special reports focused on the issue of youth
suicide in Canada. For this research, I explored some of the work of the Children’s
Advocacy offices in Western provinces of Canada. In recently completed reports by the
Children’s Advocates offices in British Columbia, Alberta, Manitoba, and Saskatchewan
there is a strong emphasis on recognizing the need for increased awareness and services
addressing the issue of youth mental health, addiction, and suicide (Advocate for
Children and Youth, Saskatchewan, 2017; Office of the Children’s Advocate, Manitoba,
2016; Office of the Child and Youth Advocate, Alberta, 2016; Representative for Child
and Youth, British Columbia, 2012). All of these provinces are experiencing the same
issues with youth suicide that Saskatchewan is and are aware of how crucial the need is
for providing adequate mental health and addictions services to youth, both in care and
not. Along with outlining how critical these issues are, these reports also provide, or are
in the process of providing, recommendations for addressing these issues moving
forward.

The Office of the Child and Youth Advocate (OCYA) in Alberta provided
multiple recommendations for addressing youth suicide in their report. These
recommendations include creating a provincially funded suicide prevention program with
capacity to adjust to accommodate the interests and needs of particularly vulnerable
groups; improving existing provincial services to support holistic community-led
strategies; and providing prevention strategies that are respectful of traditional and
cultural Indigenous values and practices. They also recommended implementing school-
based suicide prevention programs, and ensuring that professionals working with youth
with suicidal behaviours have been provided with enhanced suicide intervention training
(OCYA, Alberta, 2016).

Recommendations coming from the Representative for Children and Youth
(RCY) in British Columbia include strengthening youth mental health services with a
particular focus on trauma informed services. Child protection agencies should also
provide a clear plan for reducing the number of moves and disruptions a child
experiences while in care. Lastly, it is important to have a plan in place to thoroughly
assess children for patterns of trauma when they are brought into care (RCY, British
Columbia, 2012).

The Manitoba Advocate for Children and Youth’s (MACY) 2016 phase two
report focused their efforts on bringing attention to the issue of youth suicide. Their
follow-up to the phase two report is expected to provide information on their plans to
address the issue of youth suicide. This follow-up report has yet to be released. The
phase two report did not provide any specific recommendations, however, there were
findings that provide direction for future actions that can be taken. Their report found
that there is a need for ensuring that youth are provided suicide prevention materials. The
report indicates that these materials are often provided through the educational system,
but that these materials may not reach those youths who are not consistently attending school (MACY, 2016).

Saskatchewan’s Advocate for Children and Youth (ACY) released a report in 2017 addressing the youth suicide crisis occurring in northern Saskatchewan. For this report, the ACY had 264 youth, aged 10-18, participate by either joining group discussions, or completing questionnaires. The information in this report is significant for several reasons. First, it provides valuable information as to why so many youths in northern Saskatchewan struggle with issues of mental illness, addictions and suicidal behaviours. Secondly, it gave youth the chance to have their voices heard in Saskatchewan and across Canada. Including the voices of children and youth is especially important when it pertains to decisions that are impacting their lives as it aligns with the UNCRC, Articles 12, 13, 14, and 15. As per Article 24 of the Convention, health is an important aspect of all children and youth. The ACY’s report shows this by implying that their voices ought to be heard and attention needs to be paid to their health needs.

Lastly, it called upon the governments of Saskatchewan and Canada to address the issue of youth suicide providing specific calls to action. These calls to action ask that the governments of Saskatchewan and Canada work in partnership with the Federation of Sovereign Indigenous Nations (FSIN) to support a Saskatchewan Indigenous suicide prevention strategy, and, to work in partnership with the Metis Nation to further support the implementation of its suicide prevention strategy. Calls to action were also made to the governments of Saskatchewan and to Canada to utilize Jordan’s Principle\textsuperscript{11} when

\textsuperscript{11} Jordan's Principle is a principle ensuring that Indigenous children living on and off reserve in Canada have equitable access to all government funded services.
working in partnership with Indigenous leaders, communities and governments. Along with
the advocates’ calls to action for government, there were several calls to action from
the youth who participated in helping the advocate create their report. These calls to
action focused on addressing the issue of bullying, substance use in communities,
providing increased emotional support for youth in their communities, and providing
meaningful and diverse activities for youth in their communities (ACY, Saskatchewan,
2017).

The information contained in these advocate reports is relevant to my thesis as it
affirms many of the findings of my research. Saskatchewan’s ACY report is especially
relevant, as the information provided by the youth themselves affirms the significance of
issues of mental illness, addictions and suicidal behaviour. In the words of one youth,
“feeling alone, overwhelmed, or experiencing something traumatic can make them feel
like suicide is the only way out” (ACY, Saskatchewan, 2017, pp. 29). Another youth
reported the following:

Things happen to a person and maybe they seem fine, but they stay strong so
people around them don’t worry about them. No one would expect you to do or
think about it, but you do and having no one to talk to makes everything worst
[sic]. Depression builds up and then you’re stuck and don’t know how to get out
(ACY, Saskatchewan, 2017, pp. 30).

Saskatchewan’s ACY report also draws attention to the impact that addictions can
have on the suicidal behaviours of youth. One youth expressed that “when youth in the
community feel sad or depressed, they don’t talk about their emotions and it builds up.
They eventually turn to drugs, alcohol, or smoking” (ACY, Saskatchewan, 2017, pp. 23).
Other youth spoke to the damaging effects of familial addictions, indicating that the first step to helping youth was to help parents and families address their own addictions. As one youth stated, “first you have to help them [parents] with their drug and alcohol addiction” (ACY, Saskatchewan, 2017, pp. 23). Saskatchewan’s ACY report was specific to youth in Northern Saskatchewan, whereas my research looked at Saskatchewan as a whole. The findings from their report, however, are similar to mine.

**Self-Autonomy**

Olson, Scherer and Cohen (2017) discuss that children in foster care often experience more academic difficulty than non-fostered peers. Due to this limited academic achievement, many youths who age out of foster care are more likely to experience unemployment or financial difficulties. Olson et al. (2017) explain that child welfare agencies are often not able to adequately prepare youth for the transition from foster care to independence. This can lead to youth aging out of foster care to lack the necessary life skills and decisions making skills, which can lead to poor outcomes such as an inability to secure stable housing or maintain employment. Woodgate, Morakinyo and Martin (2017) explain that for youth transitioning out of care, experiencing difficulties with employment and housing can lead to the development of mental health problems.

One thing that my research revealed was that for over half of my sample of youth, once they were provided with increased independence and greater control in decision making, there were reductions in the prevalence of suicidal behaviours, and for some, mental health problems and addictions as well. For many of these youth, being in care means that MSS is responsible for ensuring that they are in a safe and stable placement where their needs can be met. Many of the youth who ended up being provided increased
independence were those who started to make a habit of running from their placements or exhibiting behaviours that resulted in their being asked to leave their placement. Once these youths were able to reside at a placement of their choosing, the number of times they ran decreased. What became evident in conducting this research was that MSS was not providing this independence as a means of absolving themselves of its responsibility for these youth, rather, it was done in an attempt to reduce harm.

Adolescence is a developmental period that is stressful and often characterized by compromised decision-making abilities and impulse control (Galvan & McGlennen, 2012). Olson et al. (2017) explain that daily stress can compromise decision-making skills in adolescents and young adults leading to a potential for higher-risk decision making. Youth-in-care often have had more negative childhood experiences and chronic stress, leading to the possibility for poorer decision-making abilities (Olson et al., 2017). The independence provided to these youth was not provided as a result of aging out of the foster care system. These youths were provided the opportunity to explore their independence for a period, while still in care, thus having a safety-net to fall back into if needed. For many of these youth, in being allowed to experience a lengthy period of time of both being in care, as well as being independent, they had the opportunity to figure out how to succeed on their own, all while having the support and encouragement of their caseworker.

It is during this pivotal period that youth looking to achieve successful independence can find themselves experiencing struggles, including involvement in criminal activity, lack of school attendance or dropout, or youth pregnancy. These are struggles that, without proper guidance and support, youth may not be able to overcome.
It is during this period of time that their support network (i.e. social workers, teachers, public) need to be aware of the needs of these youth and assist them in making their transition to independence as successful as possible. According to Allain (2007), youth aged eleven to sixteen are “at a fragile age; their identity is beginning to crystallize and they can be greatly affected by both positive and negative experiences…so important we get it right for them” (p. 136). Social work needs to understand the importance of recognizing the challenges of aging out of care, as our lack of attention to these issues may increase the risk of exacerbating the mental health problems for youth who are uncertain about their future in terms of housing, education, employment opportunities, and other areas of their lives.

McLaughlin, Enns and Seaward (2018) speak of the importance of not looking at a youth’s independence as being a specific event, often tied to the date that they officially age out of care. They express the importance of looking at the transition to independence as being a process that does not always occur in a straight line. They emphasize that youth who are transitioning out of care are often also at the developmental phase in their lives of emerging adulthood and are in need of reassurance and security. These ideas reaffirm the UNCRC’s principle that specifically directs States to recognize that "the child, by reason of his physical and mental immaturity, needs special safeguards and care, including appropriate legal protection, before as well as after birth" (OHCHR, 2018). Although the ideas of aging out of care and youth independence are not explicitly addressed in the Convention, its framework references and promotes the notions of self-reliance and the child's active participation in the community for children with mental and physical challenges.
MSS has, within its Children’s Services Manual, a set of guidelines speaking to the notion of preparing youth for the transition from being in care to independence. These guidelines, when successfully adhered to, represent for MSS a successful transition for a youth from being in care to independence. These guidelines speak to a youth’s caseworker assisting the youth in realizing their goals for their future, and understanding what supports they may need. The caseworker is to work with the youth to develop independence in term of managing their own health, educational, and self-care needs; helping them learn to navigate their relationships with family and friends; and in helping them develop the ability to manage and regulate their emotional and behavioural needs (Government of Saskatchewan, 2018). One should also add that these universal Ministry guidelines should not overshadow the case worker’s clinical skills and understanding that each youth aging out of care is unique and may have varying needs.

The OCYA in Alberta completed a report in 2013 which explored, based on discussions with both youth (either previously in care, or currently transitioning out of care) and professionals (having experience working with youth), what made for a successful transition out of care into adulthood. Three themes emerged regarding what was needed for a successful transition; access to ongoing mental health services and supports; meaningful connections with supportive adults; and the opportunity for increased resources during the transition, which, according to the youth who participated in this report, included the development of life skills (money management, nutrition education), educational opportunities, employment skills, and an understanding of healthy relationships (Office of the Child and Youth Advocate, Alberta, 2013).
Many of the youth involved in my research experienced a lengthy period of time being in care while simultaneously experiencing independence. During this time, evidence was present to show that their caseworkers were assisting these youths in accordance with the Children’s Services Manual’s guidelines for preparing a youth for independence, as well as with what the OCYA’s report indicates that youth require for a successful transition out of care. Evidence of this work includes the youth’s caseworkers providing the youth with access to mental health programming and supports, encouraging and supporting them in arranging their own medical appointments; assistance in seeking out and maintaining employment; providing them with the opportunity to learn essential life skills (budgeting, meal planning, use of transportation, etc.); and the emotional support and opportunities to maintain meaningful relationships with their families and friends. In doing so, MSS was able to provide reassurance and security as these youths developed many of the skills necessary for a successful transition to independence.

McLaughlin et al. (2018) writes that policy-makers must also recognize that those tasked with supporting youth in long-term care require specialized training and skills in order to better respond to each youth’s unique needs. It is important that governments realize the importance of their responsibility in providing for the needs of these youth. They need to be investing in these youth, respecting them, and listening to them. While these youths are still in care, their milestones (birthdays, obtaining a driver’s license, first job) need to be celebrated no differently than we would with our own children, and they need to be supported through life’s challenges. Providing this crucial level of support when youth are in care is important for governments to recognize as these youths have
fewer opportunities for ongoing support when they age out of the system and their files are closed (McLaughlin et al., 2018).

**Kinship Care**

The Child and Family Services Act is the legislation that governs the work done by MSS in the province of Saskatchewan. Section 3 states that the purpose of the act is to “promote the well-being of children in need of protection by offering, wherever appropriate, services that are designed to maintain, support and preserve the family in the least disruptive manner” (Child and Family Services Act, 1989-90). For caseworkers, the ideal course of action is always to develop a case plan with a family that allows for the child(ren) to remain in the parental home while the family addresses concerns. This option provides the least disruption while allowing for services and supports to be provided to a family.

However, there are occasions where the children are removed from the parental home due to concerns for their safety. In these situations, providing services and support to a family while the child(ren) remain in the home is not an option. When this occurs, the ideal option is to locate suitable family to assist in providing care for the child(ren) while the family addresses the concerns. Font (2014) speaks to the importance of kinship placements stating that they “tend to be more stable than non-relative placements, and placement stability is associated with reduced behavioural problems and fewer school disruptions” (p. 2077).

---

12 Kinship care homes are vetted and approved in a similar manner to foster homes, however, foster homes require several additional levels of compliance prior to their approval. Compensation rates are similar between the two.
Kikulwe and Mann-Johnson (2018) speak of the importance of recognizing the value placed on kinship care within racial and ethnic communities. When children need to be removed from their families, seeking a kinship care placement should be sought out as the first option for placement. The importance of this is also referred to within Article 20(3) of the UNCRC which states that if a child is to be removed from their family home, “due regard shall be paid to the desirability of continuity in a child's upbringing and to the child's ethnic, religious, cultural and linguistic background” (OHCHR, 2018).

MSS, whenever possible, strives to ensure that culturally appropriate placements are sought for children coming into care. The Children’s Services Manual (Government of Saskatchewan, 2018), gives direction as to what needs to be considered when seeking a placement for Indigenous children. The following criteria are to be considered when exploring a placement for Indigenous children:

- placement with extended family;
- placement with a family from the same band;
- placement with a family in another Band of similar culture and linguistic heritage;
- placement with another First Nations family; and
- placement with a non-Aboriginal family, close to the child's home community.

Caseworkers do seek to adhere to these criteria whenever possible and, in the majority of cases, are successful as is demonstrated by the significant number of out-of-home placements with kinship resources. To aide in locating viable family placements for youth, MSS employs staff whose role is to locate potential family placements for youth coming into care, as well as continuing to search for family placements for those youth in existing non-kinship care placements. MSS also utilizes an Indigenous agency-
based committee whose purpose is to assist in locating potential family placements for youth coming into care, and those currently residing in non-kinship care placements.

There are times when caseworkers seek to find placements for Indigenous youth based on the criteria above and are not able to find a home that meets the set Ministry standards. Generally, this is due to not being able to locate an appropriate family placement, or a home that is equipped to provide for the behavioural or emotional needs of a youth. Many of the youth whose cases were used in this research were placed in different types of group homes, due to their behavioural or emotional needs, or supervision requirements.

Even though these types of placements may not meet the criteria for being a ‘cultural’ placement, group homes do their best to offer cultural programming to the youth residing in their homes. Many of the groups homes commonly used by MSS provide youth access to sweat lodge ceremonies, pow wows, round dances, smudging, and Elders, as well as the opportunity to participate in cultural activities such as beading and moccasin making workshops, drumming, and sage and sweet grass picking (Egadz, 2018; Ranch Ehrlo Society, 2017). As previously stated, Article 20(3) of the UNCRC speaks to due regard being paid to the continuity in a child’s upbringing and to their ethnic, religious, cultural and linguistic background when they are removed from parental care (OHCHR, 2018). In the cases I reviewed, the caseworkers appeared mindful of the importance in seeking culturally appropriate placements for the youth, which is in line with both Article 20(3) of the UNCRC and the TRC’s call to action 4(iii).

The TRC describes one of the residential school system’s objectives to be the removal and separation of children from their culture, language and spiritual beliefs
(TRC, 2015). Residential schools served to separate siblings from each other, minimize the contact they had with their families, and prevent them from having appropriate parental role models during the periods of time that they were in school (Rose, 2018). The impacts of the residential school system and the forced transracial adoption that occurred as part of the Sixties Scoop, illustrate the importance in seeking culturally appropriate placements for youth-in-care. Culturally appropriate placements allow indigenous youth-in-care the opportunity to reside in environments where they can be connected to their culture, language and spiritual beliefs. MSS seeking cultural placements for its youth-in-care does not erase the damage done by the residential school system or the Sixties Scoop, but it is one small step towards ensuring that their legacies are not continued.

**Pursuit of Children’s Rights**

One of my research goals was to explore the supports and services provided by MSS and see if they were aligned with the UNCRC and the TRC’s Calls to Action. With the UNCRC, there were two articles in particular that I focused on. Article 24, which speaks to children being afforded the right to the best forms of health care in order to keep them healthy, and Article 39, speaking to children, as victims of abuse and neglect, being afforded whatever services necessary to assist them in recovering physically and psychologically (OHCHR, 2018). Similarly, Section 1(v), 4(ii) and 4(iii) of the TRC calls to action are of relevance to my research as they call upon child-welfare decision makers to consider the impact of the residential school experience on children and their caregivers; for all child-welfare agencies and courts to take the residential school legacy into account in their decision making; and (as an important priority) for placements of
Indigenous children into temporary and permanent care to be culturally appropriate, respectively (TRC, 2015).

Despite a small number of instances where the youth in my research required mental health treatment but were waitlisted until there was availability, services were almost always provided in a timely manner. There were also occasions when a youth was scheduled to see a psychiatrist or counsellor and skipped their appointment, resulting in the appointment being rescheduled. When youth made the decision to altogether stop seeing their psychiatrists or counsellors, the option remained for the youth to return and continue treatment at any point.

A few of the files had documentation regarding the reasons why youth had missed their appointments with counsellors or psychiatrists, however, most of files were not explicit in providing the reasons why the youth missed their appointments. Where available, some of the reasons included not attending due to cold weather, or because the youth skipped school and missed their ride to the appointment. Case documentation indicates that these appointments were rescheduled (either by the youth themselves, or their caseworker). For youth who were meeting with a counsellor or psychiatrist on a regular basis, they were able to continue with their next scheduled appointment. For those youth who were not meeting regularly with a counsellor or psychiatrist, a missed appointment resulted in a wait on average of between one to three months for another appointment.

For those youth who missed their appointments and had to wait for a lengthy period of time before their next appointment, file documentation showed that this can have a negative impact on a youth’s mental health. As mentioned earlier, the typical time
between a missed appointment and the rescheduled appointment was between one and three months. The longer the wait times for mental health services, the higher the likelihood that patients will not keep their appointments. These delays in mental health services have the potential to increase the risk of poor outcomes and exacerbate the patients’ problems (Steinman, Shoben, Dembe & Kelleher, 2015; Westin, Barksdale & Stephan, 2014). It is because of these potential impacts that it is in the best interest of both the youth, as well as the caseworker to ensure that youth are attending their appointments.

There can be many reasons why youth are resistant to attending therapy. Youth often display resistance to therapy due to the belief that they do not need help, or because they do not believe that therapy or medications will actually help them to feel better. In some cases, they have already tried some form of therapy in the past and did not feel as though they benefited from it, so do not want to try again. Some youth refuse to attend therapy because they are embarrassed about it and are worried what others may think (Child Mind Institute, 2019). Even though documentation was not typically present regarding the youth’s rationale for missing their appointments, from my own practice experience there are several reasons why this occurs.

In my own experience as a child welfare caseworker, I have observed youth to be anxious about the thought of opening up to a counsellor they are not comfortable with or have only met with a few times. Youth can feel ill-prepared to address some of the difficult issues faced in their lives. Some youth are in denial that they actually have issues warranting professional help. In some cases, youth just simply forget about their appointment and fail to show up, or are not where they are supposed to be when their
caseworker or care provider is to transport them to their appointment. Mental health is a complex issue with youth and they may be experiencing all kinds of feelings and emotions in the days leading up to their appointment.

Providing transportation for the youth to their appointments did not seem to be a major reason for youth missing their appointments as in many cases the transportation had been arranged, but the youth were simply not present for their ride. One area that may benefit from improvement could be caseworkers providing more frequent reminders to the youth in the days/weeks before their appointment. This could serve two purposes: first, as a reminder for those youth who tend to forget when their appointments are, but also to encourage discussion between the youth and the caseworker about their anxiety regarding their appointments.

In cases where youth required hospitalization for medical treatment related to a self-harm injury, youth were always provided medical treatment in a timely manner. In almost every case, the youth was taken to the hospital by their care provider within an hour or two of the determination being made that a visit to the hospital was necessary. There was one case where the youth was taken to the hospital the following day, however, the care provider was advised by a medical professional over the phone that admission the following day was acceptable. While in care, the youth’s care providers ensured that medical appointments with family physicians and specialists (dentists, optometrists) were attended and up to date. By providing these youths with timely and regular access to mental health and health services, they were being provided the most appropriate forms of health care available in an attempt to keep them healthy, both
physically and mentally. I would argue that these actions are in line with Article 24 of the UNCRC.

Though several files lacked documentation to suggest that counselling had been offered in relation to disclosures of physical/sexual abuse, most had evidence of counselling being offered in response to the disclosures. On the files where counselling was not offered in relation to the disclosures of abuse, the youth were later connected to counselling, however, the reasons for the youth beginning to meet with a counsellor were unrelated to their original disclosures of abuse. By providing these youth with access to counselling for the purpose of physical and psychological recovery, I would argue that these actions are in line with Article 39 of the UNCRC.

The TRC’s calls to action are relatively recent, but they aim to address some of the fundamental policy and practice issues within contemporary child welfare interventions. The TRC recognized the need for a fundamental shift in policies and practices when providing child welfare services to Indigenous youth and families. As a result, they made specific calls to action asking that frontline staff working with Indigenous families be educated on Indigenous culture, history, and the impact of residential schools. The TRC call to action 4(ii) asks that recognition of this legacy be taken into account when making decisions in child welfare involving Indigenous families (TRC, 2015).

All child welfare workers in Saskatchewan are required to participate in a significant amount of training as part of their employment with MSS. Much of this training is focused on specific skills that are required of a caseworker, however, there is a large amount of training specific to understanding the impact of residential schools, and
how to operate in the field of child welfare in a culturally sensitive manner. This training, often delivered by Indigenous facilitators, provides knowledge of the history of Indigenous peoples in Canada as a means of understanding the complexities in delivering child welfare services to Indigenous peoples. In participating in this training, caseworkers are able to gain a more comprehensive understanding of the impacts that residential schools have had, which hopefully assists in their decision making and case planning with Indigenous families.

In its concluding observations, the UNCRC made reference to the continued high rate of suicidal deaths among young people in Canada, particularly Indigenous youth (UN Committee on the Rights of the Child, 2012). In this report, the committee made three recommendations specific to addressing suicide rates of Indigenous youth, of which one is especially relevant to topic of supporting youth with suicidal behaviours, and is addressed in further detail within the implications for practice section:

(a) Strengthen and expand the quality of interventions to prevent suicide among children with particular attention to early detection, and expand access to confidential psychological and counselling services in all schools, including social work support in the home;

In summary, this section has provided several key learnings with respect to understanding the importance of supporting youth-in-care with suicidal behaviours. Most important is recognizing the complexity of youth mental health, and how it can be impacted by many different factors, including addictions, family history, abuse and neglect. This research has shown that for youth exhibiting suicidal behaviours, each youth requires treatment tailored to their needs and situation, and though many of the
youth involved in this research had similarities in their stories, no two situations were the same.

In recent years there has been growing awareness of the issue of youth suicide, to a point where many provincial child and youth advocates have focused their efforts on it. Many provincial advocates have published reports identifying the need for greater supports and services for youth dealing with mental health and addictions issues, and suicidal behaviours. Their efforts have brought attention to the fact that properly supporting youth exhibiting suicidal behaviours requires greater advocacy and increased access to mental health services and supports (Office of the Child and Youth Advocate, Alberta, 2016; Representative for Child and Youth, British Columbia, 2012; ACY, Saskatchewan, 2017).

Along with the work done by provincial child and youth advocates, the UNCRC and the more recent TRC have provided further direction for supporting Canadian youth. The UNCRC has laid a solid foundation for ensuring that youth, whether in governmental care or not, are provided all necessities required to live in safety and lead a healthy life. The TRC’s calls to action have further built upon that foundation by calling upon the Canadian governments to ensure that greater attention and support is given to the needs of Indigenous peoples. Though this research has provided some evidence that the needs of youth-in-care with suicidal behaviours, whether Indigenous or not, are being recognized and met by MSS, there exists the opportunities to improve upon the services and support provided to these youths.
Implications for Practice

This research has provided direction for some potentially positive changes in the delivery of services to youth-in-care displaying suicidal behaviours. In reviewing files for this research, documentation of contact with the youth’s counsellors for the purpose of follow-up was largely absent. Though a few cases had documentation of the caseworker and counsellor having contact to discuss a youth’s progress, the majority did not. Contact between the caseworker and the counsellor is important as it provides the caseworker with a greater understanding of the youth’s progression or regression. This is not to say that caseworker needs to be made aware of all the details of a youth’s counselling session, rather, that a caseworker having a more well-rounded understanding of a youth’s progress, and knowing where additional supports are required will only serve to benefit the youth and strengthen case-planning. More contact occurring between the counsellor and the youth’s caseworker has the potential to provide beneficial results.

With respect to the importance of providing youth with independence, my findings are reinforced by the research of others. Currently, the Children’s Services Manual (Government of Saskatchewan, 2018) does speak to the idea of preparing youth for independence once they reach the age of 15. My research found that though many of the youth did have successes once provided additional independence, it was only provided at the point where the youths’ caseworkers were struggling to find placements for them. My findings suggest that for youth with suicidal behaviours, exploring independent living arrangements or at least supporting a placement of their choice as a primary option may yield positive results. This research does not make the assumption that exploring independence for youth with suicidal behaviours will be successful in all
cases. Rather, that this option be explored where and when appropriate, and with the understanding that a certain level of ‘trial and error’ should be expected.

My research, supported by literature, has shown that many specific factors are common among youth exhibiting suicidal behaviours. These factors include mental health problems (Bennett et al, 2015), addictions (Rowan, 2001; Wong et al., 2013), history of trauma (de Arauju & Lara, 2016; Liu et al, 2017) and having a parent(s) who were involved with the residential school system (Evans et al, 2017; Hackett et al., 2016). With the knowledge that these identified factors are linked to suicidal behaviours in youth, developing policy, practice, or both to proactively identify and support youth with these factors would be of great benefit. As referenced earlier, the importance of this is addressed within the concluding observations of the United Nations Committee on the Rights of the Child (UN Committee on the Rights of the Child, 2012), which states that Canada needs to “Strengthen and expand the quality of interventions to prevent suicide among children with particular attention to early detection”.

In the case of MSS, the involvement of Indigenous trainers in the development of child welfare caseworkers is a welcomed effort in promoting collaboration with the community and keeping children safe. Caseworkers remain the primary decision makers for the families they work with, however, there are likely benefits in providing relevant members of the Indigenous community a more active role in this decision-making process.

Articles 15(2) and 22(1)(2) of the United Nations Declaration on the Rights of Indigenous Peoples (The United Nations General Assembly, 2007)), speak to the importance of working in consultation and cooperation with Indigenous peoples in
combating and eliminating prejudice. These articles also stress the importance of paying particular attention to youth and working in conjunction with Indigenous peoples to ensure that children enjoy the full protection and guarantees against all forms of violence and discrimination. The TRC further reiterates the importance of these articles in its own calls to action (43 & 44), by asking Canadian governments to fully adopt the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) as the framework for reconciliation and develop a national action plan and strategy to achieve the goals of UNDRIP (TRC, 2015).

In several of its articles, the UNCRC speaks to the importance of keeping children and families together when and where possible. Article 7(1) speaks to the child having the right to know and be cared for by their parents. Article 8(1) speaks to state parties respecting the right of the child in the preservation of their family relations. Article 9(1) speaks to not removing a child from their family unless deemed necessary and in the best interests of the child. Lastly, Article 18(1) speaks to the recognition that parents have a responsibility for the upbringing and development of their child (OHCHR, 2018). MSS, whenever possible, tries to work with families to prevent children from coming into care. When children do have to be brought into care, the goal becomes trying to find a way to help families address the concerns in order to safely return the children.

For those youth who are unable to return home, they end up remaining in care through some form of long-term order, and residing in MSS approved placements, many of which are group home placements. Collin-Vezina, Coleman, Milne, Sell and Daigneault (2011) state that research has shown that those youth residing in residential group homes present with more negatives symptoms than those residing in other out-of-
home care placements (i.e. kinship or foster care). Their research also found that youth receiving child welfare services while at home versus in care showed lower rates of trauma. I believe that there may be a benefit (where appropriate) to allowing youth to explore their own placements rather than continuing to place them in MSS approved resources.

Many of the youth in the care of MSS expressing suicidal behaviours are Indigenous, as such, there may be benefits to MSS exploring traditional Indigenous healing in place of, or in conjunction with traditional Westernized therapy. Barker, Goodman and DeBeck (2017) state that a growing body of research is beginning to show that conventional Westernized individual-level therapies for treating suicidal behaviours in Indigenous youth are culturally discordant with traditional Indigenous beliefs. They argue that the context and conditions leading to Indigenous youth suicide are different than that of non-Indigenous youth and need to be treated differently.

Barker et al. (2017) state that in select settings across North America, interventions are currently underway which explore the use of cultural identity and connectedness to treat and reduce health and social inequities. With growing knowledge indicating that Indigenous health issues may need to be looked at differently than those of their non-Indigenous counterparts, there would be a benefit to MSS exploring the use of culture as part of their case-planning with suicidal youth rather than relying solely on western-based therapies as the traditional form of support.

In completing this research, another area that warrants being explored by MSS in its support of youth with suicidal behaviours, is the use of trauma-informed practice. Trauma-informed practice refers to a ‘clinician’s understanding of trauma diagnoses and
symptoms as well as the clinician’s astute awareness of the unique challenges and
difficulties that a trauma survivor may face within the context of relationships, personal
and therapeutic” (Szczygiel, 2018, p.115). Tullberg, Kerker, Muradwij and Saxe (2017)
speak to the fact that children who have been in foster care are disproportionately
affected by trauma with a large number of those meeting the criteria for complex trauma,
which often leads to higher rates of post-traumatic stress and clinical diagnoses than other
children.

Tullberg et al. (2017) advise that given the complexities of the trauma youth in
the foster care system are often subject to, there is a growing recognition that trauma-
informed practices should be integrated into child welfare settings, which should include
the development of close relationships with mental health practitioners who are trained in
trauma-focused interventions. Though my research only focussed on eight youth’s cases,
the trauma that those youth had experienced is likely reflective of the trauma that many
youth in the care of MSS have been subject to. With an understanding that many of
MSS’ youth in care experiencing suicidal behaviours have histories of trauma in their
lives, the use of trauma-informed practices should be explored in their treatment plans.

In completing this research, there was an area of service delivery that warrants
being mentioned as it speaks to the notion of working collectively for the betterment of
youth. There were many examples of MSS caseworkers who were routinely in contact
with other ministries also working with the same youth. These discussions were often
regarding the scheduling of appointments for the youth, but many times were also
focused on ensuring that both ministries involved were working toward the same goals
for the youth. Working collaboratively with other involved agencies is something that
MSS did well and should continue to do whenever possible. As many of the youth involved in this research were actively involved with other governmental and community-based organizations (health, education, justice, family support agencies, etc.), there is an opportunity to provide a more thorough and well-rounded level of support to youth through collaboration.

**Strengths and Limitations**

One of the limitations of this research came from the method and methodology being used. Though case study research is valuable for its ability to provide a well-rounded perspective on a certain topic or situation, it is also limited in that the sample sizes are small and may not be reflective of a larger population (Creswell, 2013). As mentioned earlier, I chose to utilize a multiple case study method rather than looking at a single case study as I felt that it would provide me with the opportunity to be as thorough as possible on the subject I was researching. Though I am fully aware that my research is not reflective of all youth-in-care with suicidal behaviours, I believe that it does provide a depth of information to answer the three research questions of this study and that this research will be of value to future studies exploring issues and concerns regarding mental health problems and wellbeing for youth in the care of MSS.

Another limitation to this research comes as result of using content analysis. By using content analysis as a research methodology, I found that I was limited to whatever content was available on the files. There were several instances where the medical reports I was seeking were not present on the files. These reports would have provided a more thorough view of what specific follow-up treatment had been requested by the psychiatrist. Progress reports from counsellors were also largely absent from the files,
which again, may have yielded additional beneficial information. Lastly, as detailed as
many of the case notes were on some of the files reviewed, there was evidence that case
documentation was missing regarding the outcome of certain events, or as to when
certain services (counselling, youth mentorship) had begun and completed.

**Future Research**

After completing this research, there are several areas I feel would benefit from
further research: the impact of providing increased independence to youth with mental
health problems; and the impact on youth’s mental health when placed in residential care,
specifically group homes. Further, while my research did find literature speaking to
importance of developing independence and skill building in youth, it lacked a focus on
how this independence and skill building affects youth exhibiting suicidal behaviours.
Likewise, though literature does exist with respect to youth in residential group home
environments, it focuses more on how youth in these types of placements have
experienced more traumatic experiences than youth in non-group home placements.
Considering that research has shown that youth placed in residential group homes are at a
higher risk for exhibiting suicidal behaviours, there would be a benefit to exploring in
greater detail why this is.

While my research has provided a focus on some of the work being done with
youth-in-care in Saskatchewan exhibiting suicidal behaviours, my sample size was small
and the results not able to be generalized to the larger population. I would recommend
that if further research is done to explore the services provided by MSS to youth-in-care
with suicidal behaviours in Saskatchewan, the sample size should be larger in order to
capture a greater range of data for analysis. As well, while my sample represents a high
number of female youth-in-care with suicidal behaviours, future research should aim to include a higher representation of other sexual or gender identities.

Another recommendation for future research would be to explore in greater detail the differences that exist in providing support to youth with suicidal behaviours in urban settings versus rural settings. This research aimed to provide a provincial view by exploring cases from the South, Centre and North service areas of the province. I feel there would be value in exploring this in greater depth. Between urban and rural centres, there may differences in the types of services available to youth, as well as the availability of services. Further research in exploring these differences could be beneficial in addressing the issue of youth suicide.
Chapter 7
Conclusion

The aim of this research was to explore how MSS provides support to its youth-in-care exhibiting suicidal behaviours. In completing this research, I utilized a multiple case study method to analyze MSS’ involvement with eight youth-in-care. My research explored cases where youth were at one point exhibiting suicidal behaviours, followed by a significant period of time without exhibiting suicidal behaviours. The focus of this research was to explore whether the support provided to these youth by MSS assisted in reducing their suicidal behaviours.

Current literature shows that youth in Canada, especially Indigenous youth, are at high risk for suicidal behaviours (Health Canada, 2013). Literature tells us that there are other factors that increase an adolescent’s risk for suicidal behaviours, including pre-existing mental health problems (Baidawi et al., 2014; Butler & Pang, 2014), addictions (Garnefski & Jan De Wilde, 1998; Rowan, 2001; Wong et al., 2013), and history of trauma (de Araujo & Lara, 2016; Liu et al, 2017). Research also speaks to increased risk of suicidal behaviour for youth exposed to neglect, maltreatment, physical and sexual abuse, and those placed in state care (Taussig et al, 2014).

Suicide rates for Indigenous youth in Canada are high (Eggertson, 2015). This is noteworthy, as the majority of the cases I reviewed involved Indigenous youth. It is imperative that we recognize that though the issue of youth suicide is in and of itself concerning, it is having a significant impact on Indigenous youth. The importance of taking steps to address the issue of youth suicide is something that provincial child and youth advocates across Canada have been focusing on over the past couple of years, many of which have written special reports complete with recommendations for change.
This research has also explored the significant role that the UNCRC and TRC have, and continue to have, in the fight to ensure that children are afforded every opportunity in life whether in state care or not. The efforts of these committees are significant as they call upon our governments to ensure that work being done with children and youth is focused on providing for their physical, emotional and cultural needs. It was due to the significance of this need that I chose to ground my research within a human rights perspective.

In conducting this research, it is clear that efforts are being made to ensure that services and supports for the mental health and addictions are being provided by MSS to their youth-in-care. Caseworkers worked hard to ensure that these youth received appropriate psychiatric care in response to their suicidal behaviours, which as Bostwick et al. (2016) has stated, can reduce the risk of suicidal death. As current literature indicates that mental health problems, addictions and abuse issues are often a precursor to suicidal behaviour, MSS’ provision of services and support appear to be in line with what literature states should be provided to youth with suicidal behaviours. By supporting youth in the exploration of their independence, my research found evidence of successes in reduction of suicidal behaviours, mental health problems and substance use.

Much of the work being done with these youth was in line with, or exceeded MSS policy requirements, and while MSS’s work with these youth is in line with the UNCRC, and several of the calls to action provided by TRC, there is still room for improvement in ensuring that this work continues to align with these documents.

This research draws attention to several implications for policy and practice, which have the potential for positive outcomes and warrant being explored. Additionally,
my research found that there was a lack of literature regarding certain aspects on the topic of youth suicide; areas where further research would likely be beneficial. The hope is that the results of this research will aim to build upon the current literature that exists regarding vulnerable youth exhibiting suicidal behaviours.
References


https://www.med.upenn.edu/psychotherapy/newsletter_selfinjury.html


generation indian residential school survivors. Transcultural Psychiatry, 48(4),
367-391.

residential schools: implications for the concept of historical trauma.
Transcultural Psychiatry, 51(3), 320-328.

Bostwick, J., Pabbati, C., Geske, J., & McKean, A. (2016). Suicide attempt as a risk
factor for completed suicide: Even more lethal than we knew. American Journal
of Psychiatry, 173(11), 1094-1100.

Brent, D., Kolko, D., Wartella, M., Boylan, M., Moritz, G., Baugher, M., & Zelenak, J.
(1993). Adolescent psychiatric inpatients' risk of suicide attempt at 6-month
follow-up. Journal of the American Academy of Child & Adolescent Psychiatry,
32(1), 95-105.


Towards belonging: negotiating new relationships for adopted children and those

attempted suicide: A 2-year follow-up study. Journal of the American Academy of
Child and Adolescent Psychiatry, 47(8), 948-957.


Huggins, A., Weist, M., McCall, M., Kloos, B., Miller, E., & George, M. (2016). Qualitative analysis of key informant interviews about adolescent stigma
surrounding use of school mental health services. *International Journal of Mental Health Promotion, 18*(1), 21-32.


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

In Badry, D., Montgomery, H., Kikulwe, D., Bennett, M., & Fuchs, D (Eds),
*Imagining Child Welfare in the Spirit of Reconciliation* (pp.69-92). Regina, SK: University of Regina Press.


hPvgGue7.pdf


http://apps.who.int/iris/bitstream/10665/131056/1/9789241564779_eng.pdf?ua=1 &ua=1


Appendix “A”

1. Age
2. Male/Female
3. Indigenous (yes/no)
4. Location of involvement: North Service Area/South Service Area/Centre Service Area?
5. Cumulative length of time in care?
6. What are the reasons for involvement with Child and Family services (addictions, family violence, neglect, etc)?
7. Foster home/Family placement/Group home?
8. Length of time in most recent placement
9. Cumulative number of placement moves
10. What type of suicidal behaviours has the youth exhibited (suicidal ideation, NSSI, suicide attempt)?
11. How many reported incidents of suicidal behaviour are on file according to MSS documentation?
12. What follow-up was provided to the youth as a result of each incident (medical, mental health, etc)?
13. How long did follow-up occur for?
14. Did contact occur between youth and an MSS worker after each incident? If so, how long between incident and contact.
15. Was a follow-up treatment plan created by MSS for youth?
16. How long after each incident before follow-up treatment plans were created?
17. Have there been any issues with addictions for this youth? If so, did treatment occur?
18. Have there been any prior or current concerns with mental health problems? If so, did treatment occur?
19. Has the youth ever been a victim of physical and/or sexual abuse in the past?
20. Were any additional services offered? If so, what were they?
21. Were there any barriers present to prevent MSS from being able to deliver support or services to the youth? If so, what were they?