

TOWARD A BETTER TOMORROW

Addressing the Challenge of Aboriginal Youth Suicide

14-YEAR-OLD ASINAY

15-YEAR-OLD SAGE

18-YEAR-OLD CEDAR

15-YEAR-OLD MORLEY

15-YEAR-OLD KARI

15-YEAR-OLD VICTORIA

18-YEAR-OLD JACOB





Under my authority and duty as identified in the *Child and Youth Advocate Act (CYAA)*, I am providing the following Investigative Review regarding the deaths of seven Aboriginal young people.

Each of these young people died by suicide. The responsibility of telling each of their stories weighs heavily on me and my staff. We sought guidance from Elders and through ceremony. One Elder shared, “The youth are still on their journey and while they struggled in life, the Creator gives them hope for a better tomorrow.”

While this is a public report, it contains detailed information about children and families. Although my office has taken great care to protect the privacy of the youth and their families, I cannot guarantee that interested parties will not be able to identify them. Accordingly, I would request that readers and interested parties, including the media, respect this privacy and not focus on identifying the individuals and locations involved.

In accordance with the *CYAA*, all names used in this report are pseudonyms (false names). Finding an appropriate pseudonym is difficult because a young person’s name is part of who they are. However, it is a requirement that my office takes seriously and respectfully. The names used for the young people in this report were identified in consultation with their family members and those closest to them.

This review identifies opportunities for child-serving systems to strengthen how they support children and families. It is critical that the recommendations contained in this report be acted upon as soon as possible.

While this report places a particular focus on suicide by Aboriginal young people, all youth suicides are terrible tragedies. It is only through open discussion and responsive action that fewer children will end their own lives and similar tragedies will be prevented.

[Original signed by Del Graff]

Del Graff

Child and Youth Advocate

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EXECUTIVE SUMMARY

Alberta's Child and Youth Advocate ("the Advocate") is an independent officer reporting directly to the Legislature of Alberta, deriving his authority from the *Child and Youth Advocate Act (CYAA)*. The Advocate has the authority to conduct investigations into systemic issues related to the death of a child receiving designated services, or who had received Child Intervention Services within two years of their death if, in the opinion of the Advocate, the investigation is warranted or in the public interest.

Over 18 months during 2013 and 2014, the Advocate received reports regarding seven Aboriginal young people, from different communities, who died by suicide:

- 14-Year-Old Asinay¹
- 15-Year-Old Sage
- 18-Year-Old Cedar
- 15-Year-Old Morley
- 15-Year-Old Kari
- 15-Year-Old Victoria
- 18-Year-Old Jacob

Each of these young people was receiving services from Child Intervention Services when they passed away, or had received services within two years of their death. They were individuals with unique life experiences, which we honour in this report. Their deaths by suicide are heartbreaking and focuses attention on what can only be described as a terrible tragedy that is occurring among Aboriginal young people.

Within the Aboriginal youth population, suicide is one of the leading causes of death. They are five to six times more likely to be affected by suicide than the general population, and over a third of all deaths among Aboriginal youth are attributed to suicide. The suicide rate among First Nations male youth is five times higher, and among First Nations female youth it is seven times higher, compared to those of their non-Aboriginal peers.

Meaningful action is long overdue.

The Advocate examined the lives and circumstances of Asinay, Cedar, Sage, Morley, Kari, Victoria and Jacob as part of a broader review, with the goal of trying to

1 All names throughout this report are pseudonyms to ensure the privacy of the young person and their family.

understand the high rate of youth suicide faced by Aboriginal Peoples, families and communities.

Why Is Suicide Happening?

Literature identifies a number of risk factors that pre-dispose young people to suicide, which can occur at the individual, relational and community levels.

Significant individual-level risk factors for suicide include depression, substance abuse, anxiety, mental health problems, disruptive behaviours and the inability to regulate emotions. These factors may be related to early childhood trauma.

Risk factors at the relational level, such as high levels of parent-child conflict, parental mental illness, exposure to family violence, generational suicidal behaviours and substance abuse also increase a young person's risk for suicide.

Community-level risk factors, such as socioeconomic disadvantage and poor access to services impact everyone in a community and make it more challenging for families to access the assistance they need. This is the case not only for those residing in Aboriginal communities, but also those who live 'off-reserve' or 'off-settlement'. It is important to note that Asinay, Cedar, Sage, Morley, Kari, Victoria and Jacob did not all live in Aboriginal communities; some lived in urban centres.

The risk factors for suicide are applicable for all young people. Aboriginal youth have markedly higher rates of suicide than non-Aboriginal youth. It is also important to note there are significant variations in the rates of youth suicide between Aboriginal communities across Alberta and across the country.

These differences indicate that there are additional factors that impact Aboriginal youth. These are rooted in the historical treatment of Aboriginal Peoples and the resulting effects on Aboriginal culture, communities and families.

Two significant elements of Canadian history are noteworthy for the systemic discrimination they perpetrated. One is the residential school system; the other is known as the 'sixties scoop'. Both involved forced separation of Aboriginal children from their families and communities. Families who lost children to residential schools or through the 'sixties scoop' were left with unimaginable grief and a profound sense of loss. Aboriginal communities lost significant numbers of their children, creating major gaps in their social fabric.

Many survivors of residential schools and the 'sixties scoop' were left with identity confusion. They internalized feelings of shame about being Aboriginal. They often lost their native language and had challenges communicating with family members and Elders. Their traditions became foreign to them. As they grew up and became parents, many continued to have unresolved grief, loss and anger, which contributed to situations of substance abuse, family violence, family dysfunction and impaired child-

parent relationships. The legacy of residential schools and the 'sixties scoop' has been passed from one generation to the next.

The lives of Asinay, Cedar, Sage, Morley, Kari, Victoria and Jacob were each marked by the presence of risk factors for suicide. They all experienced early childhood trauma resulting from exposure to domestic violence, parental addictions and/or parental mental health issues. Most were separated from their loved ones and from healthy family connections and they experienced multiple moves. A number of them also experienced the death of family members by suicide. Many came from backgrounds and communities of socioeconomic disadvantage. All were impacted by the legacy of residential schools.

What Can Be Done

In looking at the lives of Asinay, Cedar, Sage, Morley, Kari, Victoria and Jacob, a number of opportunities were identified for systemic improvement:

1. Pursuing community-led strategies to address Aboriginal youth suicide

Alberta requires a comprehensive, strategic approach to prevent and address Aboriginal youth suicide. Each community faces unique challenges and is best positioned to develop local solutions so strategies must be community-led. The Government of Alberta is best positioned to serve as a champion and information resource and to use its policy and financial levers to support community-led strategies.

2. Addressing Aboriginal youth suicide holistically

Communities need to engage community leaders, service providers and key professionals to collaborate in the development and implementation of their community-led strategies. Each strategy should include efforts and responses in the areas of prevention, intervention and aftercare. They should also demonstrate an understanding that at-risk youth need to be assisted holistically: physically, emotionally, psychologically and spiritually.

3. Building on protective factors

Research demonstrates the importance of protective factors outweighing risk factors. This is critical for a child's healthy development and in preventing youth suicide. Protective factors are conditions or characteristics that promote social, physical, emotional and psychological health and well-being. Community-led strategies should seek to create and strengthen protective factors at all levels. Developing a young person's skills, teaching them how to have positive relationships, increasing their problem-solving capabilities, increasing their self-esteem and giving them an environment of social support, all help build protective factors. Connecting Aboriginal youth with their traditions and cultures is essential because it enhances their sense of meaning and belonging.

To improve outcomes for Aboriginal young people and help prevent incidents of Aboriginal youth suicide, the Advocate makes the following **12 recommendations**:

Recommendation 1

- A) The Government of Alberta should have a provincially funded suicide prevention strategy that supports the development and implementation of **community-led** strategies across the province. The strategy needs the capacity to adjust to accommodate the interests and needs of particularly vulnerable groups at elevated risk for suicide.
- B) Strategies to prevent Aboriginal youth suicide must be developed within the context, and in recognition of, the traditional values and cultural practices relevant to Aboriginal youth in the community.

Recommendation 2

The Government of Alberta should act on ways to improve provincial services and systems to support holistic community-led strategies to address Aboriginal youth suicide. For example, the government should consider:

- Can these services and systems be used or leveraged to help reduce risk factors among Aboriginal youth and their families?
- Does the current operation of these services and systems present any barriers that make it difficult to access assistance for at-risk Aboriginal youth?
- How might these services and systems be inadvertently contributing to risk factors among at-risk Aboriginal youth and their families?

Recommendation 3

Alberta Human Services, with its service delivery partners, should ensure that supports are available to Aboriginal young people who have lost someone significant to suicide and that those services are deliberate and proactive.

Recommendation 4

The Ministry of Human Services should review child intervention case practice to ensure that intervention is focused on the child's needs. The impact on a child exposed to domestic violence, parental substance abuse and other forms of child maltreatment must be addressed early in conjunction with their caregivers' treatment plans.

Recommendation 5

The Ministry of Human Services, with its service delivery partners, should ensure that case practice reflects a strength-based approach that focuses on the attachment needs of children while ensuring that their risk for harm is addressed.

Recommendation 6

Alberta Education should develop and implement school-based suicide prevention programs. Consideration should be given to developing a peer support component.

Recommendation 7

Alberta Mental Health Services should ensure that cultural components are incorporated in treatment strategies for young people.

Recommendation 8

The Government of Alberta should ensure that mental health programs are more accessible, holistic and readily available in First Nations communities.

Recommendation 9

The Ministries of Human Services, Education and Health, along with their service delivery partners, should require that professionals working with Aboriginal young people have enhanced suicide intervention training.

Recommendation 10

The Ministries of Human Services, Education and Health, along with their service delivery partners, should require that professionals working with Aboriginal Peoples have adequate training regarding the pre and post-colonial history specific to Aboriginal Peoples so that they have a good understanding of the potential risks, strengths and needs within Aboriginal families.

Recommendation 11

Alberta Human Services should review the Delegation Training for Suicide Intervention Skills and ensure that it contains information about the need for culturally-relevant resources and how caseworkers can access them.

Recommendation 12

The Government of Alberta should support increased levels of self-determination of First Nations in Alberta through reconciliation processes in partnership with First Nations, federal and provincial governments. Consideration should be given to greater levels of self-determination regarding child intervention balanced with support as a protective factor for suicide prevention.

The Office of the Child and Youth Advocate

Alberta's Child and Youth Advocate (the "Advocate") is an independent officer reporting directly to the Legislature of Alberta. The Advocate derives his authority from the *Child and Youth Advocate Act (CYAA)*,² which came into force on April 1, 2012.

The role of the Advocate is to represent the rights, interests and viewpoints of children receiving services through the *Child, Youth and Family Enhancement Act*³ (*the Enhancement Act*), the *Protection of Sexually Exploited Children Act*⁴ (*PSECA*), or from the youth justice system.

Investigative Reviews

The Advocate has the authority to conduct investigations into systemic issues related to the death of a child receiving designated services, or who had received Child Intervention Services within two years of their death if, in the opinion of the Advocate, the investigation is warranted or in the public interest.

Upon completion of an investigation under the *CYAA*, the Advocate releases a public Investigative Review report. The purpose is to make findings regarding the services that were provided to the young person and make recommendations that may help prevent similar incidents from occurring in the future.

An Investigative Review does not assign legal responsibilities or draw legal conclusions, nor does it replace other processes that may occur, such as investigations or prosecutions under the *Criminal Code of Canada*. The intent of an Investigative Review is not to find fault with specific individuals but to identify key issues along with meaningful recommendations which are:

- prepared in such a way that they address systemic issue(s); and,
- specific enough that progress made on recommendations can be evaluated; yet,
- not so prescriptive as to direct the practice of Alberta government ministries.

It is expected that ministries will take careful consideration of the recommendations and plan and manage their implementation along with existing service responsibilities.

2 *Child and Youth Advocate Act*, S.A. 2011, c. C-11.5.

3 *Child, Youth and Family Enhancement Act*, RSA 2000, c. C-12.

4 *Protection of Sexually Exploited Children Act*, RSA 2000, c. P-30.3.

The Advocate provides an external review and advocates for system improvements that will help enhance the overall safety and well-being of children who are receiving designated services. Fundamentally, an Investigative Review is about learning lessons, rather than assigning blame.

About This Review

The Advocate learned of the deaths of seven Aboriginal young people who died by suicide over 18 months during 2013 and 2014:

- 14-Year-Old Asinay⁵
- 15-Year-Old Sage
- 18-Year-Old Cedar
- 15-Year-Old Morley
- 15-Year-Old Kari
- 15-Year-Old Victoria
- 18-Year-Old Jacob

Each of these young people was receiving services from Child Intervention Services when they passed away, or had received services within two years of their death.

Each young person's child intervention record was thoroughly reviewed by investigative staff from the Office of the Child and Youth Advocate (OCYA). Initial reports were completed that identified potential systemic issues and the Advocate determined that full Investigative Reviews were required. The Ministry of Human Services was subsequently notified that there would be an Investigative Review regarding each of the seven youth.

Terms of Reference for each review were established and are summarized in Appendix 1. A team gathered information and conducted an analysis of each young person's circumstances through a review of relevant documentation, interviews and research.

Wherever possible, the Investigative Review team met with family members and those closest to the young person, as well as caregivers, support people, caseworkers and other professionals.

A preliminary report was completed and presented to a committee of subject matter experts and a committee comprised of senior leadership from the Ministries of Human Services, Education, Health and Indigenous Relations. The subject matter experts included Elders and professionals who had expertise working with Aboriginal

5 All names throughout this report are pseudonyms to ensure the privacy of the young person and their family.

youth and communities, child and adolescent mental health, placement resources and high-risk populations. The committee members provided advice related to findings and recommendations. A list of committee membership is provided in Appendix 2.

During the Investigative Review process, the Advocate made the decision to examine the stories, circumstances and experiences of Asinay, Cedar, Sage, Morley, Kari, Victoria and Jacob as part of a broader collective review. As with any Investigative Review, focused and dedicated attention has been made to each young person's situation. As information was gathered, it became clear that there were common concerns across their stories.

All seven experienced early childhood trauma resulting from exposure to domestic violence, parental addictions and/or parental mental health issues. Most were separated from their loved ones and from healthy family connections and they experienced multiple moves. A number of the young people also experienced the death of family members by suicide.

Asinay, Cedar, Sage, Morley, Kari, Victoria and Jacob were all Aboriginal. Their deaths, all occurring within a period of only 18 months, serve to highlight the terrible trend of Aboriginal youth suicide, which is having serious effects on our province and our entire country.

There are some alarming statistics:

- In Canada, suicide rates of Aboriginal young people between 15 and 19 years of age, almost **tripled** from the 1950s to the 1980s.
- The suicide rate for First Nations male youth (between 15 and 24 years of age) is 126 per 100,000—**over five times higher** than the rate of suicide for non-Aboriginal male youth.⁶
- For First Nations females between 15 and 24 years of age, the suicide rate is 35 per 100,000—**seven times higher** than the rate of suicide for non-Aboriginal female youth.⁷
- Within the Aboriginal youth population, suicide is one of the leading causes of death. **They are five to six times more likely to be affected by suicide** than the general population.^{8,9}
- Between the ages of 10 and 19, Aboriginal youth on Reserves are 5 to 6 times more likely to die by suicide than youth in the general population.¹⁰
- Over a third of all deaths among Aboriginal youth are attributed to suicide.¹¹

6 Statistics Canada (2013)

7 Statistics Canada (2013)

8 Banerji (2012)

9 Health Canada (2013)

10 Aboriginal Healing Foundation (2007)

11 Health Canada (2003)

There are considerable variations in suicide rates across First Nation, Métis and Inuit communities in Alberta and across Canada. Where some communities have been largely unaffected, other communities have a significantly higher rate of youth suicide.¹² However, it cannot be denied that a troubling picture has taken shape when it comes to Aboriginal young people.

Over 30 years ago, a Public Inquiry was held into the death of 17-year-old Richard Cardinal, who died by suicide. That Public Inquiry identified 22 recommendations for the prevention of similar deaths.¹³ While there have been significant changes in the various systems that provide services to Aboriginal children and families, outcomes for some of Alberta's most vulnerable young people have seen little change.

The stories of these seven young people represent only some of the Aboriginal youth suicides that the Advocate has learned about, some of which have been examined in previous Investigative Reviews.

Action on this issue is long overdue.

To that end, the Advocate has examined the lives and circumstances of Asinay, Cedar, Sage, Morley, Kari, Victoria and Jacob as part of a broader review, with the goal of attempting to understand the high rate of youth suicide faced by Aboriginal Peoples, families and communities. It is the Advocate's sincere hope that this Investigative Review will shine a spotlight on this serious concern and motivate governments, communities and service providers to take real action that will prevent incidents of Aboriginal youth suicide and enhance the safety and well-being of Aboriginal children and youth.

To assist in the readability of this Investigative Review, a Glossary of Terms is provided in Appendix 3.

12 Chandler & Lalonde (2004)

13 Report to the Attorney General (November, 1984) Public Inquiry, Richard Cardinal

14-YEAR-OLD ASINAY



14-YEAR-OLD ASINAY

About Asinay

Asinay was 14 years old when he passed away. He was of Métis and First Nations ancestry and those who knew him described him as a gentle giant. He was polite, articulate, confident and friendly. At school, he could be awkward around peers. Asinay's friends miss him dearly and regret that they were unable to stop him from taking his life. Asinay was intelligent; he had a tender heart and a great smile.

Asinay's Family

Asinay had a close relationship with his grandmother, Kohkom, who helped his mother, Okawiya, raise him. Kohkom spent much of her childhood in residential school. The abuse that she witnessed and suffered had a negative impact on her.

Until he was 10 years old, Asinay was an only child and he received undivided attention from his mother and grandmother. However, they had opposing views on parenting and were often at odds, which affected him. After Asinay's 10th birthday, his mother had two more children and he was protective and affectionate towards them. Their father struggled with addictions and Asinay did not have a relationship with him.

History of Involvement with Child Intervention Services

The family received Child Intervention Services from a Child and Family Services region. At the time of his death, Asinay was receiving services through a Family Enhancement Agreement. He was living with his grandmother and had regular contact with his mother.

Asinay from Birth to 11 Years Old

There was no child intervention involvement during Asinay's first six years.

When Asinay was seven years old, his mother had difficulty managing his behaviours. He had angry episodes in which he would yell and throw things. Child Intervention Services referred her to community services for parenting assistance.

When Asinay was nine years old, Child Intervention Services became involved twice due to the disharmony between his mother and grandmother. They could not agree on how to parent Asinay. Their conflict escalated; his mother took him and moved to another city. Soon after, however, Kohkom joined them in their new home. The family sought assistance through community services.

There was no Child Intervention Services involvement with the family for two years.

Asinay from 12 to 14 Years Old

When Asinay was 12 years old, Child Intervention Services became involved because of concerns he was being verbally abused by Kohkom and exposed to drug and alcohol use by his mother. The family was referred to community supports.

Throughout his life, Asinay would ask Kohkom about death, dying and suicide. He had trouble sleeping and suffered from nightmares. He started cutting his arms and attempted to overdose on a family member's medication. Asinay stabbed himself in the chest following a disagreement with his mother.

Shortly before Asinay's 14th birthday, Child Intervention Services received a concern that he was home alone and talking about suicide. Involvement ended as Kohkom was at home with him. Within weeks, another concern was received that Asinay was talking about wanting to kill himself and Child Intervention Services became involved.

Approximately two months later, Asinay had an argument with his mother that resulted in her telling him that he could not live at home. Asinay told his caseworker that he wanted to burn her house down. He also said he thought of suicide often, most recently during the last fight with his mother. Asinay believed that if he died, Kohkom would join him soon because she had told him that she was preparing for her final journey. Asinay had a plan to end his life.

Child intervention staff viewed Asinay as being at high risk for suicide and arranged for Kohkom to take him to the hospital. A physician recommended mental health services and Asinay was prescribed anti-depressants. Kohkom and Asinay were opposed to the medication but agreed that he would take them.

At Asinay's request, the caseworker quickly arranged for a counsellor. Asinay attended three sessions. He was frustrated because he did not feel that the medication was working and in an attempt to feel better faster, he took more than what was prescribed.

Asinay's caseworker worked with him to help him see the positives in his life. On one occasion, they talked about three wishes and he expressed that he wanted a certain brand of ice tea. On her next visit, the caseworker gave Asinay a case of his desired drink to show him that wishes could come true.

At school, Asinay was given special considerations. Some days when he was tired and sitting in a classroom was difficult, he was allowed to work with the school maintenance worker. This provided him with the opportunity to be outside doing physical work that he enjoyed. He spent time with a close relative and they would spend the whole day exploring the outdoors. Asinay was very happy during these times.

The caseworker met with the family and arranged for Kohkom to receive financial support so that Asinay could live with her. During this meeting, Asinay and his mother argued and the caseworker needed to intervene. It was agreed that Asinay would not have overnight visits with her.

Two weeks later, the caseworker spoke with Asinay. He said everything was fine and he planned to attend a counselling appointment the following day.

That night, Asinay and Kohkom stayed at his mother's house. Asinay erected poles for a tipi, which he planned to dedicate to Kohkom. After an argument, he left the home, telling his mother and grandmother that they "would be sorry."

The police found Asinay's body approximately six hours later. He died by suicide.

15-YEAR-OLD SAGE

18-YEAR-OLD CEDAR



15-YEAR-OLD SAGE 18-YEAR-OLD CEDAR

About Sage and Cedar

Sage and Cedar were brothers who died by suicide four months apart.

Sage was 15 years old when he passed away. He was described as shy and tended to hide behind his older brothers. When he was very young, Sage dreamed of becoming a famous Aboriginal violinist. Later, he dreamed of becoming a famous rap artist.

Cedar was 18 years old when he passed away (four months after his brother). He was outgoing and outspoken. He took on the role of protector of his younger brothers. Cedar was athletic and loved to skateboard and snowboard. He dressed in skinny jeans and sneakers.

About Sage and Cedar's Family

Cedar and Sage were the third and fifth children, respectively, of a large sibling group who lived in their First Nations community. Their mother, Carol, was exposed to domestic violence when she was a child. Her parents struggled with addictions. When she was quite young, Carol became involved in a long-term relationship and had several children. Domestic violence and addictions marred this relationship and it ended. The children's father had no involvement with them.

After the relationship ended, Carol was involved in relationships that exposed her children to violence and addictions. The children witnessed her being physically and emotionally abused on a number of occasions.

History of Involvement with Child Intervention Services

The family received Child Intervention Services from a Delegated First Nation Agency. Both Cedar and Sage were living with their mother at the time of their deaths.

Cedar from Birth to 4 Years Old

During Cedar's first two years, the family's involvement with Child Intervention Services was due to family violence and substance abuse. Services and supports were provided in the home. By the time Cedar was two years old, intervention involvement ended.

Child Intervention Services then had no involvement with the family for two years.

Cedar from 4 to 8 Years Old / Sage from Birth to 5 Years Old

When Cedar was four years old and Sage was six months old, they were apprehended along with their siblings. Carol had left the children with extended family members and did not return. Cedar, Sage and their brothers were placed together in one foster home on-reserve, while their sister was placed with extended family.

The children remained in foster care for approximately one year and did very well. Cedar was involved in recreational activities and counselling. While in foster care, Cedar and his older brother disclosed having witnessed physical and verbal abuse between their parents. Cedar and Sage were physically aggressive with each other.

All of the children transitioned back to their mother's care. Approximately three months after their return, Carol had another child. Child intervention involvement ended about three months after the new baby's birth.

Approximately one year later, all of the children were apprehended because of neglect and parental substance abuse. They had to be placed separately. The brothers were placed in two foster homes on-reserve, while their sister was placed with extended family.

About one year later, the children were returned to their mother's care. Carol entered into a six-month Family Enhancement Agreement to help with the transition. At the end of the agreement, child intervention involvement ended. Just prior to the involvement ending, Carol had another child.

Cedar from 9 to 14 Years Old / Sage from 6 to 11 Years Old

Approximately one year later, when Cedar was nine years old and Sage was six years old, all of the children were apprehended because they were left alone with no food. Cedar and Sage were placed together in a foster home on-reserve, where they remained for almost five years.

Permanent Guardianship Orders were granted for all the children approximately 18 months after they came into care.

While in foster care, Cedar became aggressive with Sage. It was felt that this behaviour was due to the frustrations Cedar felt because he could not live with his mother; he wanted to return home. He began counselling and was connected with a youth worker who exposed him to his First Nations culture and taught him to hunt and fish.

Sage did well in school and was involved in his First Nations culture through dance and hunting. He played hockey and the violin; and, a youth worker spent time with him.

There were ongoing concerns about the boys' foster home. There were allegations related to neglect and physical abuse, and of Cedar bullying Sage. Almost five years after coming into care, 13-year-old Cedar was moved to a group home because he did

not get along with his foster mother and refused to stay. Sage, who was 11 years old, remained in the foster home. Around this time, the children began having unsupervised visits with their mother.

Shortly after the visits began, the Permanent Guardianship Orders were rescinded (withdrawn) and all of Carol's children were returned to her care. Child Intervention Services ended its involvement.

Cedar from 15 to 18 Years Old / Sage from 12 to 15 Years Old

Approximately 18 months later, concerns were received about lack of supervision, parental substance abuse and the children not attending school.

About nine months after these concerns were received, 13-year-old Sage and seven of his siblings were apprehended. Sixteen-year-old Cedar and their older brother were left with Carol because child intervention staff believed they would run back home if they were brought into care. Cedar was not attending school and was abusing substances.

Within the week, Sage and one of his brothers returned to Carol's care. Two months later, Permanent Guardianship Orders were granted on the youngest children. An Application for a Supervision Order was made for Cedar, Sage and their older brothers. The application was denied because the Judge felt the intervention needed to be more intrusive. No further court applications were made regarding Cedar, Sage and their older brothers.

Carol struggled with caring for her sons. Neither Cedar nor Sage were attending school and both were abusing substances. The caseworker met with Cedar and Carol and discussed their progress in addressing the protection concerns. Carol was directed to look for placement options where Cedar's addictions and educational needs could be met.

Almost six months after returning to his mother's care, Sage came back into care and was moved to a group home for a behavioural assessment. Over the next 13 months, Sage had three group home placements and one placement in a residential facility outside of his home community. He often ran away to his family home.

Carol and the group home staff had ongoing concerns about Sage. They felt he was not himself. It was reported that Sage thought people were out to get him. He internalized his fears and anxiety and became very sad. A partial assessment, completed by a psychologist, indicated that Sage required placement in a residential facility that could provide structure and supervision. It was felt he would benefit from connection to his First Nations culture and from individual and family counselling.

Upon discharge from the group home, Sage returned to his mother's care under a Family Enhancement Agreement. Carol was to provide a safe home environment that was free of drugs and alcohol and provide adequate supervision. She was to ensure her

children attended school and she was to attend counselling to help her learn to parent teenagers.

Six months later the agreement expired, but Child Intervention Services continued to be involved. Carol was becoming increasingly concerned about ongoing issues with her children. She felt Sage was not the same since returning from the group home. It was difficult to stop him from abusing alcohol. He was angry and punched holes in the walls. He kept to himself, did not speak or participate in family functions and often wandered off by himself.

Sage was found deceased in his family home when he was 15 years old. He died by suicide. Cedar felt responsible for his brother's death and the family struggled to cope with their loss. They were offered counselling in their community but did not attend because they wanted to see somebody who worked outside of the community.

Almost four months later, 18-year-old Cedar was found deceased in the family home. He died by suicide. Cedar had no child intervention involvement when he passed away.

15-YEAR-OLD MORLEY



15-YEAR-OLD MORLEY

About Morley

Morley was 15 years old when she passed away. She took great pride in her appearance. Morley was described as kind-hearted, outgoing and very social. She cared deeply for others, especially her younger brother. She offered support and advice to those experiencing difficulties and took them under her wing. Morley longed to live at home with her mother and siblings.

About Morley's Family

Morley's mother, Melva, experienced childhood abuse and was a victim of domestic violence in her relationships. She struggled with depression and addictions, which resulted in the neglect of her children. Morley was the second oldest of a large sibling group. The family lived in an urban centre away from their First Nation community.

History of Involvement with Child Intervention Services

The family received Child Intervention Services from a Child and Family Services region. At the time of her death, Morley was the subject of a Permanent Guardianship Order and residing in a group home.

Morley from Birth to 11 Years Old

Morley's family had sporadic Child Intervention Services' involvement until she was eight years old due to parental addictions, family violence and neglect concerns. Child intervention remained involved with her family for two years. Morley and her younger brother, Cory, spent most of this time in care.

Melva completed a parenting program and a substance abuse program. Near the end of child intervention involvement, she had another child. Shortly after the birth of this child, 10-year-old Morley and 4-year-old Cory returned to Melva's care. Approximately three months later, Child Intervention Services ended their involvement.

Morley from 11 to 13 Years Old

Over the next two years, Child Intervention Services received four concerns related to Melva feeling overwhelmed with parenting. Child intervention had no long-term involvement because Melva was connected to community resources and had family supports.

Shortly before Morley's 13th birthday, Child Intervention Services received two concerns within one week. Melva had a new baby. She was drinking and involved in a violent relationship. Morley told a caseworker that she had to feed the baby sterilized water because she had no formula.

Two months later, Morley disclosed to a caseworker that she had thought of suicide. She also disclosed that she cut herself on her arms and legs with a razor blade because it made her feel good. More than 50 marks were noted on Morley's arms, at various stages of healing. She indicated that two weeks earlier she had put a cord around her neck and tried to hang herself. She was taken for a mental health assessment.

That same day, Morley and her brothers and sisters came into care. Morley was placed with a foster family in a rural community and her siblings were placed in group care.

Morley's inability to sleep was a significant issue while in her foster home. Initially, her foster mother slept outside of her room because Morley had suicidal thoughts. She was scared of sleeping because her mother's boyfriend had told her that he would kill her while she slept. She was very fearful and did not want to be alone.

The caseworker consulted with local community mental health service providers because Morley was cutting herself. A plan was developed that included supports and an educational assessment.

Over the next several months, Morley's foster parents reported that she was hearing voices telling her to cut herself. Morley loved her mother but their relationship was difficult and Morley displayed negative behaviours after speaking to her. A psychiatrist diagnosed her with Post Traumatic Stress Disorder. She internalized past abuse, which resulted in her hearing voices. Morley had suicidal thoughts. She was prescribed medication and was to have bi-weekly counselling.

Over the following months, Morley's behaviours deteriorated. She did not take her prescribed medication. She stockpiled razor blades, heard voices more frequently and engaged in self-harming behaviours.

There was an incident in which Morley was found with a rope around her neck. She was taken to hospital, given medication and discharged. Upon returning home, she threatened to stab herself and started hitting her head on the floor trying to get the voices out. The police and Emergency Medical Services responded and took Morley back to the hospital in restraints.

Child mental health professionals concluded that Morley was not depressed and had no psychosis. She was at high risk of suicide because she lacked coping skills. Her issues were assessed as stress-related and behavioural in nature. She did not fit the criteria for a mental health diagnosis. The mental health team agreed to follow up with Morley in the community. After one night in hospital, she was placed in a residential facility and continued to maintain contact with her foster parents.

Approximately one month later, Morley told her caseworker that the medication appeared to be working because the hallucinations were fading. A psychologist was working with her.

At age 13, Morley began to have unsupervised visits with Melva. Morley's psychologist

warned that Morley was cutting and that care was required during family visits. Morley again disclosed historical abuse by her mother's boyfriend, who was back in the family home.

About one month later, Melva consented to a Permanent Guardianship Order. Over the next three months, Morley continued to hear voices and to leave her placement without permission (AWOL). While AWOL she did not take her medication, which caused the hallucinations to return.

Morley said she thought about suicide, but then thought about her brothers and sisters and her need to protect them. She missed them and was anxious about not having visits. She felt no one wanted or loved her and felt conflicted about her mother.

Morley at 14 Years Old

When Morley was 14 years old, she was placed in secure unit at a residential facility because she was considered a risk to herself. She was abusing substances and associating with people involved in criminal activities. She said she felt sad about her relationship with her mother.

Morley refused to take her medication because she did not like the way it made her feel. She was referred to a psychiatrist but only attended a few appointments. She then moved to an open unit at the residential facility. Over the next eight months, the pattern of AWOLs, substance abuse and self-harm continued. Morley was taken to the hospital twice, once for cutting her arms and once for drinking excessively.

Morley's caseworker made a referral to a multi-disciplinary team that specialized in working with high-risk youth. It was recommended that a harm-reduction approach be taken; Morley would benefit from regular contact with her brothers and sisters; she should be connected to mental health services and engage in physical activities. Although arrangements were made for all of these, Morley did not follow through.

Morley later connected to a community-based youth service where she was assisted to make a self-referral to a group home, into which she moved. Her youth worker helped her get to medical appointments. There were no reports that she put herself at risk during this time. She appeared happy and content.

Morley at 15 Years Old

Over the next few months, 15-year-old Morley appeared to be making slow but steady progress. She had not self-harmed in months and appeared to be more confident. She did not appear to be stressed or anxious.

Approximately one month later, group home staff found Morley deceased in her bedroom.

Those who worked with Morley were shocked to hear about her death. They were not aware of any recent suicidal ideations and felt that Morley had been doing relatively well.

15-YEAR-OLD KARI



15-YEAR-OLD KARI

About Kari

Kari was 15 years old when she passed away. She was a friendly, quiet youth who adored her siblings. She liked to have fun and had a wonderful sense of humour. Those who knew her said that Kari was affectionate and protective of those she loved.

About Kari's Family

Kari was the second oldest of a large sibling group. Her parents, Trisha and Eugene, struggled with substance abuse and had a volatile relationship. Trisha often left the family home, relying on Eugene to be the children's sole caregiver.

Eugene experienced the loss of close family members and struggled with suicidal ideation. When Kari was about 11 years old, Eugene had an accident that resulted in a brain injury.

History of Involvement with Child Intervention Services

The family received Child Intervention Services from a Delegated First Nation Agency. At the time of her death, Kari was the subject of a Permanent Guardianship Order and living with her father.

Kari from Birth to 6 Years Old

Involvement with Child Intervention Services began when Kari was 18 months old. She and her three-year-old brother were found unattended in a home with no food. They were apprehended and returned to their parents' care the following day under a Family Enhancement Agreement.

When Kari was about four years old, she was apprehended along with her five-year-old brother and 15-month-old sibling because they did not have a sober caregiver. The children were placed with a foster family because Trisha and Eugene were struggling with addictions and did not have stable housing. Kari had difficulty adjusting to the foster home and often cried for hours. The children remained in care for almost two years.

Eugene and Trisha completed residential treatment and parenting programs and the children were returned to their care under a Family Enhancement Agreement.

Kari from 7 to 10 Years Old

When Kari was seven years old, Trisha and Eugene continued to struggle with addictions. They consented to a Supervision Order that was in place for about one year.

After the Supervision Order ended, Trisha had another child and admitted to using drugs while pregnant. The children remained in their parents' care and there was no child intervention involvement for about two years.

Kari from 11 to 14 Years Old

When Kari was 11 years old, Eugene attempted to hang himself in the family home while intoxicated. It is not clear if Kari witnessed his attempt.

Four months later, there were concerns that Eugene and Trisha were again struggling with their addictions. Child Intervention Services was involved but there was no indication of substance abuse.

Five months later, Eugene was involved in an accident that resulted in a significant brain injury and considerably decreased mental capacity. Within months of the injury, Child Intervention Services became involved because Trisha was leaving the children in Eugene's care for extended periods. Trisha and Eugene agreed that they needed help and entered into a Family Enhancement Agreement.

Approximately six months later, 12-year-old Kari and her siblings were apprehended. Kari and her three sisters were placed with their aunt Davina.

About four months later, Eugene was hospitalized and assessed as high risk for suicide. A psychological assessment concluded that he required assistance with day-to-day living. It was recommended that the children be placed permanently with alternate caregivers. Permanent Guardianship Orders were subsequently granted on 13-year-old Kari and her brothers and sisters.

While with their aunt Davina, the sisters disclosed that their parents physically abused them and they were relieved to be safe. Over the next three years, Kari formed a close bond with her aunt. After an extended family member died by suicide, Kari asked her aunt about suicide. They had a frank discussion and talked about some of the consequences.

Kari at 15 Years Old

When Kari was 15 years old, she began to spend weekends with Eugene. Trisha was not in the home.

Six months later, Kari and her siblings witnessed an incident of violence in Davina's home that involved alcohol abuse. The children had a summer visit planned with their father. As they prepared for the visit, Davina informed them that due to this incident,

they would permanently move back to their father's care. She told them that this had not been her decision. Kari was very upset about leaving her aunt's home.

Kari and her sisters (who were four, six and eight years old) were placed with Eugene under an extended visit. A family member moved into the home to assist with cooking and maintaining the house. A youth worker was involved with the children and their caseworker made frequent home visits.

About two weeks after Kari returned to her father's care, the after-hours child intervention office received a report that Kari had spoken to a friend about wanting to die. Kari had made an agreement with one friend that they would both end their lives. Kari had conversations with Eugene about suicide. He informed her that he had made multiple attempts to take his own life and that he remembered it hurt but that he always survived.

Approximately three months after returning to her father's care, Kari began to withdraw, participating less in family events and outings with her youth worker.

One evening, Eugene found Kari unresponsive in the basement. She received medical attention but passed away early the next morning. Kari died by suicide.

15-YEAR-OLD VICTORIA



15-YEAR-OLD VICTORIA

About Victoria

Victoria was 15 years old when she passed away. She enjoyed music. She presented as shy but was able to voice her needs and wants. She adored her younger siblings and was protective of them. Victoria had numerous placements and her wish was to be adopted.

About Victoria's Family

Victoria had a number of siblings and several half-siblings. Her parents, Carolyn and Ralph, struggled with alcohol abuse and exposed their children to domestic violence. His response to conflict or stressful situations was to leave the home. After Carolyn and Ralph separated, he found himself homeless and lived with relatives or friends.

Carolyn grew up in a home where she was abused and neglected. She struggled with anger and was emotionally and physically abusive to her children. Carolyn battled with depression and had multiple suicide attempts. Shortly after Victoria's seventh birthday, Carolyn passed away from a drug overdose. It is not known whether her death was accidental or a suicide.

History of Involvement with Child Intervention Services

The family received Child Intervention Services from a Delegated First Nation Agency. At the time of her death, Victoria was the subject of a Permanent Guardianship Order and living with a foster family.

Prior to Victoria's Birth

The family's involvement with Child Intervention Services started seven years prior to Victoria's birth. Concerns were related to abandonment and physical and emotional abuse. Shortly before Victoria's birth, Child Intervention Services was involved because Carolyn was struggling with alcohol abuse, depression and had made two suicide attempts. Child intervention involvement ended with a referral to community supports.

Victoria from Birth to 9 Years Old

During Victoria's first four years, Child Intervention Services had extensive involvement with her family. Concerns were related to her mother's addictions, anger, depression and suicide attempts. Carolyn and Ralph had a volatile relationship; they separated and reunited several times. Their children were exposed to alcohol abuse, domestic violence and neglect. In addition to receiving in-home support services, Victoria and her siblings were placed in foster care a number of times.

When Victoria was five years old, her mother was able to resume care of Victoria and her three-year-old brother, Lewis. Carolyn arranged to have her two younger children adopted by a family member.

Approximately a year after being in their mother's care, there were concerns that Victoria and Lewis were being exposed to alcohol abuse and violence. They were apprehended and placed in foster care. Six months later, Carolyn requested that her sister, Beth, care for the children.

Approximately three weeks later, Carolyn died from a drug overdose. Victoria was seven years old at the time.

Within two months of their mother's death, Permanent Guardianship Orders were granted. The children remained in their foster home and had visits with their aunt Beth. They were placed with her shortly after the orders were granted.

Two years later, Beth adopted nine-year-old Victoria and seven-year-old Lewis.

Victoria from 10 to 13 Years Old

Seven months after their adoption, concerns were received that Victoria and Lewis had witnessed Beth threaten to harm herself. The incident occurred when she was drinking. Beth took steps to address her addictions.

Approximately three months later, 10-year-old Victoria and 8-year-old Lewis were apprehended due to concerns related to physical abuse. Beth pled guilty to assaulting the children. Victoria and Lewis were placed with kinship caregivers.

About six weeks later, Victoria and Lewis started having visits with their father, Ralph. Four months later, they were placed in his care. Child intervention involvement ended.

Over the next three months, the family had extensive involvement with Child Intervention Services. At Ralph's request, the children were brought back into care. Their first placement was in a foster home but within a short time, the children moved to a kinship home.

Four months later, 11-year-old Victoria and 8-year-old Lewis were returned to Ralph's care. Within one week, they were again placed in a kinship home due to Ralph's addictions. Three days later, they moved to another kinship home.

The children remained in this home for approximately four months and then moved to another kinship home because their caregivers were experiencing personal difficulties. This move occurred one week before Permanent Guardianship Orders were granted.

After approximately nine months with this family, Victoria and Lewis were returned to their father's care under an extended visit, with the intent of rescinding (withdrawing) the Permanent Guardianship Orders. Within a month, Ralph requested the children be removed from his care because he was not able to provide for them. The children were

placed with a foster family outside of their community. Victoria began seeing a mental health therapist and talked about her disappointment in her father's lack of follow-through.

Approximately 18 months after being in this placement, 13-year-old Victoria moved back to Beth's home. A short time later, there were reports that Victoria was having difficulty with the expectations in the home.

Victoria from 14 to 15 Years Old

Approximately five months after moving back to Beth's home, Victoria overdosed on prescription medication and was hospitalized. The overdose followed a conflict about house rules. While in the hospital, she disclosed recent stressors that included the death of her best friend's sister.

A suicide risk assessment determined that Victoria was not "acutely" suicidal. There was a conclusion that she might suffer from Attachment Disorder and Post-Traumatic Stress Disorder related to the losses she had experienced. It was recommended that Victoria see a psychiatrist and a therapist. She was subsequently moved to a foster home in her home community. Seven months into this placement, she wanted her foster parents to adopt her.

Victoria began to split her time between her foster home and Beth's home. She talked about missing her mother and wanted to visit her gravesite. She often wrote to her mother in her journal and spoke about suicide as a way of reconnecting with her.

Victoria was looking forward to a visit with Ralph and her younger sisters, but the visit was canceled at the last minute. She left her foster home. A day later, 15-year-old Victoria was found deceased near her foster home. She had died by suicide.

18-YEAR-OLD JACOB



18-YEAR-OLD JACOB

About Jacob

Jacob was 18 years old when he passed away. Those who knew him described Jacob as outgoing. He loved his family and idolized his father. Jacob was respectful, polite and had a great sense of humour. He loved being around horses. Shortly before his 17th birthday, Jacob and his girlfriend had a baby. Jacob wanted to provide a stable home for his family.

Jacob experienced many losses and traumatic events.

About Jacob's Family

Jacob's parents, Audrey and Sayer, struggled with addictions and anger issues. They had several children.

Audrey spent most of her life in her First Nation community. She died by suicide in the family home when Jacob was 11 years old.

Sayer was often violent when he drank. He moved between his home community and the city. Jacob wanted to be with Sayer and lived with him sporadically.

History of Involvement with Child Intervention Services

Jacob received Child Intervention Services from a Child and Family Services region. At the time of his death, Jacob was receiving services under a Support and Financial Assistance Agreement. He did not have a residence.

Jacob from Birth to Ten Years Old

Shortly after his birth, Jacob's family became involved with Child Intervention Services due to concerns related to neglect, parental addictions and lack of appropriate housing.

When Jacob was six years old, the children were apprehended because of drinking in the home. Initially they were placed together with extended family, but the placement broke down because his kinship care providers could not manage Jacob's behaviours. Jacob moved to a foster home where he stayed for five months and formed a strong attachment to his foster father.

Jacob struggled in school both academically and socially. By the age of seven, he was diagnosed with generalized anxiety and depression, which required immediate treatment. He had some autistic tendencies and a referral was made for an assessment.

Audrey and Sayer attempted to make the necessary changes to meet their children's needs. They attended parenting and addictions programming as well as counselling. Although there were continued concerns about Sayer's sobriety, the children were returned to their parents' care.

Jacob from 11 to 14 Years Old

When Jacob was about 11 years old, Audrey died by suicide in the family home. After her death, the children went to live with their aunt. However, she found it difficult to care for all the children so they moved to their grandmother's home.

Jacob stayed with his grandmother for approximately 18 months. He did not want to stay there and, at his request, Jacob moved back to his aunt's home. Jacob stayed with his aunt for two years.

When 13-year-old Jacob was in grade six, he had a Psycho-Educational and Behavioural Assessment. It indicated that he had mild to moderate cognitive delays. His behaviours included aggression, which was consistent with Oppositional Defiance Disorder.

When Jacob was 14 years old, he started having visits with Sayer. Jacob said that he was afraid of his dad but loved being with him. He refused to live anywhere else so his caseworker agreed to the placement. Sayer, Sayer's spouse and Jacob did not have a permanent residence and often moved between their First Nation and the city. Sayer had a number of criminal convictions and while he was incarcerated, Jacob stayed with relatives. At times, Jacob's caseworker did not know where he was.

Sayer encouraged Jacob's violent and aggressive behaviours. On a number of occasions, Jacob had a gun and used it to protect his father. Jacob became involved with the justice system and was placed on probation and alternate measures programs.

Jacob from 15 to 19 Years Old

Over the next four years, Jacob stayed with friends and relatives because he did not have a place to live. He was referred for counselling to help him deal with the traumatic events he had experienced. Jacob attended one counselling session.

When Jacob was 15 years old, he attempted suicide twice. First, he was found lying on the railroad tracks but denied that it was a suicide attempt. He did not go to hospital nor was the situation reported to his caseworker. Approximately two weeks later, Jacob tried to hang himself and was taken to hospital. His condition was very serious.

Although Jacob made a full physical recovery, he was transferred to a secure area at the hospital for a mental health assessment. A specialized group home was recommended because of his cognitive delays. While Jacob would not benefit from therapy, it was suggested that a focus be placed on maintaining stability in his living arrangements and establishing appropriate programming for him.

After leaving the hospital, Jacob was placed in a secure unit at a residential treatment facility because he was considered a risk to himself. After a short stay, he was moved to an open setting within the facility where he stayed for about four months. During that time, his aunt died by suicide. Jacob began cutting himself. His relationship with his girlfriend was unstable and he started abusing drugs and alcohol.

When Jacob was 16 years old, he could no longer stay in the residential facility due to his behaviours. He was referred to an addictions treatment program but did not attend. He attempted suicide a third time. He continued to abuse substances and was placed in an addictions safe house. After three days, Jacob was released to a youth shelter because there were no other placements for him.

Shortly before his 17th birthday, Jacob and his girlfriend had a baby. Fatherhood appeared to be a stabilizing influence. Jacob worked odd jobs when he could get them and focused on his baby. This was the most stable he had ever been. Jacob wanted a home for his family and asked his caseworker for a youth worker and a Supported Independent Living (SIL) placement.

During his 17th year, Jacob and his young family moved from place to place, staying with friends and family. By the time he was 18 years old, Jacob appeared depressed and sad. He and his family were homeless. His girlfriend's mother was caring for his child. The agencies that provided SIL services would not provide a placement for him, stating that he had not shown enough stability.

Prior to Jacob's 19th birthday, his uncle died by suicide. He had difficulty accepting his uncle's death and, soon afterward, Jacob died by suicide.

DISCUSSION AND RECOMMENDATIONS

DISCUSSION

The stories of these seven young people illustrate the challenges they faced in their all-too-short lives. When they came to the attention of Child Intervention Services, each child's life was chaotic and characterized by instability.

While the details of each of their stories are unique, there can be no question that Asinay, Cedar, Sage, Morley, Kari, Victoria and Jacob were all in degrees of pain—emotional, psychological, and even in some cases, physical. They had all been exposed to conditions that were harmful and their social, emotional and psychological development had been impaired.

Ultimately, the assistance that was offered and provided by caregivers, professionals and others was not sufficient to help them work through their trauma. In the end, all seven turned to suicide as a way of ending their pain.

Youth Suicide: Understanding Risk and Protective Factors

Suicide is a complex issue. The Centre for Suicide Prevention reflects on the cause for suicide:

“The path that leads a person to consider suicide is as unique as he is. The key is that the vast majority of people who consider, attempt or die by suicide do not actually want to die: they want the pain of living to end.”¹⁴

Literature about youth suicide points to a number of risk factors that predispose people to suicide. The exposure to negative life events during their developmental stages caused Asinay, Cedar, Sage, Morley, Kari, Victoria and Jacob to experience many vulnerabilities and suicidal risk factors.

As discussed later in more detail, many of these risk factors arose from the trauma they endured. Each young person's life was marked by a pattern of complex trauma due to exposure to parental addictions and family violence. Some of these children were exposed to suicidal behaviours. Most were identified as having emotional disturbances. Most experienced numerous placement moves.

14 Centre for Suicide Prevention (2015)

Complex trauma affects a child's development and the formation of self. It affects physical health, brain development, emotional responses behaviour, cognition, self-concept and future orientation. Young people who experience complex trauma may also suffer from dissociation, separating themselves from a current or past experience and effectively losing touch with various aspects of themselves.¹⁵

Literature about youth suicide also identifies a number of protective factors. These are conditions or characteristics that promote social, physical, emotional and psychological health and well-being. Protective factors help build resilience.

The interplay of risk factors and protective factors is instrumental in a child's healthy development, and in preventing youth suicide. Research demonstrates the importance of changing the balance between protective and risk factors so that protective factors outweigh risk factors.¹⁶ Risks can never be fully eliminated, but young people can be empowered with the skills they need to successfully navigate and cope with risks they encounter. Having this resiliency can help prevent young people from turning to suicide.

Later in this report, we go into more detail about protective factors and how they can be enhanced. First, it helps to discuss how risk factors contribute to suicide.

Risk Factors

Risk factors occur at both the **individual and relational levels**.

People are not islands. Our identity, character and physical and mental health are shaped by our experiences and our environment. As such, the complex web of interactions we have with others (in our families, peer groups, schools, etc.) shapes us from birth.

In addition to being present at different levels, risk factors have influences at different times in relation to suicide.

Some risk factors are **predisposing**—their presence makes a person more vulnerable to begin with and places them at greater risk of suicide. Other risk factors are **contributing**—they have a 'piling on' effect that places already vulnerable individuals at even greater risk. There are also risk factors that are said to be **precipitating**—those events or 'triggers' that cause an individual at risk of suicide to attempt the act (for example, an argument). Finally, certain risk factors are **enabling**—those conditions that make it easier for a person to take their own life. (Intoxication and the availability of firearms are two often-cited enabling risk factors.)¹⁷

15 The National Child Traumatic Stress Network (2014)

16 Child Welfare Information Gateway (2014)

17 Health Canada (2013)

Significant individual-level risk factors for suicide include depression, substance abuse, anxiety, mental health problems and disruptive behaviours.¹⁸ The inability to regulate emotions is also a risk factor. The presence of these factors can be the consequence of a young person having experienced forms of abuse, neglect and a number of disruptions in their life. Abuse, neglect and disruption can be experienced at the individual or the relational level (e.g., family members). Risk factors at the relational level, such as high levels of parent-child conflict, a parent's mental illness, a history of family violence, generational suicidal behaviours and substance abuse can increase the young person's risk for suicide.¹⁹

Over time, risk factors can result in the young person lacking coping skills, having limited cognitive capacity and having emotional disturbances. These conditions can result in an elevated risk for suicide.²⁰ In their vulnerable state, young people are far less equipped to deal with adversities. Stressful life events such as loss, violence, trauma and conflict typically precipitate suicidal acts.²¹

To understand what leads to suicide, we need to look holistically at the presence of risk factors (or absence of protective factors) from infancy to death.

The table on the following page summarizes risk factors at the individual and relational (family, peers, school) levels.

18 Esposito-Smythers et al. (2012)

19 Steele & Doey (2007); Spirito & Esposito-Smythers (2006)

20 Evans, Hawton, & Rodham (2004); King & Merchant (2008); Spirito & Esposito-Smythers (2006)

21 Evans, Hawton, & Rodham (2004)

LEVEL		PREDISPOSING FACTORS	CONTRIBUTING FACTORS	PRECIPITATING FACTORS
INDIVIDUAL		<ul style="list-style-type: none"> • Previous suicide attempts • Depression • Substance use • Anxiety, mental health problems • Failure to regulate emotions • History of childhood neglect, sexual abuse, or physical abuse 	<ul style="list-style-type: none"> • Poor coping skills • Substance use • Aggression • Impulsivity • Limited distress tolerance skills • Rigid cognitive style • Hypersensitivity • Anxiety 	<ul style="list-style-type: none"> • Loss • Personal failure • Victim of cruelty • Humiliation • Violence • Individual trauma
RELATIONAL	Family	<ul style="list-style-type: none"> • Family history of suicidal behaviour/ suicide • Family history of mental disorder • Early childhood loss/separation 	<ul style="list-style-type: none"> • Family discord • Punitive parenting • Impaired parent-child relationship • Multi-generational trauma and losses • Physical, emotional or sexual abuse 	<ul style="list-style-type: none"> • Loss of significant family member • Death of a family member, especially by suicide • Recent conflict
	Peers	<ul style="list-style-type: none"> • Social isolation and alienation 	<ul style="list-style-type: none"> • Negative attitudes toward help seeking • Limited/conflicted peer relationships • Suicidal behaviours among peers 	<ul style="list-style-type: none"> • Interpersonal loss or conflict • Peer victimization • Rejection • Peer death by suicide
	School	<ul style="list-style-type: none"> • History of negative school experience • Lack of meaningful connection to school 	<ul style="list-style-type: none"> • Reluctance/ uncertainty about how to help among school staff 	<ul style="list-style-type: none"> • Failure • Expulsion • Disciplinary crisis • School based harassment

Some risk factors are present at many levels, in particular:

- Depression
- Substance abuse
- Suicidal behaviour
- Mental health problems
- Neglect, physical abuse or sexual abuse
- Loss of relationship/connections

Asinay, Cedar, Sage, Morley, Kari, Victoria and Jacob each experienced these factors.

Asinay

Asinay was exposed to alcohol, drug abuse and family disharmony. The relationship between his mother and grandmother was marked by considerable conflict and it caused him a great deal of anxiety. He struggled with that relationship and with the differing parenting styles of his mother and grandmother. His mother required mental health services, counselling and parenting assistance for short periods.

The substance abuse and family disharmony clearly impacted Asinay. At seven years old, he had angry episodes. Before he was 10 years old, he displayed mental health concerns. He suffered from recurring nightmares and had difficulty sleeping. Over time, he engaged in self-harming behaviour, attempted suicide more than once and frequently spoke about suicide with friends and family. Near the end of his life, Asinay abused substances. His risk factors included mental health concerns, substance abuse, a history of suicide attempts and suicidal ideation. Conflict with his mother and grandmother was arguably a precipitating risk factor.

Sage and Cedar

Sage and Cedar's family had a history of suicide and self-harming behaviour. Their grandmother and uncle both died by suicide. Their mother struggled with mental health concerns, addictions and was overwhelmed being a single parent to many children. It is unclear whether the original protection concerns that brought Cedar, Sage and their siblings into care were ever alleviated. At the relational level, Cedar and Sage were exposed to parental substance abuse and they witnessed physical and emotional abuse of their mother.

The boys were clearly impacted by all of this. Cedar was aggressive with Sage and bullied him. As time went on, both Cedar and Sage stopped attending school and began abusing substances. Sage became withdrawn and disconnected from his family. He also reportedly displayed paranoia and internalized his fears and anxiety.

Both boys also struggled with loss. They experienced several moves in and out of care. Sometimes they were separated from each other and from their other siblings. They were also removed from their community. During these times they lost connections with those closest to them and with the community they knew. Cedar, in addition, felt profound loss at Sage's suicide. He felt responsible for his brother's death and appeared depressed.

Morley

Morley experienced significant trauma. During her first 13 years, she was exposed to parental substance abuse, domestic violence and neglect.

By the time she was removed from her mother's care, Morley had an established pattern of behaviour that included self-harm and suicidal ideations. Her behaviours escalated to include violent outbursts. She was diagnosed with Post Traumatic Stress Disorder. Morley also experienced grief and loss. She felt sad about her fractured relationship with her mother and she was separated from her brother; these were her two most significant relationships.

Kari

In her early years, Kari was exposed to family violence, substance abuse and an unpredictable home environment. While it is not clear whether she witnessed her father's suicide attempt, it is clear that her family was impacted by suicide. In addition to the attempt by Kari's father, it is known that another extended family member died by suicide and that Kari discussed this with her aunt.

Kari experienced grief and loss when she was suddenly moved from her aunt's home (with whom she was close) to her father's care. She lost contact with her aunt due to family conflict and this loss was significant for her. While Kari's father could take care of some of her daily needs, he was not capable of providing the emotional support that Kari required. Eventually, Kari began talking about suicide. She withdrew, participating less and less in family events and outings with her youth worker.

Victoria

From infancy, Victoria was exposed to many family-level risk factors. These included exposure to parental addictions and family violence. She had no lengthy periods of stability. Her mother had a history of attempting suicide, suffered from depression and died from a drug overdose when Victoria was only seven years old. Victoria was moved a number of times and had 18 placements over 12 years.

Victoria longed to be part of a family and talked about how she wanted to be adopted and was disappointed when this did not happen. There were three unsuccessful attempts to reunite Victoria with her father. She struggled with her relationship with him. She wanted to be with him but was disappointed repeatedly when he could not care for her.

Over time, Victoria exhibited suicidal behaviour. She told a close friend that she thought about dying so she could be with her mother. She was referred to a psychiatrist and a therapist for her mental health concerns. Victoria clearly felt loss, sadness and disappointment.

Jacob

From early childhood, Jacob was exposed to substance abuse and violence. During his adolescence, he had a number of placements—at times drifting from relative to relative. From the age of 15, he had no stable residence. Jacob was also affected by the suicides of family members. At 11 years old, his mother died by suicide; at 15 years old, his aunt died by suicide; and, at 19 years old, his uncle died by suicide.

These experiences impacted Jacob's development. By the age of seven, he was diagnosed with generalized anxiety and depression. Jacob was later found to be cognitively delayed and had difficulty self-regulating. He struggled with substance abuse. Jacob also attempted suicide more than once, the first time when he was 15 years old.

By his 17th birthday, Jacob was a father himself. He yearned for stability and tried to give his child a better life. Jacob made progress, but his relationship with his girlfriend was volatile. When a referral was made to a Supported Independent Living program, he was rejected because he had not shown stability. Jacob was sad and depressed; and, he and his family were homeless.

In addition to feeling depressed, Jacob felt a great deal of grief and loss. His uncle's suicide was a precipitating risk factor in Jacob's own death.

Aboriginal Youth Suicide: The Social/Community Dimension

The risk factors for suicide are applicable for all young people. However, not all young people in Canada are turning to the tragic avenue of suicide at the same rate. Aboriginal youth have markedly higher rates of suicide than non-Aboriginal youth. Research and past examinations of this issue are helpful in explaining the differences.

Just as there are risk factors for suicide at the individual and relational levels, there are also risk factors present at the social/community level.

The quality and health of our communities dramatically influences the quality of the routine settings in which we have our interactions with others (such as families and schools). The presence of risk factors at the community level affects everyone in the community, compounding the difficulties that some individuals and families already face. Community-level risk factors can make it even more challenging for struggling families to access effective assistance so that they can become more stable and well.²²

22 Chandler & Lalonde (2004)

This is the case not only for families and young people residing in Aboriginal communities, but also those who live 'off-reserve' or 'off-settlement'. It is important to note that Asinay, Cedar, Sage, Morley, Kari, Victoria and Jacob did not all live in Aboriginal communities, some lived in urban centres.

Aboriginal youth living off-reserve can face barriers in accessing services due to the presence of community-level risk factors. For example, although the necessary services might be present, there may be insufficient cultural sensitivity or understanding in the delivery of these services. Service providers might have limited experience regarding youth who are at risk for suicide, or regarding at-risk Aboriginal youth.

A significant risk factor at the social/community level is socioeconomic disadvantage. One study of Aboriginal people on 26 Reserves in Alberta found a strong correlation between suicide rates and the percentage of the population living below the poverty level.²³

It is well documented that many Aboriginal communities are socioeconomically disadvantaged. A large number of Aboriginal people live in communities that have notably high levels of poverty, poor housing conditions and limited health services.²⁴ It has been noted that underfunding of important resources and services (such as education and health) significantly contributes to the poor health situation that many Aboriginal Peoples currently experience.²⁵

Many Aboriginal communities also struggle with unemployment, which contributes not only to poverty but can also have harmful social and psychological effects. Unemployment can rob adults of their pride, dignity and feelings of self-worth. It can contribute to parental substance abuse, family violence and family dysfunction.

A community's socioeconomic disadvantage can and will have impacts on their families, contributing to problems such as addictions, mental health issues and family violence. This leads to impaired parent-child relationships, diminished parenting capacity and family discord. Essentially, a number of relational-level risk factors can take root, creating and contributing to risk factors for the young people in the family.

In some cases, children may be taken into care because of their family's circumstances, which can disrupt their emotional and cultural connections and cause additional feelings of grief and loss. This compounds the risk factors for suicide that were already present.

23 Aboriginal Healing Foundation (2007)

24 Royal Commission on Aboriginal Peoples (1996)

25 Browne, McDonald, & Elliott (2009); Reading & Wien (2009)

The table below summarizes risk factors at the social/community level.

LEVEL		PREDISPOSING FACTORS	CONTRIBUTING FACTORS	PRECIPITATING FACTORS
SOCIAL/ COMMUNITY	Health and Social Services	<ul style="list-style-type: none"> Limited access to appropriate services Lack of consistent health professional 	<ul style="list-style-type: none"> Lack of understanding by health professionals Lack of education and awareness around suicide among youth 	<ul style="list-style-type: none"> Crisis
	Community	<ul style="list-style-type: none"> Multiple suicides Community marginalization Socioeconomic disadvantage 	<ul style="list-style-type: none"> Uncertainty about how to help among key workers Inaccessible community resources 	<ul style="list-style-type: none"> High profile deaths by suicide Conflict with the law

These risk factors can affect a community’s capacity to assist a young person who is in need or at risk. Even if an Aboriginal young person or a healthy adult in their life seeks help, their community may not be in a position to lend assistance.

A risk factor that is especially challenging for some Aboriginal communities is the occurrence of high-profile or multiple suicides. When a young person dies by suicide in a relatively small, tight-knit Aboriginal community, the impact of their death is profound. In some communities, it is not uncommon for a youth suicide to be followed by another within a short time. When a community suffers from repeated losses, a sense of hopelessness can grow.

Aboriginal Youth Suicide: The Historic and Cultural Context

There are significant variations in the rates of youth suicide between Aboriginal communities across Alberta and across the country. While some have been terribly impacted and have very high rates of youth suicide, others have been relatively untouched.²⁶

These variations suggest that risk factors for suicide at the individual, relational and social/community levels are not the only factors. There are broader forces rooted in the historical treatment of Aboriginal Peoples and the resulting effects on Aboriginal culture, communities and families.

26 Chandler & Lalonde (2004)

Residential Schools and the ‘Sixties Scoop’

While not the first instances of poor treatment of Aboriginal Peoples by European-based culture, two significant elements of Canadian history are noteworthy for the systemic discrimination they perpetrated. One is the residential school system; the other is known as the ‘sixties scoop’.

Beginning in the late 1800s, many Aboriginal children were taken from their families and placed in residential schools, typically located some distance from their communities. While at school (approximately 10 months of the year), children had little or no contact with their families and communities.

Children at the schools were not allowed to practice or learn about their traditional cultures. The curricula and its method of delivery were firmly based on European values and approaches; traditional methods of Aboriginal learning were not incorporated. Children were discouraged from learning about, expressing or taking an interest in their traditional cultures or backgrounds. They were expected to adopt the school’s values, ideology and European-based way of life. Many children later disclosed that while at residential schools they were victims of physical, emotional and sexual abuse.

Back in their communities, the children’s families struggled with their loss. Aboriginal Peoples traditionally have an expansive sense of ‘family’, beyond the nuclear family. Extended family and other community members also played roles in child-rearing. As a result, the removal of children had a dramatic impact not only on the children’s immediate families, but also on the community in general.

By the 1950s, the federal government began phasing out residential schools, but they continued to operate for several more decades. The last residential school in Alberta closed in 1975.²⁷ The last federally-run residential school to close in Canada was the Gordon Indian Residential School in Punnichy, Saskatchewan in 1996.²⁸

A 1951 amendment to the *Indian Act* gave provincial governments the authority to provide services to Aboriginal Peoples that were not provided federally, including child protection. This amendment resulted in what is now known as the ‘sixties scoop’. During this time, a disproportionate number of Aboriginal children were brought into government care because social workers believed that they were in need of protection.

Social workers were not required to have knowledge or training in Aboriginal culture and did not understand that a traditional lifestyle could meet the needs of children. It was believed that Aboriginal children were at risk because their families did not conform to middle-class Euro-Canadian values. This practice led to an alarming rate of Aboriginal children being apprehended and placed in non-Aboriginal homes. By the

27 University of British Columbia, First Nations Studies Program (2009)

28 The Legacy of Hope Foundation (2016)

1970s, almost one third of children in care were Aboriginal.²⁹ This over-representation of Aboriginal children in care continues to date.

The ‘sixties scoop’ also resulted in a high number of international adoptions. Children lost all connection with their families, communities, traditions and culture.

Families who lost children to residential schools or through the ‘sixties scoop’ were left with unimaginable grief and a profound sense of loss. Aboriginal communities lost significant numbers of their children, creating major gaps in their social fabric.

Families that were torn apart by the residential school system and the ‘sixties scoop’ were forever changed. Individuals affected by these “well-meaning” initiatives often dealt with their strong unresolved emotions by turning to substance abuse or making other unhealthy choices.³⁰

The Linkages to Suicide

Our identity is a critical anchor in our lives; it is central to our being, telling us fundamental things about ourselves such as:

- Where we come from
- What we believe in
- The language we use
- Our traditions and cultural practices
- The values we hold
- Our sense of right and wrong
- How we perceive the world
- Who we belong to and where we belong

Not all survivors of residential schools or the ‘sixties scoop’ had the same experiences. But for many, the result was identity confusion. Many struggled to make sense of their place in their families and communities. They had internalized feelings of shame about being Aboriginal. They often lost their native language and had challenges communicating with family members and Elders; their traditions became foreign to them. They were caught between two worlds, no longer comfortably fitting within their Aboriginal culture nor the European-based culture.³¹

As they grew up, former students became parents, but the disruption caused by residential schools and the ‘sixties scoop’ left many ill-equipped to take on parenting roles. Many continued to have unresolved grief, loss and anger, which contributed to

29 Aboriginal Healing Foundation (2007)

30 Aboriginal Healing Foundation (2007)

31 Chandler & Lalonde (2004)

situations of substance abuse, family violence, family dysfunction and impaired child-parent relationships. Research indicates that some survivors rejected traditional ideas and values out of a sense of shame.³² This may have resulted in traditional languages and cultural practices not being passed down from one generation to the next.

All of this inevitably impacted their children; and, the legacy of residential schools and the ‘sixties scoop’ was passed from one generation to the next. Aboriginal children often grow up in families that carry these tragic legacies, which contributes to a higher prevalence of risk factors for suicide.³³

In addition to this trauma, Canadian history reflects that there was significant cultural stress placed on Aboriginal Peoples because of their contact with colonial interests. Racism and classism were at the heart of systemic attempts by the federal government and others, to assimilate Aboriginal Peoples. Even today, social injustice and social exclusion continue to be issues for Aboriginal Peoples in the modern country of Canada.

Risk factors for suicide are also identified at the sociopolitical level. These are factors that are beyond the control of the individual or their family, and which have their origins in history and cultural evolution.

The table below summarizes these risk factors.

LEVEL	PREDISPOSING FACTORS	CONTRIBUTING FACTORS	PRECIPITATING FACTORS
SOCIOPOLITICAL	<ul style="list-style-type: none"> • Colonialism • Historical trauma • Cultural stress • Lateral violence 	<ul style="list-style-type: none"> • Racism • Classism 	<ul style="list-style-type: none"> • Social exclusion • Social injustice

We cannot say for certain how these risk factors may have contributed to the deaths of these seven young people. However, it is likely that all of the families of these young people were impacted to varying degrees.

Clearly, Asinay was directly impacted because his grandmother, Kohkom, spent much of her childhood in a residential school and she was one of his primary caregivers. During the Investigative Review, Kohkom explained how her parenting was influenced by the traumatic events she experienced at the school. This helps to explain the conflict that Kohkom had with her daughter (Asinay’s mother) in how to parent Asinay, which in turn affected his emotional well-being. Therefore, in addition to risk factors for suicide at the individual and relational levels, there were also sociopolitical risk factors present.

³² Chandler & Lalonde (2004)

³³ Aboriginal Healing Foundation (2007)

Asinay’s situation is an important example—when assessing and supporting Aboriginal young people, who are facing difficult situations, service providers must be mindful of how the legacies of the past continue to influence the present.

Today’s child welfare system focuses on keeping children physically safe from harm. However, there is considerable room for improvement when it comes to safeguarding and enhancing children’s emotional, mental and spiritual well-being. The child welfare system must adapt and ensure that history is considered when working with Aboriginal children and their families.

The Importance of Protective Factors

Like risk factors, protective factors can be present at the individual, relational, social/ community and sociopolitical levels. This table summarizes protective factors.

LEVEL		PROTECTIVE FACTORS
INDIVIDUAL		<ul style="list-style-type: none"> • Individual coping skills • Willingness to seek help • Good physical and mental health • Experiencing feelings of success • Strong cultural identity and spiritual beliefs • Living in balance and harmony
RELATIONAL	Family	<ul style="list-style-type: none"> • Family cohesion and warmth • Positive parent-child connection • Positive role models • Active parental supervision • High and realistic expectation • Support and involvement of extended family members and Elders
	Peers	<ul style="list-style-type: none"> • Social competence • Healthy peer modeling • Peer friendship, acceptance, and support
	School	<ul style="list-style-type: none"> • Success at school • Interpersonal connection • Sense of belonging • Supportive school climate • School engagement • Anti-harassment policies

LEVEL		PROTECTIVE FACTORS
SOCIAL/ COMMUNITY	Health and Social Services	<ul style="list-style-type: none"> • Improved knowledge/awareness of suicide among health professionals • Consistent health professional who has a relationship with the youth
	Community	<ul style="list-style-type: none"> • Opportunities for youth participation • Availability of resources • Community ownership • Culturally safe healing spaces • Opportunities to connect to land
SOCIOPOLITICAL		<ul style="list-style-type: none"> • Social capital • Social justice • Social safety net • Social determinants of health

People are impacted by the conditions and characteristics of their family and peer relationships, and of the community and broader society. When these conditions and characteristics are favourable and protective, they contribute to healthy development.

Empowering a young person with individual coping skills, improving their self-esteem and giving them an environment of social support, all provide youth with the tools that help to protect against social problems.³⁴ Developing a young person's skills, teaching them how to have positive relationships and increasing their problem-solving capabilities also helps to build their resilience.

Traditions and culture are critical to enhancing meaning in a young person's life and helps to build protective factors in relationships, improve self-esteem and self-mastery. All of these traits help to prevent or reduce the risk of suicide.^{35,36}

This is especially relevant for Aboriginal youth. For reasons outlined earlier, many Aboriginal young people may not have fully formed healthy identities and may struggle to understand their place in the world. Cultural teachings, cultural programming and culturally relevant supports are critical to enhancing their resilience. Having ties to traditions and culture helps keep a young person grounded and supports their physical, mental, emotional and spiritual well-being.³⁷ When young people have traditional and cultural ties, they report lower thoughts about suicide and experience fewer suicide

34 Alcanatara & Gone (2008); Prilleltensky & Prilleltensky (2006); Russell (2005)

35 O'Donoghue, Kirshner & McLaughlin (2002)

36 Oliver, Collin, Burns & Nicholas (2006)

37 Mussell, Cardiff & White (2004)

attempts.³⁸ Treatments that use traditional healing practices, as a complementary therapy, are important considerations to help Aboriginal young people overcome trauma and bridge two cultures.³⁹

We can see from the lives of Asinay, Cedar, Sage, Morley, Kari, Victoria and Jacob how the presence or absence of protective factors specifically related to traditions, culture and healthy activities, were influential.

Asinay was reportedly very happy during times that he spent doing physical work outside and exploring nature.

Cedar appeared to have a period of relative stability when his youth worker exposed him to his culture and taught him to hunt and fish.

Sage, during the same period, was involved in his culture through dance and hunting. He also played hockey and the violin.

Morley appeared to make slow but steady progress, displaying more confidence and less anxiety after she was connected with a community-based youth service.

Kari, Victoria and Jacob had few lengthy periods of stability and, perhaps not surprisingly, limited identifiable periods during which efforts were made to connect them to their traditions or culture.

It is noteworthy that while some of the young people had Aboriginal youth workers, there was a lack of culturally-relevant supports overall. The majority of resources provided were conventional counselling and therapy.

Sadly, the protective factors in these young people's lives were not strengthened so that they outweighed their risk factors. However, we can see from their stories how some of them had periods of stability that were associated with the presence of protective factors.

38 The First Nations Information Governance Centre (2014)

39 National Aboriginal Health Organization (2005)

RECOMMENDATIONS

Having a better understanding of the risk factors that contribute to Aboriginal youth suicide is helpful in determining how we can prevent and reduce incidents of suicide.

In reviewing the lives of Asinay, Cedar, Sage, Morley, Kari, Victoria and Jacob, and other information and research gathered, a number of opportunities were identified for systemic improvement:

- 1. Pursuing community-led strategies to address Aboriginal youth suicide**
- 2. Addressing Aboriginal youth suicide holistically**
- 3. Building on protective factors**

Pursuing Community-Led Strategies to Address Aboriginal Youth Suicide

Over the years, attempts have been made at the national, provincial and local levels to address the high number of Aboriginal suicides. The Advocate makes no comment about the effectiveness or appropriateness of these strategies. But clearly, something more is needed because the rate of suicide by Aboriginal young people has not markedly decreased.

When young people contemplate or attempt suicide they are driven by very personal matters that are influenced by their family circumstances, their relationships and their environment. As mentioned earlier, rates of Aboriginal youth suicide are not consistent across the province. Some communities are struggling with high rates while others are comparatively less challenged. The complexity of youth suicide and its contributing factors are different in every community. Each community has unique needs depending upon the nature of the challenges facing their at-risk youth and families. Effective interventions to address youth suicide should be delivered by local providers.

In relation to the unique needs of each community, the challenge of Aboriginal youth suicide is similar to the challenge of homelessness, even though the subject matter is extremely different.

In response to the serious problem of homelessness, the provincial government established the Alberta Secretariat for Action on Homelessness to develop a strategy for addressing homelessness.⁴⁰ In its report, the Secretariat noted that the nature of homelessness was different in each community and required community-level responses. It called for the Government of Alberta to play certain roles in encouraging,

⁴⁰ The Alberta Secretariat for Action on Homelessness (2008)

championing and assisting in the development and implementation of community-led strategies to end homelessness.

The premise was straightforward: community members know their community best. They are best positioned to identify, assess and respond to social challenges in their community using their own networks, partnerships and tailored approaches. The government, meanwhile, is best positioned to use its policy and financial levers to assist communities in developing and implementing their responses. It serves as an important champion and information resource. Government is also a partner in its role as a provider of health, education and child welfare services.

Presently, Alberta does not have a comprehensive, strategic approach to prevent, reduce or address Aboriginal youth suicide. To the extent that groups of individuals or organizations are working to address this issue, it is occurring in limited fashion in pockets of the province. There is no coordinated province-wide effort with a clear champion. A workable and effective strategy is needed.

Integral to this is the notion of “community-led”, with a recognition that the concept of community is flexible. Here again, local leaders and partners are best positioned to determine what ‘community’ should mean in their context. For example, a community could be a single First Nation, a single Métis Settlement, or a single municipality. Alternatively, it could be a grouping of these.

Most importantly, Aboriginal Peoples from the community need to have meaningful roles in shaping each community-led strategy. Aboriginal views on addressing suicide are not viewed as the responsibility of the individual or to be dealt with in isolation. Suicide risk cannot be separated from family, community, cultural and spiritual well-being.⁴¹ Cultural connections are vital for giving young people meaning in their lives, which buffers them against risk factors for suicide.

Community-led strategies to address Aboriginal youth suicide will need to look different from one another. One of the hallmarks is flexibility, such that each community can use programs, services and other tactics that will best suit the conditions and needs in their community.

41 White (2007)

Recommendation 1

A) The Government of Alberta should have a provincially funded suicide prevention strategy that supports the development and implementation of **community-led** strategies across the province. The strategy needs the capacity to adjust to accommodate the interests and needs of particularly vulnerable groups at elevated risk for suicide.

B) Strategies to prevent Aboriginal youth suicide must be developed within the context, and in recognition of, the traditional values and cultural practices relevant to Aboriginal youth in the community.

Addressing Aboriginal Youth Suicide Holistically

No one individual or organization can address the challenge of Aboriginal youth suicide independently. Suicide is a complex issue that has to do with an individual's social, emotional, physical and psychological health and well-being. An at-risk youth will likely have more than one contributing condition or circumstance. Professionals, caregivers and service providers all have important roles in assisting the youth, so that the well-being of their entire person can be improved—physically, emotionally, psychologically and spiritually.

It is important to look at the young person's life as a whole. Research has shown that to protect children and youth from suicidal risk factors, early and ongoing treatment is necessary.^{42,43} In addition, the emotional and developmental needs of children change as they grow, so supports and resources also need to change. To remain relevant and helpful, these supports and resources may need to range from counselling to sports programming and various things in between. In addition, critical to these supports is the ongoing connection to their traditions and culture.

Communities need to engage key professionals, service providers and community leaders to collaborate in the development and implementation of their community-led strategies. A strategy should not have a solely medical focus, nor a solely spiritual focus. A community's strategy must demonstrate an understanding that at-risk youth need to be assisted holistically. The people and organizations that come together to develop the strategy, and those who collaborate to implement it, should understand their roles within the strategy.

Literature suggests that effectively addressing youth suicide requires efforts in three main areas: prevention, intervention and aftercare.⁴⁴ Community-led strategies need to include efforts and responses in all three areas because they are all interconnected.

42 Centre on the Developing Child at Harvard (2010)

43 Anda, et al. (2006)

44 Centre for Suicide Prevention (2009)

Prevention

We need to raise awareness about the challenge of suicide. Family members, peers and other community members need to know what the risk and protective factors are so that they can identify when a young person is at risk of suicide and know what to do about it.

Providing young people with positive connections is also preventative. When young people become actively involved in their community and have healthy friends they improve their social competence and have a sense of acceptance.^{45,46} Cultural programs taught in school (e.g. drumming, singing, dramatic arts, etc.) are important tools for youth healing.⁴⁷ After-school programming and sports clubs also act as preventative measures.

Intervention

There must be a direct and timely response when a young person talks about suicide and/or attempts suicide. This is about helping an at-risk youth start to work through their trauma.

These efforts are not limited to Child Intervention Services. Rather, they require collaboration among many individuals and organizations. When a youth requires suicide intervention they are in a painful and fragile place. Open communication, information sharing and collaboration are critical among professionals, caregivers and service providers. Those who come into contact with a suicidal youth, such as first-responders, front-line health workers or crisis workers, can have a profound influence.

Research has shown that a hospital's emergency department can play a significant role in addressing suicide intervention.⁴⁸ Best practices in emergency departments show that how a young person is initially assessed is just as important as the continuity of care and the comprehensive discharge plan they receive.⁴⁹

Intervention efforts must continue after the crisis passes. This is especially important for youth who suffer from mental health problems. There needs to be a collaborative approach to treating mental health concerns that is culturally responsive and long lasting.⁵⁰

45 Morsillo & Prilleltensky (2006)

46 Wang (2006)

47 National Aboriginal Health Organization (2005)

48 Centers for Disease Control and Prevention (2012)

49 Suicide Prevention Resource Center (2013)

50 Jobes, Rudd, Overholser & Joiner (2008)

Aftercare

Those interventions that are made after a suicide, largely taking the form of support for those left behind. Some research suggests that at least six people close to the individual who died will be left in a state of grief and loss.⁵¹ Losing someone close to suicide commonly results in intense emotional trauma, shock, grief and guilt; and, both physical and mental health can be negatively impacted.⁵² Information and support are important in helping the bereaved.

When a youth has a relative who has attempted suicide or died by suicide, there needs to be deliberate, proactive supports to help the young person. Suicidal behaviour by family members is positively associated with the suicidal behaviour of young people, which needs to be considered when working with particularly vulnerable youth.⁵³ Exposure to peer suicide may also increase the suicide risk⁵⁴ and supports are required.

Recommendation 2

The Government of Alberta should act on ways to improve provincial services and systems to support holistic community-led strategies to address Aboriginal youth suicide. For example, the government should consider:

- Can these services and systems be used or leveraged to help reduce risk factors among Aboriginal youth and their families?
- Does the current operation of these services and systems present any barriers that make it difficult to access assistance for at-risk Aboriginal youth?
- How might these services and systems be inadvertently contributing to risk factors among at-risk Aboriginal youth and their families?

Recommendation 3

Alberta Human Services, with its service delivery partners, should ensure that supports are available to Aboriginal young people who have lost someone significant to suicide and that those services are deliberate and proactive.

51 Postvention Australia (2014)

52 Joe & Bryant (2007)

53 Ali, Dwyer & Rizzo (2011)

54 Swanson & Colman (2013)

Taking Action at a Broader Level

In previous Investigative Reviews involving youth suicide, the Advocate has made several recommendations aimed at improving provincial systems and services to enhance the health and well-being of young people. These recommendations, provided in Appendix 4, are all applicable for Asinay, Cedar, Sage, Morley, Kari, Victoria and Jacob.

While several of these recommendations have been met, there has been little notable progress on others. From the Advocate's perspective, the implementation of all the recommendations would position provincial systems and services to be more effective partners in preventing and reducing incidents of Aboriginal youth suicide.

For example, one recommendation yet to be addressed is the need for Child Intervention Services to engage in comprehensive assessments, so that a balance is struck between child-focused and family-centered approaches. This would help ensure that services provided by this provincial system not only address the presenting concerns in a family, but also fully examine and address the impacts those concerns have had on their children.

For all seven young people discussed in this report, interventions provided were largely focused on their parents (or other caregivers) without a similar focus on the children. This is troubling.

For example, during Asinay's adolescence, there was significant conflict between his mother and grandmother and they were connected with parenting assistance. However, equal focus does not appear to have been given to how the disharmony was impacting Asinay's development, or on providing interventions to address such impacts. Later, he began to receive services but by this time his development had already been affected by the many years of conflict within his family.

Cedar and Sage were removed from their parents' care several times and intervention services focused on their mother's challenges. Once she fulfilled agreements and expectations, her children were returned to her. However, there does not appear to have been a balanced focus on how the children were impacted by their mother's repeated struggles with substance abuse.

Morley faced a similar situation, wherein her mother struggled with substance abuse and parenting challenges. In Morley's early years and adolescence, intervention services focused on helping her mother address her challenges, without a similar focus on helping Morley deal with any impacts resulting from those challenges.

Kari and her siblings were clearly impacted by their parents' challenges. While in a placement, they disclosed that they had been physically abused by their parents. Despite this, intervention services were focused on their parents (the requirement to complete a parenting course and a substance abuse treatment program), without a

balanced focus on the services that their children needed because of their exposure to physical abuse and parental substance abuse.

Victoria was exposed to parental substance abuse, domestic abuse and neglect from early childhood. Interventions focused on getting her mother to a place where she could resume care for Victoria, without any similar focus on assessing or addressing the impacts on Victoria. When Victoria was only seven years old, her mother died and Victoria was subsequently exposed to substance abuse and physical abuse in her kinship home. Intervention services also focused on Victoria's kinship caregiver without a similar focus on Victoria.

Jacob's family was involved with Child Intervention Services shortly after his birth for a variety of concerns. By the age of seven, he was assessed with anxiety and depression. Intervention services focused on his parents' challenges during his early years, but by the time there was a focus on Jacob the impacts of his parents' challenges had already seriously affected his development.

Had better balance been struck between both family-centered and child-focused approaches, these young people could have received assistance much earlier to help address the impacts that their family environments were having on them. This could have helped buffer them against their risk factors. With greater resilience, they might have been better able to navigate their future challenges, and might have been at less risk for suicide.

Recommendation 4

Alberta Human Services should review child intervention case practice to ensure that intervention is focused on the child's needs. The impact on a child exposed to domestic violence, parental substance abuse and other forms of child maltreatment must be addressed early in conjunction with their caregivers' treatment plans.

Building on Protective Factors

Each community-led strategy should build on 'protective factors'. This means undertaking efforts that can **reduce the presence of risk factors** for suicide among Aboriginal youth, while at the same time, undertaking efforts that can **strengthen protective factors**.

A young person's family is an important source of support as they navigate life events. When children experience disruptions in their family functioning, including parenting inconsistencies, impaired relationships and multi-generational trauma, there is an elevated risk of suicide.

Research demonstrates the need to strengthen parent bonding and parent-child relationships.⁵⁵ Building effective family functioning skills and improved communication can reduce the risks for children and youth who experience social and mental health problems, especially when targeted at an early age.⁵⁶ Family-focused interventions that aim to improve cognitive, affective and behavioural changes can lead to longer lasting improvements.⁵⁷ Families require supports that focus on their strengths and are collaborative, so that they can create their own solutions and are empowered to improve their situations.⁵⁸

Ideally, parents are healthy and well enough to care for their children. However, sometimes a young person must be placed with others, whether a kinship caregiver, a foster home or some other type of placement. Sadly, there may be times that a young person experiences multiple placements.

During and throughout such moves, it is critical that a young person has a relationship with at least one person, especially if the young person needs to be moved outside of their community. Secure attachment between a child and a caring adult is essential to healthy development.⁵⁹ A long-lasting connection to a healthy individual helps build resiliency and provides a sense of belonging. Research indicates that outcomes improve for young people when there is at least one positive constant relationship in their lives.⁶⁰

Recommendation 5

The Ministry of Human Services, with its service delivery partners, should ensure that case practice reflects a strength-based approach that focuses on the attachment needs of children while ensuring that their risk for harm is addressed.

Fostering a healthy connection between a young person and their school environment is also protective. As a place of learning, the school environment offers opportunities to enhance creativity, problem-solving, critical thinking and raise awareness about healthy lifestyle choices, which can help provide resiliency against risk factors.⁶¹

55 Toumbourou & Gregg (2002)

56 Toumbourou & Gregg (2002)

57 Kumpfer & Aldarondo (2003)

58 Kumpfer & Aldarondo (2003)

59 Schweinhart (2003)

60 Harden (2004)

61 Elias & Weissberg (2000)

Schools are also places where risk can be identified and responded to early. The proximity to young people places school-based staff in a unique position to detect potential signs of depression and suicide risks. School-based screening has increasingly been recommended as a strategy to reduce the number of youth suicides.⁶² However, to be effective, screening tools need to be adapted for Aboriginal youth and school staff need to be trained on how to properly implement them.⁶³ They also need to be empowered with the tools and skills that can help them further develop connections and trust with youth; and, with resources so that they know how to refer young people who need supports.⁶⁴

Another avenue for strengthening relational-level protective factors is a young person's relationships with their peers. Positive peer relationships and supportive friendships are critical in encouraging healthy youth development.⁶⁵ When young people experience social isolation and do not have a relationship with a positive individual, they are at a higher risk for suicide.⁶⁶ Prevention strategies that are aimed at student peer leaders can promote positive peer relationships.

It is important to note that while school environments can be leveraged to help address Aboriginal youth suicide, their influence depends on regular school attendance. For Asinay, Cedar, Sage, Morley, Kari, Victoria and Jacob, there were several periods when they did not attend school. Many factors influence school attendance including safety, housing and food.

Recommendation 6

Alberta Education should develop and implement school-based suicide prevention programs. Consideration should be given to developing a peer support component.

The availability of culturally appropriate services, delivered in culturally sensitive ways, serves as a protective factor. By contrast, their absence serves as a risk factor as it can impede at-risk Aboriginal youth and families from seeking or accessing help. Research notes that when Aboriginal people access health services in urban centres, they face discrimination, feel excluded and ignored; and, are typically unable to receive culturally

62 Joe & Bryant (2007); Shaffer et al., (2004)

63 Joe & Bryant (2007); Hallfors et al.,(2006)

64 Capp, Deane, & Lambert (2001); White (2015)

65 Terzian (2012)

66 Marshall, Galea, Wood & Kerr (2011)

sensitive services.⁶⁷ In some Aboriginal communities, the primary challenge may not be whether services are culturally appropriate, but whether services are available at all.

To assist young people who have risk factors for suicide, or are in crisis, communities need ready access to mental health services. They also need the capacity to assist young people with their physical and mental health needs on an ongoing basis.

Strategies should promote traditional sources of strength within First Nations communities.⁶⁸ Programs should be accessible, well-coordinated and guided by principles that are holistic and population-based. Further, programs should be located in a meeting place that is culturally appropriate and enables community members to feel they can access help when they need it without fear or stigmatization.⁶⁹

Recommendation 7

Alberta Mental Health Services should ensure that cultural components are incorporated in treatment strategies for young people.

Recommendation 8

The Government of Alberta should ensure that mental health programs are more accessible, holistic and readily available in First Nations communities.

Enhanced awareness and knowledge about youth suicide among health professionals is a protective factor. Evidence shows that improving knowledge and education in the early identification and treatment of common mental health disorders can contribute to youth suicide prevention.⁷⁰ It has been found that even providing a brief, 90-minute training session on youth suicide intervention can increase health professionals' rates of inquiry into suicide.⁷¹

67 Adelson (2005); Browne (2005); Place (2012); Sookraj, Hutchinson, Evans & Murphy (2012); Tang & Browne (2008)

68 Mussell et al. (2004)

69 Ball (2005)

70 Taliaferro & Borowky (2011)

71 Jobes, Rudd, Overholser & Joiner (2008)

Recommendation 9

The Ministries of Human Services, Education and Health, along with their service delivery partners, should require that professionals working with Aboriginal young people have enhanced suicide intervention training.

Many First Nations, Métis, and Inuit people continue to maintain strong ties to their traditions, languages and culture despite the challenges they have faced. These cultural ties have proven to be important factors in building resiliency. Recent events such as the Truth and Reconciliation Commission of Canada⁷² have taken important steps in acknowledging the importance of Aboriginal Peoples history.

As discussed earlier, colonial practices have contributed to inter-generational trauma among Aboriginal Peoples and communities. Residential schools and the ‘sixties scoop’ left a generation of displaced children, parents and communities who were grieving and resulted in a break in cultural teachings.⁷³ These disruptions led to inter/multi-generational trauma, lateral violence, a loss of language and cultural discontinuity.^{74,75,76} It is necessary to recognize the role these events have played in the high rates of suicide among Aboriginal youth.⁷⁷

By learning the pre and post-colonial history that is specific to Aboriginal Peoples, service providers can be better positioned to understand the potential risks, strengths and needs within Aboriginal families. Aboriginal young people can have a sense of pride and self-identity when service providers acknowledge and recognize their history when delivering services.

The Advocate notes that the *Delegation Training for Suicide Intervention Skills*⁷⁸ for caseworkers provides information on the higher risk of suicide in Aboriginal communities. However, it does not provide information about culturally relevant resources, such as Elders and ceremony, that caseworkers could draw upon to assist Aboriginal youth.

72 Truth and Reconciliation Commissions of Canada (2015a)

73 Bennett & Blackstock (2005)

74 Isaak, et al. (2010)

75 Truth and Reconciliation Commission of Canada (2015b)

76 Truth and Reconciliation Commission of Canada (2015c)

77 Masecar (2006)

78 Workforce Development Delegation Training (May 2015)

Recommendation 10

The Ministries of Human Services, Education and Health, along with their service delivery partners, should require that professionals working with Aboriginal Peoples have adequate training regarding the pre and post-colonial history specific to Aboriginal Peoples so that they have a good understanding of the potential risks, strengths and needs within Aboriginal families.

Recommendation 11

Alberta Human Services should review the Delegation Training for Suicide Intervention Skills and ensure that it contains information about the need for culturally-relevant resources and how caseworkers can access them.

Another protective factor that warrants further work is enhancing self-determination for Aboriginal communities.

Community self-determination has been linked to protecting communities from high suicide rates.⁷⁹ As evidenced in British Columbia, when First Nations communities have self-government and control of their own health and education services, child protection services and cultural facilities, their suicide rates are much lower.⁸⁰ A First Nations community that has a high degree of social capital, a culture of trust and participation, and diverse networks has been shown to have reduced risks of suicide among Aboriginal youth.⁸¹

Recommendation 12

The Government of Alberta should support increased levels of self-determination of First Nations in Alberta through reconciliation processes in partnership with First Nations, federal and provincial governments. Consideration should be given to greater levels of self-determination regarding child intervention balanced with support as a protective factor for suicide prevention.

79 Chandler & Lalonde (2004)

80 Chandler & Lalonde (2004)

81 Mignone & O'Neill (2005)

Summary of Recommendations

Recommendation 1

- A) The Government of Alberta should have a provincially funded suicide prevention strategy that supports the development and implementation of **community-led** strategies across the province. The strategy needs the capacity to adjust to accommodate the interests and needs of particularly vulnerable groups at elevated risk for suicide.
- B) Strategies to prevent Aboriginal youth suicide must be developed within the context, and in recognition of, the traditional values and cultural practices relevant to Aboriginal youth in the community.

Recommendation 2

The Government of Alberta should act on ways to improve provincial services and systems to support holistic community-led strategies to address Aboriginal youth suicide. For example, the government should consider:

- Can these services and systems be used or leveraged to help reduce risk factors among Aboriginal youth and their families?
- Does the current operation of these services and systems present any barriers that make it difficult to access assistance for at-risk Aboriginal youth?
- How might these services and systems be inadvertently contributing to risk factors among at-risk Aboriginal youth and their families?

Recommendation 3

Alberta Human Services, with its service delivery partners, should ensure that supports are available to Aboriginal young people who have lost someone significant to suicide and that those services are deliberate and proactive.

Recommendation 4

Alberta Human Services should review child intervention case practice to ensure that intervention is focused on the child's needs. The impact on a child exposed to domestic violence, parental substance abuse and other forms of child maltreatment must be addressed early in conjunction with their caregivers' treatment plans.

Recommendation 5

The Ministry of Human Services, with its service delivery partners, should ensure that case practice reflects a strength-based approach that focuses on the attachment needs of children while ensuring that their risk for harm is addressed.

Recommendation 6

Alberta Education should develop and implement school-based suicide prevention programs. Consideration should be given to developing a peer support component.

Recommendation 7

Alberta Mental Health Services should ensure that cultural components are incorporated in treatment strategies for young people.

Recommendation 8

The Government of Alberta should ensure that mental health programs are more accessible, holistic and readily available in First Nations communities.

Recommendation 9

The Ministries of Human Services, Education and Health, along with their service delivery partners, should require that professionals working with Aboriginal young people have enhanced suicide intervention training.

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Alberta Human Services should review the Delegation Training for Suicide Intervention Skills and ensure that it contains information about the need for culturally-relevant resources and how caseworkers can access them.

Recommendation 12

The Government of Alberta should support increased levels of self-determination of First Nations in Alberta through reconciliation processes in partnership with First Nations, federal and provincial governments. Consideration should be given to greater levels of self-determination regarding child intervention balanced with support as a protective factor for suicide prevention.

CLOSING REMARKS

I wish to thank everybody who spoke with us through this review—all of those who knew and loved Asinay, Cedar, Sage, Morley, Kari, Victoria and Jacob and helped us learn about them. These were remarkable young people who will be sorely missed. It is our hope that their stories will bring about changes that help prevent similar tragedies.

Suicide is complex, but it is preventable. The complexity is compounded for Aboriginal young people because of their history and the legacy of residential schools and the ‘sixties scoop’. The problem is not a lack of knowledge. We know what factors and circumstances contribute to higher rates of suicide; and, we know what can be done to address and reduce them. What is required is a willingness to make this issue a priority and to devote the resources needed to address it effectively.

We are in a time for change and a time for action. There is an obligation; and in fact, a moral imperative to act on what we know can prevent Aboriginal young people from dying by suicide. It is my heartfelt hope that this report spurs governments, communities and community leaders to think differently about Aboriginal youth suicide and take decisive action to address it. Working collaboratively, our province can better assist at-risk Aboriginal young people, strengthen their resilience, help give them meaning in their lives and guard them against the tragedy of suicide.

[Original signed by Del Graff]

Del Graff

Child and Youth Advocate

APPENDICES

APPENDIX 1: TERMS OF REFERENCE

Authority

Alberta's Child and Youth Advocate (the "Advocate") is an independent officer reporting directly to the Legislature of Alberta. The Advocate derives his authority from the *Child and Youth Advocate Act (CYAA)*. The role of the Advocate is to represent the rights, interests and viewpoints of children receiving services through the *Child, Youth and Family Enhancement Act*, the *Protection of Sexually Exploited Children Act* or from the youth justice system.

Section 9(2)(d) of the CYAA provides the Advocate with the authority to investigate systemic issues arising from a serious injury to or the death of a child who was receiving a designated service at the time of the injury or death if, in the opinion of the Advocate, the investigation is warranted or in the public interest. The Advocate also has the authority to conduct an investigation if the child received Child Intervention Services within two years of his/her death.

Incident Description

The Advocate learned of the deaths of seven Aboriginal young people who died by suicide over 18 months during 2013–2014:

- 14-Year-Old Asinay
- 15-Year-Old Sage
- 18-Year-Old Cedar
- 15-Year-Old Morley
- 15-Year-Old Kari
- 15-Year-Old Victoria
- 18-Year Old Jacob

Del Graff, the Child and Youth Advocate, made the decision to conduct an Investigative Review on each youth and then subsequently determined that their stories should be told together so that the high incidence of Aboriginal youth suicide would be emphasized and brought to the attention of decision-makers.

Objectives of the Investigative Review

1. To review and examine the supports and services provided to the seven young people
2. To comment upon relevant protocols, policies and procedures, standards and legislation

3. To prepare and submit a report which includes findings and recommendations arising from the Investigative Review

Scope/Limitations

An Investigative Review does not assign legal responsibilities or draw legal conclusions, nor does it replace other processes that may occur, such as investigations or prosecutions under the *Criminal Code of Canada*. The intent of an Investigative Review is not to find fault with specific individuals, but to identify and advocate for system improvements that will enhance the overall safety and well-being of children who are receiving designated services.

Methodology

The investigative process will include:

- Examination of critical issues
- Review of documentation and reports
- Review of Enhancement Act Policy and casework practice
- Personal interviews
- Consultation with experts
- Other factors that may arise for consideration during the investigation process

Investigative Review Committee

The Advocate and the OCYA Director of Investigations determined that two separate committees were required—one comprised of leadership from child-serving ministries and one comprised of individuals with expertise in:

- Working with Aboriginal youth and communities
- Child and adolescent mental health
- Placement resources
- Working with “high-risk youth”

The purpose of the committees is to review the preliminary Investigative Review report and to provide advice regarding findings and recommendations.

Reporting Requirement

The Child and Youth Advocate will release a Public report when the Investigative Review is completed.

APPENDIX 2: COMMITTEE MEMBERSHIP

Del Graff, Msw, Rsw (Committee Chair)

Mr. Graff is the Child and Youth Advocate for the province of Alberta. He has worked in a variety of social work, supervisory and management capacities in communities in British Columbia and Alberta. He brings experience in residential care, family support, child welfare, youth and family services, community development, addictions treatment and prevention services. He has demonstrated leadership in moving forward organizational development initiatives to improve service results for children, youth and families.

Elder Martin Eagle Child

Elder Eagle Child is from the Kainai First Nations also known as the Blood Tribe of the Blackfoot Confederacy. He grew up on the Blood Reserve where he attended St. Mary's residential school. Elder Eagle Child represented Kainai Nation members when he was on the Blood Tribe Chief and Council. He has worked in the area of addictions and served as the Blood Tribe Elder support worker with the Blood Tribe Police. Elder Eagle Child is a Medicine Pipe holder supporting Blood Tribe members in learning traditional songs and ceremonies.

Elder Francis Whiskeyjack

Elder Whiskeyjack is employed by the Edmonton Public School Board. He wears a coat of many colours at Amiskwaciy Academy in his capacity as Elder, traditional art, song and Cree instructor and Community Cultural Resource Advisor. He has been with Amiskwaciy Academy for the past 13 years. Fluent in both English and Cree, Elder Whiskeyjack is also an Adjunct Professor and Cultural Advisor at the University of Alberta.

Bruce MacLaurin, MSW, PhD (cand)

Mr. MacLaurin is an Assistant Professor with the Faculty of Social Work at the University of Calgary. He was the co-investigator on the three cycles of the Canadian Incidence Study of Reported Child Abuse and Neglect, as well as the principal investigator for provincial studies in British Columbia, Alberta, Saskatchewan and the North West Territories. His research and publishing has focused on child maltreatment, child welfare service delivery and outcomes, foster care, youth at risk and street-involved youth. He has more than 15 years of front-line and management experience in non-profit child and family services in Alberta and Ontario.

Brianna Olson, BSW, RSW

Ms. Olson is an Anishinaabe/Métis woman, registered social worker and member of Wikwemikong First Nation, currently residing in Treaty 6 territory, Edmonton, Alberta. As a lifelong member of the inner city and Indigenous community and having practiced over 10 years working with vulnerable youth populations, she brings her lived experience, identity and critical approach to social work practice to her work. Ms. Olson completed her Bachelor of Social Work with an Indigenous specialization at University of Victoria. She is currently working as a manager at iHuman Youth Society.

Florence Gaucher

Ms. Gaucher is the Program Manager of Foster Care and Kinship for Métis Child and Family Services. She has been employed with the agency for 15 years. Her experience in working in the human services field started fresh out of college in the rural area of the Peace River country 40 years ago. She has worked as a frontline worker delivering all services to clients and later into supervisory and management positions. Ms. Gaucher is fluent in Cree with real life experiences of living in a Métis community.

Christopher Lalonde, PhD

Dr. LaLonde is a developmental psychologist and Professor of Psychology at the University of Victoria. He is acting Vice-Chair of the Human Research Ethics Board at the University of Victoria and the Graduate Student Advisor for the Department of Psychology. Dr. LaLonde is currently collaborating with First Nations in British Columbia and with the Assembly of Manitoba Chiefs in a research program that aims to better understand how the promotion of First Nations cultures and the pursuit of self-determination are associated with decreased youth suicide and injury rates.

Carrielynn Lund

Ms. Lund is a Métis consultant whose primary focus is on assisting Aboriginal communities to identify and address health and social issues that have a negative impact on children and their families. She has done extensive work in the area of health research, particularly with Aboriginal youth and resilience and research ethics, much of which is focused on Aboriginal protocols around community ethical guidelines, intellectual property rights, ownership of data and knowledge translation. Her extensive committee work includes service on the Aboriginal Healing Foundation (Treasurer), the Canadian Institute of Health Research Ethics Standing Committee and the Health Canada/Public Health Agency of Canada Research Ethics Board. Her work includes coordinating community-based research and capacity building with Aboriginal communities and organizations.

Stacey Running Rabbit, BPE

Ms. Running Rabbit is a teacher at the Siksika Medicine Lodge (SML). She holds a Bachelors of Physical Education degree (BPE), with a major in Leadership and a Bachelors of Education degree (BEd), Major in Physical Education and Minor in Social Studies both from the University of Alberta. Ms. Running Rabbit has worked in both the provincial and federal education systems, within Alberta and the Northwest Territories. She began her teaching career in Inuvik, NWT and has made her journey to southern Alberta. Ms. Running Rabbit has vast experience in the multi-grade classroom environment and programming for youth with learning difficulties.

Ministry Consultation

Mark Hattori

Alberta Human Services, Assistant Deputy Minister, Child and Family Services

Dr. Michael Trew

Alberta Health Services, Chief Addictions and Mental Health Officer

Marnie Robb

Alberta Indigenous Relations, Director, Social Policy

Jane Martin

Alberta Education, Assistant Deputy Minister, First Nations, Métis and Inuit Education Division

APPENDIX 3: GLOSSARY OF TERMS

Aboriginal	Includes Treaty Status, potential to be registered, non-status, Métis and Inuit
Absent Without Leave (AWOL)	The term used when a young person is absent from a placement resource without permission
Anxiety	A feeling of worry, nervousness, or unease, typically about an imminent event or something with an uncertain outcome
Anti-depressants	A substance that is used in the treatment of mood disorders, as characterized by various manic or depressive affects
Apprehension	When a child is removed from their guardian's care because there are reasonable and probable grounds to believe that a child is in need of intervention according to the <i>Child, Youth and Family Enhancement Act</i>
Assessment	The gathering and analysis of information to determine whether a child is in need of intervention according to the <i>Child Youth and Family Enhancement Act</i> (previously known as an Investigation)
Autistic Tendencies	A developmental disorder, which is on a spectrum characterized by severe deficits in social interaction and communication and by abnormal behavior patterns, such as the repetition of specific movements or a tendency to focus on certain objects
Behavioural Assessment	The measurement of behaviour through direct observation and application of a coding system
Caseworker	A child intervention worker—for the purposes of this report, this term describes all child intervention workers

Child Maltreatment

Sometimes referred to as child abuse and neglect, includes all forms of physical and emotional ill-treatment that results in actual or potential harm to the child's health, development or dignity

**Cognitive Delay/
Impairment**

Also referred to as intellectual disability, describes the intellectual functioning level and adaptive skills in relation to the average capacity for a child of the same chronological age. Levels of cognitive impairment severity are defined by specific Intelligence Quotient (IQ) ranges which are identified through standardized testing: Mild cognitive impairment—IQ of 50 to 70, Moderate cognitive impairment—IQ of 35 to 55, Severe cognitive impairment—IQ of 20 to 40, Profound cognitive impairment—IQ below 20

Custody Agreement

A voluntary agreement that allows a parent or guardian to place their child in the care and custody of Child Intervention Services

Custody Order

An Order granted by the courts to provide the Director temporary custody and guardianship of the child until legal status can be determined

**Delegated First Nation
Agency (DFNA)**

The province has given delegations of authority under the *Child, Youth and Family Enhancement Act* necessary to enable First Nations agencies to provide the full range of provincial Child Intervention Services within their geographical boundaries. Aboriginal Affairs and Northern Development Canada (AANDC) funds the agencies for the provision of Child Intervention Services on-reserve

Depression

A mood disorder that causes a persistent feeling of sadness and loss of interest. Also called major depressive disorder or clinical depression, it affects how a person feels, thinks and behaves and can lead to a variety of emotional and physical problems

Disassociation	A wide array of experiences from mild detachment from immediate surroundings to more severe detachment from physical and emotional experience
Family Enhancement Agreement	A voluntary agreement between Child Intervention Services and a child's guardian intended to address protection concerns while the child remains in the guardian's care
Family Group Conferencing	A formal meeting between family members and caseworkers regarding the care and protection of a child
Foster Home	A family placement approved by Child Intervention Services. Foster parents must complete formal training and enter into an agreement with Child Intervention Services prior to children being placed in their care
Group Home	A residential placement staffed by childcare workers
Harm-reduction	Practical strategies and ideas aimed at reducing negative consequences associated with high-risk lifestyles
In Care	The Director has custody or guardianship of a child and the child is placed outside of their parents' care
Indigenous	Originating in and characteristic of a particular region or country; pertaining to, or concerned with the Aboriginal inhabitants of a region
Kinship Care	A placement outside of the parental home with relatives or members from a child's community who are approved by Child Intervention Services to care for a specified child(ren)
Oppositional Defiant Disorder	A childhood disorder that is characterized by negative, defiant, disobedient and often hostile behaviours toward adults and authority figures

Permanent Guardianship Order (PGO)	The Director is the sole guardian of the child
Post-Traumatic Stress Disorder (PTSD)	A mental health condition that is triggered by a terrifying event—either experiencing it or witnessing it. Symptoms may include flashbacks, nightmares and severe anxiety, as well as uncontrollable thoughts about the event
Psycho-educational and Behavioural Assessment	An assessment of the psychological aspects of learning and academic skills as well as the measurement of behaviour through direct observation and application of a coding system
Psychological Assessment	A process of testing that uses a combination of techniques to arrive at some hypotheses about a person and their behavior, personality and capabilities.
Residential Facility	Specialized group care facilities
Safety Assessment	A ten-day initial assessment that occurs to determine whether a child is in need of intervention according to the <i>Child, Youth and Family Enhancement Act</i>
Screening	A report completed when Child Intervention Services receives a concern about the possible risk to a child according to the <i>Child, Youth and Family Enhancement Act</i>
Secure Services	The Director determines that a young person must be confined for stabilization and assessment because the young person is an immediate danger to themselves or others
Self-harm	The act of deliberately harming your own body, such as cutting or burning yourself. It is typically not meant as a suicide attempt. Rather, self-injury is an unhealthy way to cope with emotional pain, intense anger and frustration

Suicide Aftercare	Activities that assist those who have lost a person to suicide or have been exposed to suicide in order to provide understanding and assist them with bereavement. Support and services can also be provided to a person who has survived a suicide attempt
Suicidal Ideations	Thoughts about or an unusual preoccupation with suicide
Suicide Intervention	Strategies and activities intended to prevent suicide
Suicide Prevention	All activities intended to reduce or delay the development of suicidal behaviours. Services and programs can assist in building protective factors and reducing risk
Suicide Risk Assessment	Used when there is some indication that an individual is at risk for suicide. Suicide assessment is also used to help develop treatment plans and track the progress of individuals
Supervision Order	The court grants mandatory supervision of a child to the Director. Guardianship and custody of the child remains with the family/legal guardian
Supported Independent Living (SIL)	Supports are provided to young people to assist them in transitioning to adulthood. May include residing in their own residence with various levels of supports
Temporary Guardianship Order (TGO)	The court awards custody and guardianship to the Director for a specified period

APPENDIX 4: PREVIOUS INVESTIGATIVE REVIEW RECOMMENDATIONS RELATED TO YOUTH SUICIDE

Responses to the Advocate's recommendations are regularly updated on our website. Please visit: www.ocya.alberta.ca/adult/publications/recommendations for the most up-to-date information.

Remembering Brian: Investigative Review (June 2013)

Recommendation 1

Child Intervention Services should engage in comprehensive assessments to ensure a balance is struck between child-focused and family-centered approaches. It is vital that intervention services not only address the presenting issues in a family, but also fully examine and address the impacts those issues have had on children in the family.

Recommendation 2

Develop guidelines that will aid caseworkers in assessing the impacts of family violence and parental addictions on children, and which provide direction for supporting children who have been exposed to these circumstances.

Recommendation 3

In developing support plans for children and their families, intervention workers should ensure that comprehensive plans are in place to support and maintain a child's cultural connections, recognizing that family, community and tradition are all important contributors to culture.

Recommendation 4

Kinship caregivers should be provided with specialized training and support plans, which are both tailored to meet their individual and unique needs. The goal should be to ensure kinship caregivers have the resources they require to manage the unique challenges that come with their caregiving, such as dual loyalties, unrealistic expectations, changes in family dynamics and feelings of loss, guilt and shame.

Recommendation 5

Intervention caseworkers should be provided specialized training to manage unique situations presented by kinship care arrangements. The goal should be to ensure caseworkers can effectively support kinship caregivers in providing protection, well-being and a bridge to permanency for children in their care.

Recommendation 6

Alberta's Human Services should review and amend policies and guidelines to bring about consistent practices among regions and ensure seamless, coordinated inter-regional delivery of intervention services.

*Kamil: An Immigrant Youth's Struggle, Investigative Review
(November 2013)*

Recommendation 1

Assessments should be undertaken with and informed by a comprehensive understanding of a young person's cultural context, including their life history, background and relationships, to improve the effectiveness of intervention services.

Recommendation 2

The child intervention system should assess each young person holistically, including identification and assessment of their protective factors, and work proactively with supportive adults to maintain and strengthen these factors to improve the young person's resiliency and well-being.

Recommendation 3

The policy regarding approval of psychotropic medications should be amended to recognize and reflect the urgency of situations in which young people require these medications. In addition, there should be a requirement to communicate back to the mental health professional(s) when a recommended medication or therapy is not approved.

Recommendation 4

Caseworkers should personally communicate with young people and their mental health providers to obtain thorough and accurate information to ensure that their client's needs and interests are met.

Recommendation 5

Human Services should increase opportunities for child intervention staff to work in a more innovative, inclusive and collaborative environment to improve the quality of decision making for vulnerable children and youth.

15-Year-Old Tony: Investigative Review (November 2014)

Recommendation 1

The Ministry of Human Services, with its service delivery partners, should strengthen processes related to:

- The search for meaningful relationships in an Aboriginal child's life and ensure that the extended family of both parents is explored
- The ability of placement facilities to provide Aboriginal children in care continuous and ongoing access to traditional knowledge and activities.

These processes should be documented and audited for compliance to ensure that Aboriginal children remain connected to their family, community and culture.

Recommendation 2

The Ministry of Human Services, with its service delivery partners, should require a suicide risk inventory be completed for all young people, who have been identified as at risk of suicide, on a regular and ongoing basis—not just at the time of crisis.

Recommendation 3

The Ministry of Human Services, with its service delivery partners, should review policy and practice in information sharing when a child transitions to a new placement. Emphasis must be placed on direct communication between day-to-day caregivers to support the continuity of successful treatment approaches. This means those caregivers who work directly with young people in their placements.

16-Year Old Sam: Serious Injury, Investigative Review (May 2015)

Recommendation 1

The Ministry of Human Services needs greater early intentional focus on assessment and intervention that includes an equal emphasis on children, siblings and parents.

Recommendation 2

The Ministry of Human Services should find ways to teach children and youth about healthy relationships and attachment. Added supports should be provided to help young people when important relationships are disrupted by change.

Recommendation 3

The Ministry of Human Services should provide caregivers and caseworkers with the skills they require to engage with suicidal youth on an ongoing regular basis and encourage young people to develop, identify and practice positive coping skills.

17-Year-Old Catherine: Investigative Review (September 2015)

Recommendation 1

Alberta Health Services should provide service coordinators for children with complex mental health needs and their families, who are accessing mental health services across multiple programs.

Recommendation 2

- The Ministry of Human Services should intervene and strengthen their response when parents request help to keep their child safe because the parent is unable to.
- The Ministry of Human Services and Alberta Health Services should enter into a formal provincial agreement identifying how they will work collaboratively to serve young people with complex mental health needs when their safety is in jeopardy.

Recommendation 3

Alberta Health Services should review how young people attending hospitals are assessed for suicide risk and standardize best practices across the province.

*17-year-old Makayla: Serious Injury, Investigative Review
(December 2015)*

Recommendation 1

The Ministry of Human Services and its service delivery partners should ensure that:

- Young people involved with Child Intervention Services are assessed to identify the impact traumatic events have on them;
- Case plans should detail interventions to directly address the identified trauma including resources required and expected outcomes; and,
- Interventions are reviewed on a regular basis and progress documented.

Recommendation 2

The Ministry of Human Services and its service delivery partners should ensure that placement moves for children and youth are planned. In situations where unplanned moves are unavoidable, mitigation strategies to address the impact of such moves are identified and documented.

APPENDIX 5: REFERENCES

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