17-YEAR-OLD SUSAN

An Investigative Review

OCTOBER 2018

Under my authority and duty as identified in the *Child and Youth Advocate Act* (*CYAA*), I am providing the following Investigative Review regarding the death of a 17-year-old youth who was, at the time, receiving services from the Government of Alberta.

This is a public report that contains detailed information about children and families. Although my office has taken great care to protect the privacy of the young person and her family, 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 their privacy and not focus on identifying the individuals and locations involved in this matter.

In accordance with the *CYAA*, Investigative Reviews must be non-identifying. Therefore, the names used in this report are pseudonyms (false names). Finding an appropriate pseudonym can be difficult, however, it is a requirement that my office takes seriously. In this situation, we have called the young person, Susan.

Susan was a First Nation youth who became involved with Child Intervention Services when she was an infant. She subsequently became the subject of a Permanent Guardianship Order and lived in a long-term foster care placement. When she was a teenager, Susan lived between her grandmother's and her parents' homes and had little stability. Susan died by suicide when she was 17 years old.

A review of Susan's circumstance revealed a number of important systemic issues young people involved with child welfare face. I have made previous recommendations to address these issues, which are found in the Discussion section of this report.

This Review highlights the importance of purposeful case planning that helps to identify a child's specific needs and provide resources that are tailored to that child. It also emphasizes the significance of relationships for children in care. A broad support network of people who may not be able to provide a place to live, but can offer guidance and emotional support is beneficial for children growing up in care.

Young people in care are often affected by adverse childhood experiences and losses. They are vulnerable to mental health issues that can place them at higher risk for suicide. Supportive, timely and culturally appropriate interventions can make the greatest difference for children.

[Original signed by Del Graff]

Del Graff
Child and Youth Advocate

#600, 9925 109 Street NW, Edmonton, AB T5K 2J8 | www.ocya.alberta.ca | 1 800 661-3446 | 780 422-6056

CONTENTS

EXECUTIVE SUMMARY 5

INTRODUCTION 7
The Office of the Child and Youth Advocate 7
Investigative Reviews 7

ABOUT THIS REVIEW 9
About Susan and Her Family 9

SUMMARY OF CHILD INTERVENTION SERVICES' INVOLVEMENT 10
Susan from Birth to 12 Years Old 10
Susan at 13 Years Old 11
Susan from 14 to 15 Years Old 11
Susan from 16 to 17 Years Old 12

DISCUSSION 14
Case Planning and Placements 14
Relationships 15
Mental Health and Suicide Intervention 16

CLOSING REMARKS 20

APPENDICES 21
Appendix 1: Summary of Significant Events 22
Appendix 2: Terms of Reference 23
Appendix 3: Previous Relevant Recommendations 25
Appendix 4: Committee Members 30
Appendix 5: Bibliography 32

EXECUTIVE SUMMARY

Susan (not her real name)[1] was 17 years old when she died by suicide. She was the subject of a Permanent Guardianship Order (PGO)[2] and living with her grandmother when she passed away.

The Investigative Review examined three systemic issues:

1. Case Planning and Placements

For the first 10 years that Susan was in care, case planning focused on returning her to her parents, who were not able to achieve long-term stability. When Susan reached adolescence, she moved from place to place without her caseworker's knowledge. When caseworkers found her, placements were often arranged as short-term solutions. Purposeful and intentional planning was needed. The Advocate has made previous recommendations that are relevant to Susan's circumstance related to planning when children are moved (see Appendix 3).

2. Relationships

Susan was taken into permanent care when she was quite young and was separated from her parents. When she was a teenager, she lost her connection to her foster parents and lost relatives to suicide.

Relationships are critical to a child's identity development and sense of belonging.[3] Susan's relationships with her foster parents, parents, brothers and grandmother were important to her. She wanted to live with them, but, individually, they could not take care of her. Children in care can benefit from a broad support network of people, who may not be able to provide a place to live, but can provide guidance and emotional support.

In 2016, the Ministry of Children's Services started an initiative to help caseworkers build support networks for children in care. The Advocate looks forward to the full implementation of this initiative resulting in better outcomes for young people, especially as they transition from adolescence into adulthood.

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

2 The Director is the sole guardian of the child. This Order is sought when it is believed that the child cannot be safely returned to their guardian within a specified time.

3 Campbell & Borgeson (2016)

3. Mental Health and Suicide Interventions

The impact of Susan's early adverse childhood experiences may have contributed to mental health difficulties in her adolescence. She suffered many losses and used alcohol to cope with her grief. Susan was involved with the youth justice system and Alberta Health Services. She was expected to access mental health and addictions programs in the community; however, she could not do this on her own.

The Advocate has released a number of Investigative Reviews related to suicide and mental health and is not making new recommendations (see Appendix 3). Government must prioritize and fully implement existing recommendations to serve vulnerable youth who urgently need help.

The Advocate regularly reports on the progress of recommendations at:
http://www.ocya.alberta.ca/adult/publications/recommendations/

The Ministry of Children's Services publicly responds to recommendations at:
http://www.humanservices.alberta.ca/publications/recommendations/15896.html

INTRODUCTION

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*).[4]

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*[5] (the *Enhancement Act*), the *Protection of Sexually Exploited Children Act*[6] (*PSECA*), or from the youth justice system.

Investigative Reviews

The *CYAA* provides the Advocate with the authority to conduct Investigative Reviews. The Advocate may investigate systemic issues arising from the death of a child who was receiving a designated service at the time of death if, in the opinion of the Advocate, the investigation is warranted or in the public interest.

Upon completion of an investigation under this section of 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 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.

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

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

6 *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 and making recommendations that result in systemic improvements for young people, when acted upon.

ABOUT THIS REVIEW

In 2016, the Advocate received a report that 17-year-old Susan (not her real name)[7] died by suicide. She was the subject of a Permanent Guardianship Order (PGO)[8] and living with her grandmother when she passed away.

Susan's child intervention records were reviewed by investigative staff from the Office of the Child and Youth Advocate. An initial report was completed that identified potential systemic issues and the Advocate determined that an Investigative Review was warranted. The Ministry of Children's Services was subsequently notified.

Terms of Reference for the Review were established and are provided in Appendix 2. An investigative team gathered information and conducted an analysis of Susan's circumstances through a review of relevant documentation, interviews and research.

A preliminary report was completed and presented to a committee of subject matter experts who provided advice related to findings and recommendations. Committee membership included an Elder and experts in the fields of youth engagement, permanency planning, child and adolescent mental health, and child intervention practice. The list of committee members is provided in Appendix 4.

About Susan and Her Family

Susan was a First Nation youth who had long, brown hair and brown eyes. She was outgoing and enjoyed music, dancing, cooking and traditional activities. She was eager to please others and wanted to become a nurse or a social worker.

Susan's parents were from First Nation communities. They frequently lived in the city where they had many relatives. Susan had two older siblings (Cody and Scott).

7 All names throughout this report are pseudonyms to ensure the privacy of the child and their family.

8 The Director is the sole guardian of the child. This Order is sought when it is believed that the child cannot be safely returned to their guardian within a specified period of time.

SUMMARY OF CHILD INTERVENTION SERVICES' INVOLVEMENT

Susan from Birth to 12 Years Old

Child Intervention Services' involvement with Susan began when she was an infant. Her parents (Roxanne and Stanley) used substances and their relationship could be violent. They separated when Susan was two years old.

Susan and her brothers were taken into care when Roxanne left them with a babysitter and did not return. They were placed in the Garcia foster home where they stayed for almost 10 years. The children became subjects of Permanent Guardianship Orders (PGO) when Susan was five years old.

Roxanne did not stay in regular contact with her children. Stanley and his new partner (Cheryl) had visits with Susan and her brothers that were positive. Through these visits, the children connected with their grandmother, aunts, uncles and cousins. When caseworkers tried to place them with Stanley and Cheryl, Stanley started drinking again and the children were returned to the Garcia's.

Susan's foster mother wanted her to go to counselling because Susan was impulsive and had difficulty controlling her emotions. Ms. Garcia questioned whether Susan might have Fetal Alcohol Spectrum Disorder (FASD).[9] Teachers raised concerns that Susan was academically delayed.[10]

When Susan was nine years old, Roxanne began visiting her children. She completed a residential addictions treatment program and did well for several months. The caseworker planned to return 10-year-old Susan and her brothers to her care, but Roxanne started drinking again before this could happen.

When Susan was 12 years old, her older brother, 16-year-old Cody, left the Garcia's and moved in with his mother. Five months later, her other brother, 15-year-old Scott, also left his foster home and moved in with his paternal grandmother (Faye).

9 A continuum of permanent birth defects caused by a mother's consumption of alcohol during pregnancy.

10 When Susan was in Grade 5, testing indicated that she was reading at a Grade 2 level.

Susan at 13 Years Old

At 13 years old, Susan moved in with Faye, who also looked after a number of her other grandchildren. Susan wanted to stay with her and her caseworker supported the placement. She frequently left Faye's to stay with her mother and other relatives. During this time, Susan's stepmother (Cheryl) died by suicide.

Approximately two weeks later, Susan was found intoxicated outside in the cold. She said that she started cutting herself after Cheryl's death.

After approximately five months with her grandmother, Susan was moved to a group home for Indigenous youth recovering from addictions. She often left the home and abused alcohol. Once, when she returned, she said that she had been assaulted while out in the community.[11]

Susan spoke with group home staff about her time with the Garcia family and asked about contacting them. She met with a counsellor who observed that Susan lacked emotional attachments and had gaps in her cognitive functioning. An assessment was requested, but Susan ran away before it was completed.

Susan from 14 to 15 Years Old

When Susan was 14 years old, her whereabouts were unknown for approximately four months; she had no contact with her caseworker during that time. Her brothers said that she was staying with a friend, but would not provide further information. Susan was eventually picked up by the police and returned to her group home, but left three days later. Her caseworker had visited Faye's in an attempt to find Susan and was told that she was staying with either Stanley or Roxanne. Approximately two months later, caseworkers found Susan at Faye's.

Arrangements were made for Susan to live with Stanley on his First Nation. She stayed there for approximately one year. She was often left alone because Stanley was frequently hospitalized for health problems. Susan missed school and drank alcohol. Sometimes she went to the city where she stayed with her mother, relatives or friends.

Susan was charged with minor offenses (theft and mischief) but missed court dates, which resulted in warrants being issued. She was subsequently charged with more serious offenses. The court imposed curfews and conditions that she abstain from alcohol and drugs, which she struggled to abide by.

---

11 The incident was reported to the police, but Susan did not want to speak with them and the matter was closed.

At 15 years old, Susan was taken to the hospital, intoxicated, with self-inflicted cuts on her wrist. The next day she was confined in a Secure Services[12] facility for a risk assessment. The psychologist determined that Susan was not a risk to herself or others and she was discharged one week later.

At her request, Susan was returned to the group home where she had lived two years earlier. She wanted to live with someone who did not drink and would take care of her. The counsellor at the group home[13] noted that Susan was emotionally neglected and depended on those around her to make decisions. She showed signs of grief and trauma and was uncertain about her future. The counsellor recommended that Susan go to therapy. Two months later, Susan ran away from the group home to her mother's. Roxanne was given financial assistance so her daughter could stay with her. Susan did not receive the recommended therapy.

Susan from 16 to 17 Years Old

Susan's alcohol use continued. She was charged with assault and briefly incarcerated. Her mother had a new boyfriend and Susan was unable to continue staying there.

The police found 16-year-old Susan intoxicated in the community and she was incarcerated for breaching her probation conditions. She was distraught and talked about her cousin who had recently died by suicide. Upon her release from custody, psychological and psychiatric assessments were ordered prior to sentencing. Susan went to one appointment, but left before the clinician could meet with her. Court proceeded without the assessments and she was sentenced to one year of probation.

Susan moved into a Supported Independent Living (SIL)[14] group home and was assigned a new caseworker who specialized in preparing youth for independence. Within three days, she left to stay with Faye.

The following month, Susan was hospitalized for a drug overdose.[15] When she met with her caseworker, she said that the incident was a suicide attempt and agreed not to harm herself. She returned to her grandmother's home.

Approximately one week later, Susan was intoxicated and said that she heard voices telling her to kill herself. She was admitted to an Adolescent Psychiatric Unit where she spoke about her struggle with addictions and how alcohol and drugs were always

---

12 The *Enhancement Act* allows for the confinement of a child for up to 30 days for stabilization and assessment when the child is found to be an immediate danger to themselves or others.

13 The same counsellor who met with Susan when she was previously at the group home.

14 The term used when Child Intervention Services provides support for young people to live independently and helps them transition to adulthood, including residing in their own residence or with a roommate(s).

15 Susan overdosed on antihistamines which are used to relieve allergy symptoms.

around her. She was sad that she had left the Garcia's. Nine days later, Susan left the hospital without permission to see her boyfriend. He died in a car accident before she could see him.

Approximately three weeks later, the police found Susan and returned her to the hospital. She said that she did not hear voices or have suicidal thoughts; she used alcohol to cope with her emotions. Susan asked for help to reconnect with her foster parents and wanted to return to their home.

After almost three weeks in the hospital, Susan was discharged to Faye's care. This was a temporary arrangement until a new SIL placement could be found. The medical team recommended that Susan see a therapist and an addictions counsellor. Her caseworker arranged for a therapist who tried to contact Susan at her grandmother's, but she was not there.

Approximately one month after her 17th birthday, Susan met with her new caseworker.[16] She said that she had stopped using alcohol and drugs and was helping to take care of her ailing father. Her caseworker agreed to help her get back into school, start counselling and connect with her probation officer.

Three days later, Susan died by suicide.

16 Susan had three caseworkers during the nine months prior to her death.

DISCUSSION

The Terms of Reference for this Review identified three systemic issues: family connections and placements, mental health and cognitive challenges, and suicide intervention.

Through the Review process, the systemic issues have been refined to the following:

- Case Planning and Placements
- Relationships
- Mental Health and Suicide Intervention

Case Planning and Placements

As Susan's legal guardian, Child Intervention Services had a responsibility to ensure her physical and emotional well-being. In order to achieve this, there needed to be regular contact with Susan and those closest to her, along with purposeful and intentional planning. Effective interventions are based on a thorough assessment of the child's needs and a clear plan that addresses those needs, which is reviewed and updated regularly.

In her early years, Susan's case plan focused on her return to one of her parents. Placement moves were dependent on her parents' sobriety. This resulted in short returns to parental care that were disruptive to Susan's schooling and relationships.

When Susan was 13 years old, she left her foster family. This was an unplanned move. Over the next four years, Susan repeatedly moved between a number of friends and relatives. There did not appear to be an assessment of each new home or a plan to support them to meet Susan's needs. For extended periods of time, caseworkers did not know where she was. Placements involving child intervention were often arranged following Susan's arrest or release from hospital.

The Advocate has previously recommended that Child Intervention Services should ensure that placement moves for children be planned. When unplanned moves are unavoidable, mitigation strategies to address the impact of such moves need to be identified and documented.[17] The Advocate has noted some progress on this

17 17-Year-Old Makayla: Serious Injury, An Investigative Review (Office of the Child and Youth Advocate, 2015)

recommendation.[18,19] However, more work needs to be done to ensure that young people are supported when they move and that these moves are planned and deliberate.

Relationships

Research indicates that the continuity of relationships is crucial for children to develop their sense of identity and belonging. Relationships build security through attachment and a shared history, which in turn, helps children build resiliency.[20]

Susan was taken into care when she was an infant and lived with the Garcia foster family for 10 years. During that time, there was inconsistent contact with her parents. Stanley and Roxanne had periods of sobriety and stability, but they were temporary. Casework planning focused on returning Susan and her brothers to Stanley or Roxanne. When caseworkers planned to return the children to either parent, their attempts were unsuccessful because Stanley or Roxanne relapsed.

Through contact with Stanley, Roxanne, and Faye, caseworkers were aware of other relatives who had the potential to provide Susan with a broader base of support. Some of them were strongly connected to their culture and traditions, which Susan may have benefitted from. These connections did not appear to have been pursued.

In a previous Investigative Review, the Advocate expressed concern that casework planning focused on a limited number of family members at the exclusion of others who may be sources of support.[21]

Susan was with the Garcia family until she was 12 years old. From 13 to 16 years old, Susan repeatedly said that she regretted leaving their home and the stability she had there. Susan needed support to have healthy relationships with her foster parents, parents and extended family, even when it was not possible to live with them.

In a previous Investigative Review, the Advocate made a recommendation[22] about the importance of relationships for children in care. "*The Ministry of Children's Services should ensure that the preservation or resolution of relationships are at the foundation of permanency planning for children. Children need to be involved – at a level appropriate to their understanding – in envisioning how their significant relationships will look in their futures. Attention should be given to grief and loss interventions where*

18 Ministry response to "17-year-Old Makayla: Serious Injury" www.humanservices.alberta.ca/documents/response-to-OCYA-report-makayla.pdf

19 Progress on recommendations http://www.ocya.alberta.ca/adult/publications/recommendations/

20 The Care Inquiry (2013)

21 15-Year-Old Tony, An Investigative Review (Office of the Child and Youth Advocate, 2014)

22 Progress on recommendations http://www.ocya.alberta.ca/adult/publications/recommendations/

relationships are lost or ambiguous. Transitions between parental care and placements within the system need to be deliberate and focused on a child's need for consistent relationships."[23]

Susan's parents, foster parents, brothers and grandmother were important to her. She needed more than what they could individually give her. Opportunities were missed to support this group to work together and to identify and involve others who were significant to Susan. Children in care can benefit from a broad support network of people who can help guide them through life, even if they may not be able to provide a place to live.

In 2016, Child Intervention Services started implementing, "Lifelong Connections - Pathways to Interdependence."[24] Caseworkers are encouraged to expand their focus beyond securing a placement and seek out those people who can be a lifelong support, bring them together and identify what emotional or practical involvement each can offer the child. This builds ongoing supports for the young person while in care and after leaving care. [25]

This initiative supports promising practice, but it is not yet fully implemented. The Advocate strongly urges Child Intervention Services to move forward with its implementation. It is hoped that this will result in better outcomes for young people, particularly as they transition from adolescence into adulthood.

Mental Health and Suicide Intervention

In her early years, Susan was exposed to parental addictions, domestic violence and neglect. These experiences can be traumatic for children and increase the risk for mental health difficulties later in life, including suicide[26] and addiction.[27] Research indicates that these harmful effects can be mitigated if children receive early, trauma-informed interventions.[28]

The impact of Susan's early childhood trauma was worsened by grief and loss in her adolescence. She wanted to live with her family, but they could not consistently care for her. Susan missed her foster family, but was not able to reconnect with them. She lost her stepmother and other relatives to suicide, her boyfriend died in an accident and her father was chronically ill. Susan depended on alcohol to cope with her pain. She started to harm herself and had thoughts of suicide.

23 7-Year Old Jack: Investigative Review (Office of the Child and Youth Advocate, 2014)

24 Ministry of Children's Services (2016)

25 Campbell & Borgeson (2016)

26 Sachs-Ericsson, Rushing, Stanley & Sheffler (2016)

27 Anda et al. (2006)

28 Smith (2018)

The Advocate has made numerous recommendations in previous Investigative Reviews that are relevant to Susan's circumstance:

- 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 had on them and that appropriate interventions are provided to address the impact of those traumatic events.[29]
- 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.[30]
- 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.[31]
- Alberta Human Services, with its service delivery partners, should ensure that supports are available to Indigenous young people who have lost someone significant to suicide and that those services are deliberate and proactive.[32]
- The Ministry of Children's Services should make certain that children and caregivers receive culturally appropriate, timely interventions that directly address the impact of trauma on the developing brain.[33]
- The Government of Alberta should create and implement cross-ministry training for all child-serving ministries specifically related to the impact of trauma at every stage of childhood development so that appropriate interventions can be provided.[34]

The year before Susan passed away, her mental health problems worsened and she became more involved with the justice and health systems. She was incarcerated and ordered by the court to undergo psychiatric and psychological assessments. Susan was admitted for psychiatric treatment after she was taken to the hospital for suicidal behaviours. It appears that the justice and health systems were either unaware of each other's involvement or did not coordinate services to meet Susan's mental health needs.

29 17-Year-Old Makayla: Serious Injury, An Investigative Review (Office of the Child and Youth Advocate, 2015)

30 Toward a Better Tomorrow, Addressing the Challenge of Aboriginal Youth Suicide (Office of the Child and Youth Advocate, 2016)

31 Ibid

32 Ibid

33 Beyond Trauma: Disrupting Cycles, Effecting Change (Office of the Child and Youth Advocate, 2017)

34 Ibid

When Susan was not hospitalized or incarcerated, she was expected to get to community mental health services on her own, but she was reluctant to meet with professionals and had challenges getting to appointments. Many at-risk youth live in poverty and have difficulty with transportation. They are more likely to use services located in their neighbourhoods or provided by outreach workers who travel to where they are and build trusting relationships over time.[35] Susan may have benefitted from this type of service.

In 2015, the government appointed the Alberta Mental Health Review Committee. The committee subsequently reported that people experiencing addictions and mental health problems are more likely to receive emergent services and be involved with the justice system. They have difficulty obtaining long-term help on their own. The committee's 32 recommendations included:

- Increased presence of mental health and addictions services in correctional facilities with stronger links to divert them to appropriate services in the community.
- Provide navigators to link with people at hospital emergency departments and stay involved to help them access long-term services.[36]

Susan was a First Nation youth who experienced significant trauma and loss; she needed help to work through her emotions. Research indicates that mental health services for Indigenous children are most successful when they are culturally relevant and focus on resiliency.[37] These include programs with Elders to help young people build on their traditions and language. Services that uphold interconnectedness to family and community and emphasize holistic wellness (physical, spiritual, mental, emotional) over focusing on a person's illness are more effective.[38] Susan had limited access to these kinds of services.

In March 2016, the Advocate released *Toward a Better Tomorrow, an Investigative Review* that described the lives of seven Indigenous youth who died by suicide. Several recommendations were made with respect to services and supports that are also relevant to Susan's circumstances.

- 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

35 Shea et al. (2013)

36 Progress on recommendations can be found at: https://open.alberta.ca/dataset/25812976-049c-43c9-9494-77526c6f6ddd/resource/684600a3-a0ea-440c-a053-38a4cef83de9/download/alberta-mental-health-review-next-steps-2017.pdf

37 Atkinson (2017)

38 Toombs, Kowash & Mushquash (2016)

accommodate the interests and needs of particularly vulnerable groups at elevated risk for suicide.

- 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.
- 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?
- Alberta Mental Health Services should ensure that cultural components are incorporated in treatment strategies for young people.[39]

The Advocate is not making new recommendations regarding mental health services and suicide intervention. The Government of Alberta must prioritize and fully implement existing recommendations to adequately serve vulnerable youth who urgently need help.

39 Progress on recommendations http://www.ocya.alberta.ca/adult/publications/recommendations/

CLOSING REMARKS

Our condolences are extended to Susan's family and all of those who knew and loved her. I want to thank those who spoke with us about Susan and shared their insights.

Susan was a young person who wanted to be a nurse or a social worker. She searched for a stable, caring place to belong. Caseworkers had difficulty keeping in contact with Susan. When they located her, planning appeared to focus on where Susan wanted to stay at that particular time. She may have benefitted from more purposeful planning that was focused on her long-term stability.

Susan wanted an ongoing relationship with her biological and foster families, but needed help to do so. I strongly encourage the government to promote casework practice that seeks out those people who can be lifelong supports to a young person, bring them together and identify what emotional or practical involvement each can offer. Securing relationships that are lasting and nurturing is critical to the well-being of children, especially those growing up in care. In Susan's own words, she wanted someone who would always be there for her.

I have released a number of Investigative Reviews with recommendations regarding the urgent issue of Indigenous youth suicide. Children in care are at higher risk for mental health problems that need attention. Susan's circumstances highlight the importance of identifying and responding to these needs early, using accessible and culturally appropriate services.

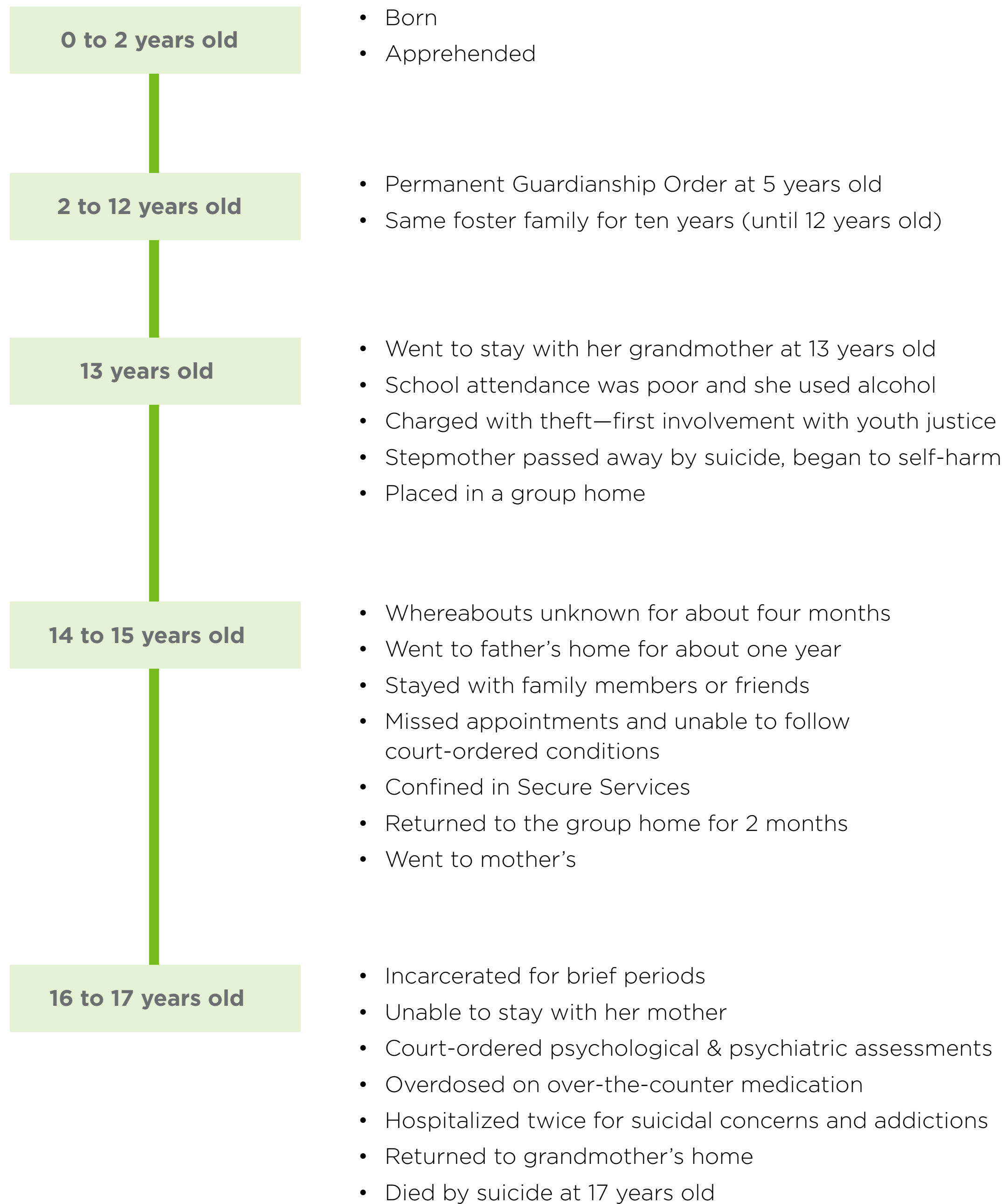
The Government of Alberta must prioritize and fully implement existing recommendations to adequately serve vulnerable youth who urgently need help.

[Original signed by Del Graff]

Del Graff
Child and Youth Advocate

APPENDICES

APPENDIX 1: SUMMARY OF SIGNIFICANT EVENTS



0 to 2 years old

- Born
- Apprehended

2 to 12 years old

- Permanent Guardianship Order at 5 years old
- Same foster family for ten years (until 12 years old)

13 years old

- Went to stay with her grandmother at 13 years old
- School attendance was poor and she used alcohol
- Charged with theft—first involvement with youth justice
- Stepmother passed away by suicide, began to self-harm
- Placed in a group home

14 to 15 years old

- Whereabouts unknown for about four months
- Went to father's home for about one year
- Stayed with family members or friends
- Missed appointments and unable to follow court-ordered conditions
- Confined in Secure Services
- Returned to the group home for 2 months
- Went to mother's

16 to 17 years old

- Incarcerated for brief periods
- Unable to stay with her mother
- Court-ordered psychological & psychiatric assessments
- Overdosed on over-the-counter medication
- Hospitalized twice for suicidal concerns and addictions
- Returned to grandmother's home
- Died by suicide at 17 years old

APPENDIX 2: TERMS OF REFERENCE

Authority

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 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.

The *CYAA* provides the Advocate with the authority to conduct Investigative Reviews. The Advocate may investigate systemic issues arising from the death of a child who was receiving a designated service at the time of the death if, in the opinion of the Advocate, the investigation is warranted or in the public interest.

Incident Description

Susan was 17 years old when she died by suicide. At the time of her death, she was the subject of a Permanent Guardianship Order.

The decision to conduct an investigation was made by Del Graff, the Child and Youth Advocate.

Objectives of the Investigative Review

To review and examine the supports and services provided to Susan and her family specifically related to:

- Family connections and placements
- Mental health and cognitive challenges
- Suicide intervention

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 policy and casework practice
- Personal interviews
- Consultation with experts
- Other factors that may arise for consideration during the investigative process

Investigative Review Committee

The membership of the committee will be determined by the Advocate and the OCYA Director of Investigations. The purpose of convening this committee is to review the preliminary Investigative Review report and to provide advice regarding findings and recommendations.

Chair: Del Graff, Child and Youth Advocate

Members: To be determined but may include:

- An Elder
- An expert in permanency planning and family reunification
- An expert in child and adolescent mental health
- A specialist in child intervention best practice

Reporting Requirement

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

APPENDIX 3: PREVIOUS RELEVANT RECOMMENDATIONS

7-Year-Old Jack: Investigative Review
(January 2014)

Recommendation:

The Ministry of Human Services should ensure the preservation or resolution of relationships are at the foundation of permanency planning for children:

- Children need to be involved—at a level appropriate to their understanding—in envisioning how their significant relationships will look in their future. Attention should be given to grief and loss interventions where relationships are lost or ambiguous; and,
- Transitions between parental care and placements within the system need to be deliberate and focused on a child's need for consistent relationships.

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

Recommendation:

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.

17-Year-Old Makayla: Serious Injury, An Investigative Review (December 2015)

Recommendation:

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

a) Young people involved with Child Intervention Services are assessed to identify the impact traumatic events have had on them;

b) Case plans should detail interventions to directly address the identified trauma including resources required and expected outcomes; and,

c) Interventions are reviewed on a regular basis and progress documented.

Toward a Better Tomorrow: Addressing the Challenge of Aboriginal Youth Suicide (March 2016; released April 2016)

Recommendation:

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:

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:

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:

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:

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:

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

Recommendation:

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

Recommendation:

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

Recommendation:

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:

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:

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:

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.

Beyond Trauma: Disrupting Cycles, Effecting Change (November 2017)

Recommendation:

The Government of Alberta should create and implement cross-ministry training for all child-serving ministries specifically related to the impact of trauma at every stage of childhood development so that appropriate interventions can be provided.

Recommendation:

The Ministry of Children's Services should make certain that children and caregivers receive culturally appropriate, timely interventions that directly address the impact of trauma on the developing brain.

The Ministry of Children's Services publicly responds to recommendations at: http://www.humanservices.alberta.ca/publications/15896.html

The Advocate regularly reports on the progress of recommendations at: http://www.ocya.alberta.ca/adult/publications/recommendations/

APPENDIX 4: COMMITTEE MEMBERS

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 Evelyn Good Striker

Elder Good Striker has worked collaboratively toward the advancement of Indigenous knowledge, equity and inclusion in Alberta's education system. She serves as Chair of the Calgary Urban Affairs Aboriginal Committee, a liaison and advisory group that facilitates connection between municipal governance and Indigenous people in Calgary. Elder Good Striker collaborated with Mount Royal University in the publication *Nistawatsamin - Exploring Traditional Parenting: A Literature Review and Expert Consultation with Blackfoot Elders*, which addresses the current state of child welfare services in Alberta.

Loiselle Arcand, BSW

Ms. Arcand's career began almost 30 years ago as a Youth and Family Support Worker in her community of Alexander First Nation. She obtained her social work degree and serves as the Alexander Band Designate and Director of Wapski Mahikan Society, which provides programs for community members involved with Child Intervention Services. Ms. Arcand has extensive experience collaborating with provincial and federal systems to improve the well-being of children and families.

Levi First Charger

Mr. First Charger is a Youth Outreach Worker with the Urban Society for Aboriginal Youth in Calgary. He has an educational background in youth justice. Mr. First Charger uses art as a medium to engage and empower youth and to connect them with their traditional culture. In 2015, he received the David Crowchild Award in recognition of his work with former youth in care entitled "Uncovering Colonial Legacies: Voices of Indigenous Youth in Child Welfare (dis)Placements."

Dr. Ann Marie Dewhurst, PhD, R. Psych.

Dr. Dewhurst is a psychologist who has been helping men and women make changes in their lives for the past twenty-six years. The individuals she works with are often dealing with anger, aggression, depression, anxiety, trauma and different forms of acting out. Many are survivors of childhood trauma and are dealing with abuse in their adult lives. Dr. Dewhurst has significant experience working in a cross-cultural context, particularly with First Nations people.

APPENDIX 5: BIBLIOGRAPHY

Alberta Children's Services. (2018). *Enhancement Act Policy Manual*. Edmonton, AB: Author. Retrieved from: https://open.alberta.ca/dataset/a1b2b48a-855b-42e4-9416-ab08ba22337b/resource/ac599a1f-2e14-4e92-804a-ffc68d2769d2/download/enhancement-act-policy-manual-july-2018.pdf

Alberta Children's Services. (2016). *Lifelong connections: Pathways to interdependence*. Unpublished report.

Alberta Education. (2017). *Success in school: Children and youth in care*. Retrieved from https://education.alberta.ca/children-and-youth-in-care/success-in-school/?searchMode=3

Alberta Health Services. (n.d.). *Mental health capacity building (MHCB) in schools initiative*. Retrieved from: https://www.albertahealthservices.ca/amh/Page2754.aspx

Atkinson, D. (2017). *Considerations for Indigenous child and youth population mental health promotion in Canada*. Canada: National Collaborating Centres for Public Health. Retrieved from: https://www.ccnsa-nccah.ca/495/Considerations_for_Indigenous_child_and_youth_population_mental_health_promotion_in_Canada.nccah?id=198

Anda, R.F., Felitti, V.J., Bremner, J.D., Walker, J.D., Whitfield, C., Perry, B.D., Giles, W.H. (2006). The enduring effects of abuse and related adverse experiences in childhood: A convergence of evidence from neurobiology and epidemiology. *European Archives of Psychiatry and Clinical Neuroscience, 256*(3), 174-186. Retrieved from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3232061/

Bellamy, J.L. (2008). Behavioral problems following reunification of children in long-term foster care. *Children and Youth Services Review, 30*(2), 216-228. Retrieved from: https://www.sciencedirect.com/science/article/pii/S0190740907001673

Campbell, K. & Borgeson, J. (2016). *A call for radical change in child protection practice: Unleashing the restorative power of relationship by authentically engaging the extending family, community and tribe*. Retrieved from the National Institute for Permanent Family Connectedness website at http://familyfinding.org/assets/files/A-Call-for-Radical-Change-in-Child-Protection-Practice-1.pdf

Government of Alberta. (2010). *Success in school for children and youth in care: Provincial protocol framework*. Retrieved from https://open.alberta.ca/publications/5078944

Government of Alberta. (2016). *Valuing mental health: Report of the Alberta Mental Health Review Committee 2015*. Retrieved from: https://open.alberta.ca/dataset/valuing-mental-health-report-alberta-mental-health-review-committee-2015

Government of Alberta. (2017). *Valuing mental health: Next steps*. Retrieved from: https://open.alberta.ca/dataset/9781460134771/resource/684600a3-a0ea-440c-a053-38a4cef83de9

Government of Alberta. (2018a). *Expanding mental health supports in schools*. Retrieved from: https://www.alberta.ca/release.cfm?xID=558974EEDA03D-E3C5-6E56-C5B7ECA0CDFC7C33

Government of Alberta. (2018b). *Walking as one: Ministerial Panel on Child Intervention's final recommendations to the Minister of Children's Services*. Retrieved from: https://open.alberta.ca/dataset/ministerial-panel-on-child-intervention-final-recommendations/resource/8e03a767-f579-4014-a9ab-4a4373f1b89e

McAuliffe, D., Tilbury, C., Chenoweth, L., Stehlik, D., Struthers, K. & Aitchison, R. (2015). (Re)valuing relationships in child protection practice. *Journal of Social Work, 30*(4), 365-377. Retrieved from: https://www.researchgate.net/publication/288872544_ReValuing_Relationships_in_Child_Protection_Practice

Office of the Child and Youth Advocate of Alberta. (2014a). *7-year-old Jack: Investigative Review*. Edmonton, AB: Author. Retrievable from: http://www.ocya.alberta.ca/wp-content/uploads/2014/08/InvRev_Jack_2014January.pdf

Office of the Child and Youth Advocate of Alberta. (2014b). *15-year-old Tony An Investigative Review*. Edmonton, AB: Author. Retrievable from: http://www.ocya.alberta.ca/wp-content/uploads/2014/08/InvRev_15-Year-Old-Tony_2014November.pdf

Office of the Child and Youth Advocate. (2015). *17-year-old Makayla: Serious Injury An Investigative Review*. Edmonton, AB: Author. Retrievable from: http://www.ocya.alberta.ca/wp-content/uploads/2014/08/InvRev_17-Year-Old-Makayla_2015December.pdf

Office of the Child and Youth Advocate of Alberta. (2016). *Toward a better tomorrow: Addressing the challenge of Aboriginal youth suicide*. Edmonton, AB: Author. Retrievable from http://www.ocya.alberta.ca/wp-content/uploads/2014/08/InvRev_Toward-a-BetterTomorrow_2016April.pdf

Office of the Child and Youth Advocate. (2017). *Beyond trauma: Disrupting cycles, effecting change*. Edmonton, AB: Author. Retrievable from: http://www.ocya.alberta.ca/wp-content/uploads/2014/08/InvRev_Beyond-Trauma_2017Nov.pdf

O'Higgins, A., Sebba. J. & Luke, N. (2015). *What is the relationship between being in care and the educational outcomes for children?* REES Centre Research in Fostering and Education.

Oxford, U.K.: The University of Oxford Department of Education. Retrieved from http://reescentre.education.ox.ac.uk/wordpress/wp-content/uploads/2015/09/ReesCentreReview_EducationalOutcomes.pdf

Sachs-Ericsson, N.J., Rushing, N.C., Stanley, I.H., & Sheffler, J. (2015). In my end is my beginning: developmental trajectories of adverse childhood experiences to late-life suicide. *Aging & Mental Health, 20*(2), 139-165. Retrieved from: https://www.researchgate.net/publication/280924119_In_my_end_is_my_beginning_Developmental_trajectories_of_adverse_childhood_experiences_to_late-life_suicide

Shea, J.M., Poudrier, J., Chad, K., Jeffery, B., Thomas, R., & Burnouf, K. (2013). In their own words: First Nations girls' resilience as reflected through their understandings of health. *Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health, 11*(1), 1-15. Retrieved from: https://www.researchgate.net/publication/302028414_In_their_own_words_First_Nations_girls'_resilience_as_reflected_through_experiences_of_health

Smith, L. (2018). Adverse Childhood Experiences (ACES): interventions in education. The Institute for Research and Innovation in Social Sciences. Retrieved from: https://www.iriss.org.uk/resources/esss-outlines/aces

The Care Inquiry. (2013). *Making not breaking: Building relationships for our most vulnerable children*. United Kingdom House of Commons. Retrieved from the Nuffield Foundation website at http://www.nuffieldfoundation.org/sites/default/files/files/Care%20Inquiry%20-%20Full%20Report%20April%202013.pdf.

Toombs, E., Kowatch, K.R., & Mushquash, C.J. (2016). Resilience in Canadian Indigenous youth: A scoping review. *International Journal of Child and Adolescent Resilience, 4*(1), 4-32. Retrieved from: https://www.researchgate.net/publication/315772338_Resilience_in_Canadian_Indigenous_Youth_A_Scoping_Review

Trout, A.L., Tyler, P.M., Stewart, M.C., & Epstein, M.H. (2012). On the way home: Program description and preliminary findings. *Children and Youth Services Review, 34*(6), 1115-1120. Retrieved from: https://www.sciencedirect.com/science/article/pii/S0190740912000692

17-YEAR-OLD SUSAN

An Investigative Review

NORTH OFFICE

#600, 9925 109 Street NW
Edmonton AB T5K 2J8

SOUTH OFFICE

#2420, 801 6 Avenue SW
Calgary AB T2P 3W3

www.ocya.alberta.ca

1 800 661 3446