

# A Way to Cope

*Exploring non-suicidal self injury  
in B.C. youth*



REPRESENTATIVE FOR  
CHILDREN AND YOUTH





Sept. 16, 2020

The Honourable Darryl Plecas  
Speaker of the Legislative Assembly  
Suite 207, Parliament Buildings  
Victoria, B.C., V8V 1X4

Dear Mr. Speaker,

I have the honour of submitting the report *A Way to Cope: Exploring non-suicidal self-injury in B.C. youth* to the Legislative Assembly of British Columbia.

This report is prepared in accordance with Sections 6(b) and 6(c) of the *Representative for Children and Youth Act*.

Sincerely,



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## Executive Summary

In the past few years, the Office of the Representative for Children and Youth (RCY) has become concerned about a small cohort of youth in B.C. receiving government services who repeatedly self-harm.<sup>1</sup> As required under the *Representative for Children and Youth Act (RCY Act)*, public bodies such as the Ministry of Children and Family Development (MCFD) must file reports of such critical injuries to the Representative's Office, where they can be reviewed, investigated and reported on to identify and analyze recurring circumstances or trends ("reportable circumstance" reports). The Representative has identified non-suicidal self-injuries (NSSI) as a trend requiring closer examination.

NSSI is common and wounds inflicted range from scratches and bruises to severe wounds that require medical attention. Repeated and severe NSSI is associated with serious consequences, in some cases resulting in youth entering government care, attending the hospital or even dying. These types of injuries also have implications for child-serving systems that are responsible for meeting the complex needs of the young people who engage in this behaviour. These youth are likely to receive treatment and other services, often without improvement.

The purpose of this report is to share what was learned about youth with NSSI through research, data analysis and case studies in order to inform decision-makers, service providers and the public.

The combined research paints a picture of youth requiring complex and nuanced supports and services, experiencing several injuries, carrying serious mental health diagnoses and having challenging family dynamics. Multiple service systems are often involved to meet their needs, including MCFD, health authorities, school districts, non-profit agencies and private practitioners, yet the research reflects gaps in services and supports for youth who engage in NSSI and highlights difficulties with waitlists while attempting to access necessary Child and Youth Mental Health (CYMH) services. While many young people were described by service providers as "not engaging," the Representative's research showed that youth experienced barriers to accessing service, and that supports were sometimes inappropriate to youths' needs or were withdrawn when symptoms decreased or when youth were perceived as difficult to engage.

### What is Non-Suicidal Self-Injury?

NSSI is the intentional and direct injuring of one's body without suicidal intent. Skin cutting is the most common form of NSSI, but other forms include burning, scratching, banging or hitting body parts, interfering with wound healing and poisoning. Others have also included limiting food intake, driving at high speeds or having unsafe sex. Youth exhibiting NSSI may experience one or more co-occurring mental health concerns or have experienced trauma, as well as NSSI. Further, youth who engage in repeated NSSI may be at risk of suicide or accidental death.

<sup>1</sup> These services are known as "reviewable services" and are outlined in the *RCY Act*. They include services or programs under the *Child, Family and Community Service Act* and the *Youth Justice Act*; mental health services for children; and addiction services for children.

## Executive Summary

This report found that suicide attempts and sexualized violence were common for youth who engaged in NSSI. Adversity and trauma in childhood has been linked to NSSI and this was echoed in the larger aggregate data set as well as with the five young people followed by the Representative. While MCFD recognizes the importance of a system-wide, trauma-informed approach to delivering services and supports to children and families, this has yet to be fully integrated into child welfare and mental health practice. In addition, it appears as if cultural connections were viewed as secondary considerations or less in the face of the chaos and crisis characteristic of these youth, as responses ignored the ways in which cultural connection could serve as a protective factor for youth with complex needs.

RCY analyzed aggregate data from 112 critical NSSI injury reports for 78 youth, comprehensively reviewed the files of five youth in order to provide more illustrative case examples and conducted a literature review. In addition to NSSI injuries, these 78 youth experienced another 146 serious non-NSSI injuries. That is, in 20 months these 78 youth experienced a total of 258 serious injuries. More than three-quarters (78 per cent) of those with one critical NSSI injury reported were in care at the time of injury but almost all (94 per cent) of those with repeated NSSI were in care.

The analysis presented in this report highlights significant concerns and raises questions that should be considered in the development and delivery of services and in the policies and practices working to serve these youth. In particular, this report's findings raise the following concerns:

- RCY has previously identified a lack of adequate services and supports for children experiencing mental health and trauma.<sup>2</sup> This report highlighted the need for a comprehensive model of care for youth with mental health challenges, including NSSI, such as the model of supports for Children and Youth with Complex Care Needs (CYCCN).
- While research demonstrates that prevention of trauma or early intervention after trauma could prevent the onset of NSSI, full implementation of MCFD's 2017 Trauma-Informed Practice Guide has not yet been achieved. While it is recognized that this would require considerable resources, it is also likely that increased awareness and capacity among MCFD staff and service providers to provide trauma-informed service and supports to young people with complex needs and families could reduce the occurrence of NSSI.
- Research and analysis indicate that families and caregivers are deeply impacted when caring for a youth engaged in NSSI, and that caregiver support and skill-building opportunities may be imperative for supporting caregivers of youth engaging in NSSI. The apparent limited accessibility and intensity of supports and services available to caregivers of these youth may contribute to missed opportunities for prevention and early intervention. Research suggests that a family's understanding of NSSI and participation in interventions leads to improved outcomes.<sup>i</sup>
- RCY's research found limited evidence that practitioners fostered or considered culture in working with youth engaging in NSSI, although expert consultation revealed that cultural connection could serve as a protective factor for youth with complex needs.

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<sup>2</sup> RCY reports: *Missing Pieces: Joshua's Story*, October 2017; *Tragedy in Waiting*, September 2016; *Trauma, Turmoil and Tragedy: Understanding the Needs of Children and Youth at Risk of Suicide and Self-Harm*, November 2012; *Who Protected Him? How B.C.'s Child Welfare System Failed One of Its Most Vulnerable Children*, February 2013; *Much More than Paperwork: Proper Planning Essential to Better Lives for B.C.'s Children in Care*, March 2013; *Still Waiting First-hand Experiences with Youth Mental Health Services in B.C.*, April 2013.



This report sets a baseline for future research and an opportunity for government to review the findings and take action to address the concerns outlined here. The Representative hopes that this report, while not directive in nature, fosters systemic change to better support children and youth with complex needs, as well as their families. RCY will follow up in 2022 with an update on services for children and youth who self-harm. While health authority mental health programs and school supports were out of scope for this study, it is hoped that all three child-serving systems explore ways to work together to support those who engage in NSSI. In fact, in response to this report, MCFD noted that child-serving systems, including school districts and health authorities, must review services to ensure best practice treatment modalities are implemented to serve this population.

## Introduction

RCY is tasked with many functions, one of which is reviewing, investigating, and reporting on critical injuries and deaths of children and youth receiving reviewable services in B.C.<sup>3</sup> The *RCY Act* authorizes the Representative to conduct a review of serious injuries and deaths to identify and analyze recurring circumstances or trends.<sup>4</sup>

The Representative is particularly concerned about a small cohort of youth in B.C. who experience a significant number of NSSI while receiving reviewable services. For example, one youth experienced 16 different occurrences of NSSI in one year. Repeated and deliberate NSSI can have serious consequences for these youth, in some cases resulting in youth entering government care, hospital visits and even death. These types of injuries also have implications for child-serving systems that are responsible for meeting the complex needs of the children who engage in this behaviour. These youth are likely to receive treatment and other services, often without improvement. The Representative recognizes that NSSI includes less severe forms of injury (e.g., superficial cuts) but these are not the injuries that fall within her mandate. The Representative acknowledges that, as those with lived experience note, all NSSI feels serious to the youth who engage in this behaviour, as well as to their loved ones.

Serious injury and death reports received by the Representative often describe the case management of youth engaging in extreme NSSI as being in “crisis mode.” The Representative acknowledges that this often leaves service providers “scrambling” to keep youth safe and meet their needs in the most comprehensive ways they know how, with the resources available to them at the time. The Representative has the unique opportunity to take a step back and review these cases, as well as to consult with service providers with expertise in order to better understand the challenges the child-serving system faces in supporting these children. With this report, the intention is to provide an opportunity for collaborative learning and knowledge sharing to achieve better outcomes for these youth.

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<sup>3</sup> Reviewable services are outlined in the *RCY Act* and include services or programs under the *Child, Family and Community Service Act* and the *Youth Justice Act*; mental health services for children; and addiction services for children.

<sup>4</sup> The *RCY Act* authorizes the Representative to review “critical” injuries, defined as those that cause, or have the potential to cause, serious or long-term impairment. NSSI reviewed in this report are those deemed to be critical.

## Approach

To gain understanding of NSSI and ground analyses, a literature scan of peer-reviewed research was conducted to identify (i) definitions of NSSI, (ii) theories of NSSI, (iii) a profile of youth who engage in NSSI, (iv) relationships, including those with parents and foster care providers and (v) promising interventions.

To facilitate an in-depth understanding of youth with serious NSSI receiving services in B.C., serious NSSI reported between April 1, 2018 and Jan. 31, 2020 were examined by the Representative in aggregate.<sup>5</sup> In total, 112 severe NSSI reports for 78 youth were reviewed. Variables related to NSSI were identified and analyzed for youth with at least one mandate NSSI. The objective of the quantitative analyses was to examine critical injury reports for youth receiving reviewable services who experience critical NSSI in B.C.

To highlight themes from the literature scan and data analysis, five youth with critical NSSI injuries were chosen for in-depth file review. This was a convenience sample of critical injuries that were already identified by the Representative for comprehensive file review. For each of these five youth, the Representative reviewed all the records from the entire span of time that the youth were receiving reviewable services. Pseudonyms are used for the five youth, and their cases are presented as composites to protect their identities. Although service provider views and actions present in the records are sometimes included to provide data and context for the cases, the aim of the case examples is to inform systemic change and improvement, and not to pass comment on the practice of service providers. The Representative recognizes the good work done by practitioners and acknowledges that practitioners are sometimes limited by the available resources in the systems they work within.

The literature scan, data analysis and case examples were provided to a group of experts for feedback.<sup>6</sup> Eight experts met with the Representative and her staff virtually for two and a half hours to comment on the work to date, suggest additions, correct misinformation and provide guidance to the project team. In addition, experts provided written feedback on a draft document and this was also incorporated into the final report.

Finally, learnings from each of these analyses were synthesized to gain understanding of the strengths and needs of the systems of support for youth with serious NSSI. While formal recommendations are not provided, the Representative highlights opportunities for improvements to services for youth (e.g., mental health services, supports for caregivers, cultural supports) and suggests future research.

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<sup>5</sup> NSSI included here are those that meet the criteria of “critical” as defined in the *RCY Act*; that is, NSSI injuries caused, or were likely to cause, serious or long-term impairment for the youth. In the research literature, NSSI does not always include self-poisoning. However, the Representative noted that youth in the current sample did sometimes self-poison (e.g., took an overdose of medication) and stated they did so for self-injury. Therefore, self-poisoning was included as an NSSI in this report.

<sup>6</sup> Experts included those with experience of NSSI in their family or who have professional experience supporting youth with NSSI. Experts received anonymized case examples as part of the draft report as they are presented in this report and signed confidentiality undertakings to further protect youth from being identified.

## Literature Scan

A scan of research related to NSSI in youth was conducted.<sup>7</sup> Presented here are definitions of NSSI, theories of NSSI, variables that may influence NSSI and recommended interventions.

### Definitions

Non-suicidal self-injury (NSSI) is the intentional and direct injuring of one's body without suicidal intent.<sup>8</sup> Skin cutting is the most common form of NSSI, but other forms include burning, scratching, banging or hitting body parts, interfering with wound healing and poisoning.<sup>ii</sup> Other researchers have also included limiting food intake, swallowing inedible objects (e.g., pins, razor blades, nails, tacks), cutting off skin or toes, driving at high speeds or having unsafe sex.<sup>iii</sup>

Although NSSI does not include suicidal intent, it can be associated with increased risk of suicide.<sup>iv</sup> One study from 2012 found that, over an eight-year period, there was a positive relationship between the number of NSSI episodes and suicide. Of those who died by suicide, 1.1 per cent had one episode of NSSI in the previous eight years, 1.6 per cent had two episodes of NSSI, and 10.7 per cent had three or more episodes of NSSI prior to suicide. Results also revealed that NSSI by cutting, as opposed to poisoning, was associated with an increased risk of suicide.<sup>v</sup> There are several factors associated with both NSSI and suicidality including depressive symptoms, anhedonia, trauma, maltreatment and lack of parental support.<sup>9,vi</sup> A meta-analysis of research related to NSSI and mental health revealed that those with a mental health diagnosis were significantly more likely to engage in NSSI than those without a diagnosis.<sup>10</sup> The largest relationship between diagnosis and NSSI in this research study was for panic disorder and post-traumatic stress disorder (PTSD).<sup>11,vii</sup> In one B.C. city, 13 per cent of youth aged 14 to 21 years reported lifetime occurrence of NSSI and NSSI was associated with symptoms of depression as well as deficits in regulation of attention, impulsivity and activity.<sup>viii</sup>

Together, the literature describes NSSI as a complex condition. Youth exhibiting NSSI may experience one or more co-occurring mental health concerns or have experienced trauma, as well as NSSI. Further, youth who engage in repeated NSSI may be at risk of suicide or accidental death.

### Theoretical Model

Current theory outlines the ways in which NSSI develops and is maintained by its function. For example, in 2004 Nock and Prinstein developed one model of NSSI in which this behaviour serves one of two purposes: social regulation or emotion regulation.<sup>12,ix</sup> Figure 1 provides a graphic depiction of this model.<sup>13</sup>

<sup>7</sup> The Representative considers youth to include those aged 12 to 18 years.

<sup>8</sup> Terminology for self-injury is challenging. Another term similar to NSSI is deliberate self-harm. Expert feedback suggested that NSSI is more timely, associated with less stigma and is the more accurate term.

<sup>9</sup> See Appendix A for definitions of mental health diagnoses and other terms.

<sup>10</sup> In this study, mental health disorders included were mood disorders, bipolar disorders and anxiety disorders.

<sup>11</sup> See Appendix A for definitions of mental health diagnoses and other terms.

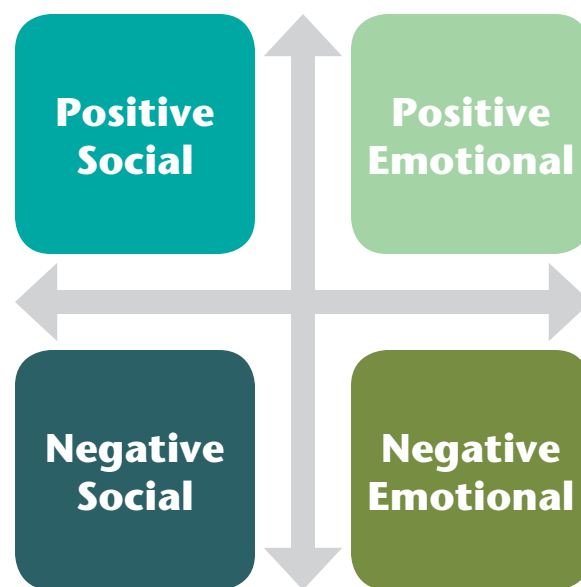
<sup>12</sup> Emotion regulation is the process of enhancing, maintaining or inhibiting emotional arousal for the purpose of meeting goals. There are internal and external motivations for engaging in emotion regulation.

<sup>13</sup> Note that there are more theoretical models of NSSI. However, a full review of theories is beyond the scope of this report.

In the model, NSSI may serve positive social reinforcement; that is, NSSI enables an individual to gain attention from others (e.g., paramedic attention after cutting) or gain access to materials (e.g., a parent provides a tablet for social media use as an alternative to NSSI). NSSI may also serve as negative social reinforcement; that is, NSSI enables an individual to avoid social situations that are undesirable (e.g., avoiding an academic test at school).

On the other hand, NSSI may serve to provide positive emotion regulation. In this way, NSSI can create a pleasurable emotional state or may allow an individual to “feel something,” even if the feeling is pain. Finally, NSSI can provide negative emotion regulation. In this way, NSSI may alleviate feelings of anxiety or stress. Nock and Prinstein’s (2004) research revealed that adolescents who engaged in NSSI endorsed all these reasons for NSSI and that emotion regulation was most frequently cited as a reason for NSSI.

Figure 1. Nock and Prinstein’s (2004) Functional Model of NSSI



There is good empirical support for the model. The B.C. Adolescent Health Survey is completed in schools every five years across the province by students aged 12 to 19. In the 2018 report, B.C. youth aged 12 to 19 years that reported at least one instance of NSSI in the previous year reported that NSSI most commonly served to regulate emotions. Common reasons cited by students who engaged in NSSI were:

- To calm down (negative emotional)
- To punish oneself (positive emotional)
- To stop feeling numb (positive emotional)
- To stop suicidal thoughts (negative emotional).

B.C. students also endorsed social reasons for NSSI, including:

- To create a physical sign that one feels awful (positive social)
- To show others one’s pain (positive social)
- To fit in with peers (positive social).<sup>x</sup>

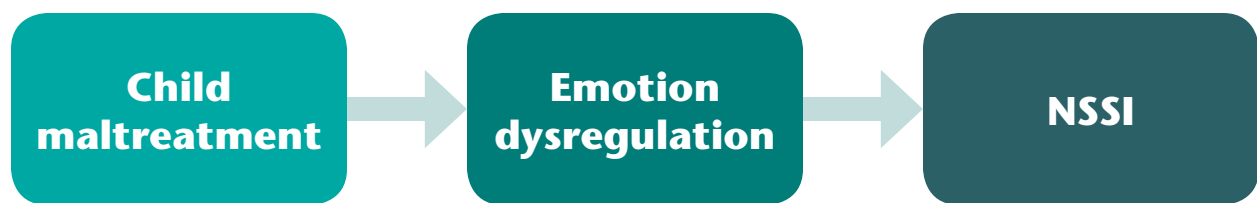
## Literature Scan

In one study of foster caregivers, participants were interviewed to determine the meanings they ascribed to episodes of NSSI. These caregivers described NSSI as authentic (in Nock and Prinstein's terms, for the purpose of emotion regulation) or superficial (in Nock and Prinstein's terms, for the purpose of social reinforcement).<sup>14</sup> Authentic NSSI was described by caregivers as rare and largely hidden from others, carried out by those with mental illness and by those in need of specialist clinical intervention. Caregivers also assumed that authentic NSSI would lead to suicidality. When youth were considered to be engaging in authentic NSSI, caregivers were more open to specialist intervention and were more likely to believe these youth should be placed in mental health institutions.

On the other hand, caregivers believed superficial NSSI to be more common and as having the intention of being seen by others. Caregivers constructed superficial NSSI as providing control and agency to youth. For example, caregivers described youth who engaged in so-called superficial NSSI as being able to better access and navigate health systems. Caregivers also constructed superficial NSSI as a means of communication. For example, youth who could not verbally communicate a need for help used NSSI to signal this need, or youth who felt abandoned used NSSI to gain attention. Finally, caregivers constructed superficial NSSI as a means to test the security and authenticity of their relationship between youth and their caregivers. For example, NSSI may be one method for testing a caregiver's ability to keep youth safe.<sup>xi</sup>

In addition, research has demonstrated a link between childhood trauma and NSSI for the purpose of emotion regulation (the second type of NSSI in Nock and Prinstein's model). Figure 2 provides a graphic representation of the path from childhood trauma to NSSI for emotion regulation purposes.

Figure 2. Role of emotion regulation in NSSI



For example, one study of youth aged 12- to 18-years-old recruited from inpatient and outpatient mental health programs demonstrated that childhood emotional and physical abuse were found to be positively related to emotion dysregulation and emotion dysregulation was found to be positively related to frequency of NSSI episodes. Further, statistical analyses revealed that childhood emotional and physical abuse predisposed youth to emotion dysregulation, which in turn predisposed youth to engage in NSSI.<sup>xii</sup>

Further, a large-scale school-based survey of youth from Europe and Australia demonstrated a relationship between physical or sexual abuse and the occurrence of NSSI. Very few youth (six per cent) who never engaged in NSSI had a history of abuse whereas 19 per cent of those who thought about NSSI and 31 per cent of those who had engaged in one episode of NSSI had a history of abuse. Finally, 39 per cent of those with more than one episode of NSSI had a history of abuse. In addition, there was a positive correlation between mental health conditions (depression, anxiety and impulsivity) associated with emotion dysregulation and occurrence of NSSI.<sup>xiii</sup>

<sup>14</sup> Authentic and superficial were the terms used in this article. They are not typically used terms as they can promote stigma for youth with NSSI.

In sum, current theory posits that NSSI may serve two different functions for youth: social or emotion regulation. NSSI for social purposes is influenced by relationship – that is, the desire for relationship or the wish to avoid social situations. Research indicates that NSSI for emotion regulation often has roots in childhood trauma that hamper development of more adaptive emotion regulation skills.

## Demographic Variables

Among youth, NSSI is a common behaviour. The prevalence of NSSI in youth ranges from 15.5 per cent to 31.3 per cent.<sup>xiv,xv</sup> In B.C., youth NSSI rates are no different. In 2018, 17 per cent of students reported NSSI in the previous year. This was an increase from 2013 when 15 per cent of students reported NSSI.<sup>xvi</sup> Overall, research suggests that factors such as age, gender and caregiver-youth relationships are related to NSSI in youth.

The risk of engaging in NSSI appears to peak in adolescence and decrease in the adult years.

Administrative data from hospital emergency departments in Ireland revealed that more than one-third (34.5 per cent) of those presenting with an NSSI episode for the first time were between 15 and 19 years of age. This decreased to 33.1 per cent for those aged 20 to 24 years and 26.3 per cent for those aged 25 to 29 years. Only six per cent of children aged 10 to 14 years presented to emergency rooms (ER) with an initial NSSI episode.<sup>xvii</sup> These results demonstrate that age is an important factor to consider when examining NSSI, especially in adolescence.

Current research suggests that more females than males engage in NSSI. In one study that included youth and young adults between the ages of 10 and 29 years, more females than males presented to ER for NSSI.<sup>xviii</sup> Similarly, a study using administrative data from Ontario found that, among youth aged 12 to 17 years who presented to ER for NSSI, females were over-represented compared to males.<sup>xix</sup> Baetens, Claes, Onghena, Grietens, Van Leeuwen, Pieters and colleagues explored NSSI in a large sample of youth and found that, at the age of 15, significantly more females than males reported NSSI.<sup>xx</sup> Similarly, results of the 2018 B.C. Adolescent Health Survey found that female youth reported higher rates of NSSI (24 per cent) than male children and youth (11 per cent). In 2018, 47 per cent of gender diverse youth reported NSSI in the previous year.<sup>xxi</sup>

Together this research demonstrates that age and gender are important to consider when examining NSSI in youth. Specifically, this research indicates that girls are at the highest risk of engaging in NSSI during late adolescence. Further, it shows that males also engage in NSSI to a lesser degree, although they are at higher risk in early adulthood.

### NSSI is common

Research reveals that up to one-third of youth engage in some form of NSSI. Severe NSSI, such as that described in this report, may be less common but experts consulted by the Representative note that all NSSI feels severe to youth and the people who care for them. Normalizing NSSI as a means of emotion regulation or social communication is one way to reduce stigma and encourage youth and their families to seek help.

## The Role of Caregivers

### Parents

In addition to demographic factors, research demonstrates that parents can influence whether individuals engage in NSSI. For example, a meta-analysis of articles examining adolescents' perspectives on NSSI, as well as parents' perspectives, revealed that emotionally charged reactions to NSSI and the use of disciplinary measures as an attempt to reduce NSSI is viewed as unhelpful and detrimental by those engaging in NSSI. Further, when parents were afraid of stigma and were reluctant to seek professional help, this was associated with an increase in NSSI for adolescents. Adolescents who engaged in NSSI also reported that fear of being judged by parents resulted in help-seeking from peers rather than parents.<sup>xxii</sup>

Similarly, interviews with youth who regularly engaged in NSSI revealed that arguments with parents were a common stressor. These youth also commonly reported that overly emotional responses by their parents or responses that trivialized the reasons for NSSI were unhelpful. When parents' reactions to NSSI were unhelpful, this further prevented youth from reaching out to parents for help. Other youth avoided discussing NSSI with their parents to protect their parents' feelings.<sup>xxiii</sup>

Further, there is evidence that the relationship between difficult parent-youth relationships and emotion regulation problems can predispose youth to engaging in NSSI. Survey results revealed that challenges in their relationships with parents predicted engagement in NSSI and that feeling alienated from parents was particularly salient. In further exploring this relationship, it was determined that poor communication with parents and feeling alienated from parents predicted emotion dysregulation for youth and that emotion dysregulation directly increased the likelihood of youth engaging in NSSI.<sup>xxiv</sup>

### Child Welfare

While there is only a limited body of literature examining NSSI for youth in government care, some exploratory research has been conducted. Results of a standardized mental health questionnaire determined that 21 per cent of the sample of American youth in care aged 8- to 11-years-old thought about NSSI. More youth placed in staffed residential resources endorsed thoughts of NSSI than those placed in foster homes.<sup>xxv</sup>

In one sample of Ontario youth in care who engaged in NSSI, 44 per cent were female and 55 per cent were male. However, the female youth in care accounted for a higher proportion (62 per cent) of the total number of reported NSSI episodes than male youth in care (38 per cent). Almost one-third of this sample (29.8 per cent) of youth in care engaged in multiple episodes of NSSI. Youth aged 14 or older were more likely to engage in NSSI than those who were younger and those in the permanent custody of the government were more likely than those in temporary custody to engage in NSSI.<sup>xxvi</sup>

## Typical Interventions

NSSI may have deleterious effects on a youth's health and relationships with others. There is consensus in the literature that, after presentation to the hospital for an episode of NSSI, treatment is warranted and can be effective in preventing further NSSI. One meta-analysis of randomized control trials of psychological or psychosocial interventions found some benefit in all, with cognitive-behavioural therapy



(CBT) providing more robust benefits.<sup>15,xxvii</sup> Similarly, a systematic review of studies of youth engaging in NSSI found a significant reduction in occurrence of NSSI from pre- to post-treatment.<sup>xxviii</sup> Dialectical behaviour therapy for adolescents (DBT-A) was designed to address symptoms of emotion dysregulation, such as NSSI, and promote healthy coping mechanisms.<sup>16</sup> A meta-analysis of DBT-A research with youth (average age of 15 years) found that this treatment method significantly reduced episodes of NSSI.<sup>xxix</sup>

Research suggests that there are many reasons for engaging in NSSI and that mental health interventions can be useful in decreasing the frequency of NSSI. Experts consulted by the Representative stressed that more research is needed to determine the root causes, avenues for prevention (e.g., family therapy) and effective interventions for NSSI. They added that it is imperative to determine the underlying function of NSSI (e.g., trauma) and address that through mental health intervention; intervention that is focused solely on NSSI behaviour is rarely beneficial. Experts also stressed the importance of culturally relevant and accessible interventions – a topic that was not addressed in the research.

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<sup>15</sup> See Appendix A for definitions.

<sup>16</sup> See Appendix A for definitions.

## The Representative's Data

In order to better understand the experiences of B.C. youth receiving MCFD services and experiencing severe NSSI, the Representative 1) comprehensively reviewed the files of five youth in order to provide more illustrative case examples, 2) analyzed aggregate data from injury reports and 3) consulted with NSSI experts.

### Case Examples

Five youth were identified for comprehensive file review.<sup>17</sup> Anna, Cassidy, Kendra, Lindsay and Opal each experienced critical and repeated NSSI which together accounted for 68 critical injury reports to the Representative. Thirty-seven of those injuries were serious NSSI. Lindsay had 24 severe NSSI injuries reported and another eight severe non-NSSI injuries. She often cut body parts so deeply the wounds required stitches or staples. File reviews revealed that NSSI was a common occurrence for all five youth and many injuries were not reported to the Representative. Opal presented to hospital emergency rooms 67 times within two years for NSSI and other injuries. Cutting was the most common cause of NSSI injury.

Cassidy and Lindsay are First Nations and Opal is Métis. Anna and Kendra are non-Indigenous. While this report focuses on their experiences of NSSI, it is important to recognize that these young women are far more than their injuries or their mental health challenges. Lindsay loves attending pow wows and spending time with her family. Anna has a passion for make-up and special effects. Kendra loves animals and hopes to work with them some day. Opal is a dog person who likes to joke around. Cassidy is fiercely independent and loves swimming.

Not surprisingly, given their experience with severe and repeated NSSI, these five girls each had multiple serious mental health diagnoses. Diagnoses included Major Depressive Disorder (MDD), one or more anxiety disorders, PTSD and/or complex trauma and Borderline Personality Disorder (BPD).<sup>18</sup> In addition, some of these young people experienced substance misuse and two youth experienced hallucinations. Cassidy heard voices that commanded she “*kill herself*” but these were attributed to substance use, even though she had been sober for 52 days. Kendra began telling mental health professionals about a number of entities, one of which threatened to kill her family members if she did not end her own life by her 16<sup>th</sup> birthday. Her social worker saw the hallucinations as attention seeking and assumed they were fictitious and related to her BPD diagnoses.

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<sup>17</sup> Pseudonyms are used for the five youth and their cases are presented as composites to protect their identities.

<sup>18</sup> See Appendix A for definitions.

## Youth Snapshots

### Opal

Opal is Métis through her father. She is the middle child with two siblings in a blended family. She was born in another province and lived outside of Canada before the family moved to a small B.C. community. Opal first became connected to reviewable services when she was 13-years-old and experiencing mental health challenges. There were no child protection concerns for Opal but she did experience poverty and conflict with her parents. Opal began engaging in NSSI at age 14 and over time was diagnosed with six different mental health disorders. Opal came into care twice and experienced numerous placements across several communities. Opal required significant support to remain safe. As she aged, Opal was connected to adult mental health services and was noted to be excited to turn 19. She transitioned out of MCFD care when she became an adult and now lives independently.

### Cassidy

Cassidy was First Nations through her father and her mother was white. She and her four siblings were raised by their father on reserve in central B.C. Cassidy's mother reportedly experienced significant mental health challenges. At age 14, Cassidy began engaging in NSSI and experiencing suicidality. She was diagnosed with many mental health disorders and disclosed sexual abuse by a family member as a young child. Cassidy was an excellent advocate for her needs. Despite being clear that she wanted individual therapy, she was offered only group therapy and was perceived as resistant to services. Cassidy began using drugs and alcohol and moved out of her family's home. She was placed on a Youth Agreement to facilitate access to an addiction recovery program. While living independently, Cassidy experienced many instances of NSSI, as well as a suicide attempt and an accidental overdose. She was hospitalized six times as a youth and was diagnosed with multiple mental health challenges. When Cassidy was 18-years-old, she died of an accidental overdose.

### Lindsay

Lindsay is First Nations and grew up in an urban community with her mother, stepfather and a sibling. Lindsay experienced significant mental health challenges beginning as early as age 11 and began cutting at age 14. Lindsay often cuts her body so severely that she needs stitches or staples. She sometimes picks at these wounds, resulting in infection. While her parents were very supportive of her, they struggled to keep her safe and Lindsay spent some time in the care of her grandmother. After a significant suicide attempt, Lindsay came into care at age 14 via a Special Needs Agreement (SNA). She was initially placed in a foster home but that placement broke down as her caregivers struggled to meet her needs. Lindsay then received inpatient services for three months, then was transitioned to a specialized staffed resource where two staff are with her at all times, even remaining awake overnight. Despite these intensive supports, Lindsay continues to engage in serious NSSI and suicide attempts.

### Anna

Anna is of European descent and is an only child. Anna witnessed domestic violence as a young child. Anna's mother and father divorced, and Anna's mother supported her children with her full-time job and with the help of extended family, although poverty was an ongoing concern. Anna's struggles with mental health began at a young age and have progressed over time. She has numerous mental health diagnoses and has an intellectual disability. Anna has also struggled with misusing alcohol and drugs. Anna was brought into care via SNA after two suicide attempts in less than six months. Anna has had a long-term placement in a specialized staffed resource and has a hospital-based mental health team. Still, Anna's care team has, at times, struggled to keep Anna safe. Anna remains in care and is in high school. The Representative continues to receive injury reports for Anna's severe NSSI and suicide attempts.

### Kendra

Kendra had little contact with her biological father and she and her three siblings were raised in a suburban area by her mother and, at times, a stepfather. Social workers first became involved with Kendra and her family when Kendra disclosed sexual abuse as a young child. As a teenager, Kendra was supported by MCFD due to significant parent-teen conflict. In addition, Kendra was experiencing increasing mental health challenges including command hallucinations and homicidal ideation. After one hospitalization for a suicide attempt, Kendra refused to return home where conflict with her mother had escalated. Kendra was brought into care via a Voluntary Care Agreement (VCA). When the VCA expired, Kendra moved to a safe house. Just after her 19th birthday, Kendra signed an Agreement with Young Adults. As an adult, Kendra graduated from an education program and is living independently.

Together these stories paint a picture of youth requiring complex and nuanced supports and services. As reflected in the research literature, each of the youth described here carried multiple serious mental health diagnoses and experienced challenging family dynamics. For example, in the files reviewed, clinicians spoke of parent-teen conflict for Opal and Kendra, and Lindsay's grandmother was reported to be dismissive of Lindsay's mental health needs. Many of the youth had significant histories of sexualized violence. In these contexts, multiple service systems (e.g., MCFD, ministries of Health and Education, community agencies) and providers were engaged with each of these youth to try to support their safety, recovery and healing.

## Aggregate Data

To facilitate understanding of youth with serious NSSI receiving services in B.C., injury data was explored in aggregate. Specifically, themes were analyzed for youth with at least one serious NSSI. The objective of the quantitative analyses was to examine critical injury reports for youth receiving reviewable services who experience critical NSSI in B.C. Injuries reported between April 1, 2018 and Jan. 31, 2020 were examined.

In this timeframe, severe NSSI was reported for 78 youth. Almost all youth in the aggregate data sample with reported NSSI injuries were between the ages of 13 and 18 years with an average age of 15.8 years.<sup>19</sup> The youngest youth with reported NSSI was 10-years-old. The majority of youth who engaged in NSSI were female (n=53). Twenty-one male youth and four gender diverse youth were reported have at least one mandate NSSI injury. The proportion of non-Indigenous (n=37) and First Nations (n=34) youth with reported mandate NSSI injuries were nearly equivalent. There were seven Métis youth with mandate NSSI injuries reported (see Table 1 for an overview of demographic characteristics). It is important to note that, according to Statistics Canada, First Nations people make up eight per cent of B.C.'s total population and Métis people make up two per cent of B.C.'s population. It would be reasonable to expect, then, that fewer NSSI would be reported for First Nations and Métis youth than non-Indigenous youth. With this in mind, it appears that in the current data set, Indigenous youth experiencing NSSI are substantially over-represented.

Table 1. Demographic characteristics of youth with NSSI

| Gender         | Frequency (%) |
|----------------|---------------|
| Female         | 53 (68%)      |
| Male           | 21 (27%)      |
| Gender diverse | 4 (5%)        |
| Total          | 78            |
| Indigeneity    |               |
| Non-Indigenous | 37 (47%)      |
| First Nations  | 34 (44%)      |
| Métis          | 7 (9%)        |
| Total          | 78            |

<sup>19</sup> The age used was for the first critical NSSI injury RCY received within the snapshot timeframe. This means that youth could have had previous NSSI before the snapshot. Further, often youth with first-time NSSI reported to RCY have a history of unreported NSSI recorded in their case files.

## Data Analysis

### Youth with NSSI

Between April 2018 and January 2020, there were 112 critical NSSI injury reports for 78 youth. The average number of critical NSSI injuries reported was 1.4 per youth. However, there were some youth who experienced more NSSI; one youth in this sample had 18 critical NSSI injuries reported. Seventeen youth (22 per cent) experienced repeated NSSI. For these youth, the median number of critical NSSI injuries was two. Youth with repeated NSSI injuries (median=17 years) were older than youth with one reported NSSI injury (median=16 years). Nine youth with repeated (two or more) NSSI were female and 10 were non-Indigenous.

### Other Injuries Associated with NSSI

Not only did youth experience serious and repeated NSSI, more often than not they also experienced other injuries. In addition to NSSI injuries, the Representative's data revealed another 146 non-NSSI injuries reported. That is, in 20 months these 78 youth experienced a total of 258 critical injuries. The five young people whose cases the Representative examined over time also experienced other injuries. Suicide attempts were most commonly reported. Altogether there were 29 suicide attempts reported for these five youth. Anna's file review revealed four suicide-related hospitalizations by the time she was 13-years-old. Anna was also hospitalized for an accidental overdose. Similarly, Opal had five hospitalizations in two years for NSSI behaviours that included cutting and eating inedible objects (e.g., a nail).

The link between NSSI and suicidality was not limited to these five youth. The Representative found that suicide attempts were common for youth who engaged in NSSI. Between April 2018 and January 2020, 26 youth (33 per cent) in the aggregated data set had at least one reported suicide attempt and half of these youth (n=13) made more than one suicide attempt. For those with repeated NSSI, suicidality was more likely to be reported: whereas those with one NSSI injury had an average of 0.6 suicide attempts, those with repeated NSSI had an average of 2.8 suicidality injuries. Also, those youth with only one mandate NSSI injury had a range from 0 to 6 suicidality injuries reported but those with repeated mandate NSSI injuries had a range of up to 14 suicidality injuries reported.

Adversity and trauma in childhood has been linked to NSSI and this was true for the five young people followed by the Representative. Almost all these youth experienced sexualized violence in their lives. Opal was sexually assaulted in her co-ed staffed residential resource (SRR). Prior to this, she had reported that she did not feel safe in this resource "*full of men.*" Three of the youth were sexually abused by family members when they were young. Cassidy told her mental health clinician that she was sexually abused at the age of five years and that she was raped at ages 14 and 15. Her clinician attributed some of her NSSI behaviour to this trauma, noting that Cassidy's "*emotional problems [were] frequently triggered by thoughts of past sexual abuse.*" Anna disclosed sexual abuse by an adult family member, but other family members denied this, and the family member was allowed to remain in the family home. Finally, Kendra disclosed being sexually abused by her stepfather twice in her life. As well, Lindsay disclosed that her grandmother's boyfriend was sexually inappropriate with her. Further, when she was 17-years-old, Lindsay reported that she was drugged and sexually assaulted at a party.

These stories were echoed in the larger data set. Sexualized violence was reported in the 20-month period for 15 of the 78 youth with NSSI injuries. Almost all of the youth with NSSI and sexualized violence injuries were female (n=13). Two male youth were reported to have both NSSI and sexualized violence injuries. More than half (n=8) of youth with both NSSI and sexualized violence injuries were First Nations. One-quarter of youth with NSSI and sexualized violence injuries were non-Indigenous (n=4) and one-fifth were Métis (n=3). Experts consulted by the Representative also noted a history of trauma for youth with NSSI. Experts noted that NSSI tends to be a focus of attention and interventions for caregivers and clinicians but, often, it is more beneficial to address underlying trauma. In many cases, youth use NSSI to cope with the negative effects of trauma.

## Services for Youth with NSSI

Youth who engage in severe NSSI have complex care needs; these youth often experience multiple injuries and having significant mental health diagnoses. Multiple service systems are often involved to meet their needs. For example, over time, the five young people whose stories were examined in detail were receiving services through multiple systems, including MCFD (Child and Youth Mental Health, services for Children and Youth with Special Needs, contracted agencies), health authorities, school districts, non-profit agencies and private practitioners. Still, some of the youth struggled to access services due to waitlists and other barriers to service.

Cassidy advocated for one-on-one treatment; she was offered group therapy. Further, Cassidy's contact with mental health services is best described as a cycle of crises, resulting in services being implemented, and then services ending as Cassidy's mental health improved, only for Cassidy to experience another crisis. Kendra similarly received services when she and/or her family were experiencing a crisis. For example, when MCFD was informed that Kendra was sexually assaulted, services were provided. When Anna was young, she was assessed by CYMH but no services were offered as she was seeing a counsellor for therapy related to sexual abuse. On the other hand, Anna was accepted to a residential mental health program for youth and their families. However, after one week, she was discharged as program staff were unable to support her due to the severity of her self-harming behaviours. Opal was moved out of her home community as that community could not provide the intensive supports she required to be safe. Opal was moved between multiple emergency foster placements and waited six months for a long-term placement to be available. Even though Opal reported that mental health treatment was beneficial, her clinician worried that it was not intensive enough to support her mental health.

These five young people had complex mental health diagnoses and experienced serious injuries. With few exceptions, they were receiving the same supports as youth with less complexity. Only one youth received ongoing, intensive supports. Another youth received one complex case consult from a specialized mental health program.

The Representative also noted multiple service involvement for youth with NSSI injuries reported between April 2018 and January 2020. An average of 2.5 reviewable services were supporting youth who had one NSSI injury reported during this timeframe (e.g., mental health, substance use services, child protection).<sup>20</sup> An average of 3.2 reviewable services were supporting youth with repeated NSSI during

<sup>20</sup> Experts consulted by the Representative also noted that youth with developmental disabilities, such as Autism Spectrum Disorder, are more likely to engage in NSSI and may have different trajectories to NSSI. Exploration of NSSI for youth with developmental disabilities was beyond the scope of this report but will be important to consider in future research by the Representative.

## Data Analysis

this time. More than three-quarters (78 per cent) of those with one critical NSSI injury reported were in care at the time of injury while almost all (94 per cent) of those with repeated NSSI were in care.

However, many youth were described by service providers as “not engaging.” This was particularly pronounced for those with repeated NSSI. Almost two-thirds (59 per cent) of those with repeated NSSI were described as not engaging whereas 39 per cent of those with one reported critical NSSI injury were described this way. Experts consulted by the Representative also noted this theme in their experiences with youth with NSSI. Clinicians noted that sometimes youth who self-injure are harder to engage in mental health interventions for many reasons (e.g., youth may not have the self-regulation skills to engage in talk therapy). In fact, since NSSI often serves an important function for youth, whether that is emotional or social, the idea of entering therapy to reduce NSSI can lead youth to disengage. Further, experts indicated youth may find it hard to recognize when therapeutic progress is being made. For example, if youth believe that progress is the cessation of NSSI, they may fail to see a reduction in the severity and/or frequency of NSSI as an improvement. This may also lead youth to feel that therapy is not helpful and youth may then disengage. As a result, experts advocated that rather than feeling compelled to close files when youth seem to be disengaged from services, clinicians should be empowered to try creative and different techniques for engagement, evaluate the fit between available services and youth needs or simply be available in case youth become ready to engage. Systems need to be child-centred; that is, systems need to empower clinicians to learn more from young people about what might be contributing to engagement, or lack thereof.

Experts advocated for support systems that empower practitioners to:

- Try creative and different techniques for engagement
- Evaluate the fit between services and youth needs
- Remain available as youth become ready to engage.

## Impacts of NSSI

### Family issues

Four of the five youth profiled experienced significant conflict with their parents or other family members. Cassidy’s social worker assessed her father as verbally and emotionally abusive. The social worker was also concerned that Cassidy’s family had “*unrealistic expectations*” and presented as “*uncompassionate about [her] mental health.*” Cassidy cited ongoing conflict as a reason for leaving the family home. Similarly, Opal experienced a “*significant disconnect*” from her parents. The disconnect became significant parent-teen conflict that led Opal to stay with much older friends and contributed to her NSSI and significant substance use. Lindsay was abruptly sent to live with a grandparent who was dismissive of her NSSI and mental health challenges, stating that Lindsay needed to “*get over it*” and stop taking psychiatric medication. Anna’s social worker noted that Anna spoke frequently of her love for her family but that she also stated that her family was a source of stress. Anna’s social worker was concerned that Anna’s NSSI and suicidal behaviours often occurred when she was at her family home. As the literature scan revealed, conflicts between parents and youth who engage in NSSI or dismissive attitudes may exacerbate NSSI.

On the other hand, Lindsay’s parents were very supportive and went to great lengths to meet Lindsay’s mental health needs and keep her safe from injury. Lindsay’s mother reportedly left her job in order to be with Lindsay 24 hours a day. Her family’s social worker described Lindsay’s mother as “*willing to do anything*” to keep Lindsay safe and as engaged in seeking mental health supports and safety planning for Lindsay. However, Lindsay’s NSSI behaviour and mental health challenges eventually became too



much for her mother to handle alone and Lindsay came into care via an SNA. Experts consulted by the Representative noted that parents often feel scared and overwhelmed when caring for youth with NSSI. They spoke of parents requesting inpatient treatment as a means of preventing further injury as well as questions around first aid for wounds inflicted through NSSI.

## Impact on Caregivers

Four of these young people were in care and one youth was supported by a Youth Agreement. Three young people were brought into care abruptly due to mental health concerns. For example, when Lindsay was 14-years-old, she attempted to jump out of a second-storey window. As a result, she was brought into care via an SNA and placed in a foster home. Very quickly, she was moved to inpatient care and then to an SRR with two staff with her at all times. Four of these youth were placed in SRRs and three of these youth were only ever placed in an SRR while one youth was placed in both foster homes and SRR. However, sometimes SRR staff were noted to struggle to meet the needs of these youth and to follow safety plans created by medical professionals. Vicarious trauma from witnessing and responding to the severe self-inflicted injuries of the youth was a common concern for foster parents and resource staff.

NSSI injuries reported between April 2018 and January 2020 revealed similar concerns. Safety concerns with a youth's placement were noted regularly for those youth with repeated NSSI. A safety issue related to staff behaviour or the resource itself (e.g., staff failing to respond appropriately to NSSI or staff failing to follow a plan of care) was noted for more than one-third (35 per cent) of youth with repeated NSSI but for only seven per cent of youth with one reported episode of NSSI. Almost half (47 per cent) of those with repeated NSSI and more than one third (39 per cent) of youth with one episode of NSSI experienced more than three placements during their time in care. Experts consulted by the Representative were concerned that foster parents and resource staff may not have the required training to feel confident that they can meet the needs of youth with NSSI. They suggested examining training in first aid, knowledge of trauma-informed principles and psychoeducation related to mental health and NSSI for paid caregivers.

Placement breakdown was a common theme among the stories of the five young people profiled. In many cases, foster parents were not able to meet their needs. For instance, Opal experienced four placement breakdowns in six months. After being placed in an SRR with intensive supports, Opal transitioned to living independently in her own apartment. However, within three months she was hospitalized for three weeks for mental health reasons and was transferred back to the same SRR. Experts consulted by the Representative noted that caregivers of youth with NSSI, particularly the severe injuries portrayed here, can experience vicarious trauma. They highlighted the need for specific trauma supports for caregivers since, currently, it is often the youth's mental health clinician who takes on responsibility for supporting caregivers.

The aggregate data and in-depth stories of youth with NSSI paint a picture of youth requiring multiple, complex and nuanced supports and services. Some youth engaged in repeated NSSI and those youth experienced other significant injuries. Youth were found to experience barriers to service, supports were sometimes inappropriate to the youth's needs or were withdrawn when youth's symptoms decreased or when youth were perceived as difficult to engage. Caregivers struggled to keep youth with NSSI safe, experienced burn-out and vicarious trauma. In some cases, youth with NSSI were placed in care with the hope that they would receive more intensive supports and be protected from harm, however paid caregivers also struggled to meet the complex needs of youth.

## Discussion

Available literature suggests that NSSI is common, more so for female children and youth, and peaks in adolescence. NSSI reported to the Representative, although more severe than is reported in most cases, follows many of the patterns and provides insight into youth with NSSI accessing services in B.C.

### Gaps in Services and Supports

Unfortunately, the results of research and case studies presented here reflect gaps in services and supports for youth who engage in NSSI. Research related to youth who engage in NSSI has outlined different interventions that reduce the occurrence of NSSI and associated symptoms. Research suggests that different but very individualized and intensive treatments can reduce the occurrence of NSSI.

In B.C., MCFD developed a comprehensive and responsive model of care for children and youth with complex care needs (CYCCN), the foundation of which is supposed to be widely accessible community-based quality services and supports. Ideally, these supports would include CYMH, as well as school counsellors, physicians, public health nurses and community agencies. CYCCN who are in care of MCFD may access the Provincial Outreach Program (POP) for CYCCN, Complex Care and Intervention Program (CCI), Complex Care Community Residential Resources (CCCRR), and the Complex Care Unit (CCU).<sup>21, 22, 23, 24</sup>

#### Services for CYCCN

The Representative is concerned that some important supports for CYCCN, such as CCI and CCCRR, are limited to children in care and therefore not meeting the broader needs of young people. MCFD has advised that, despite youth in care waiting for CCU services, there is rarely full occupancy of the beds (highest occupancy rate was reported to be 47 per cent). MCFD told the Representative that it has put expansion of CCI on hold to align the CCI with the ministry's other service delivery frameworks. Further, the ministry was not able to provide the Representative with a timeframe for expansion of these critically important services.

Currently, CYCCN are defined as (i) between the ages of 7 and 18 years, (ii) those who have co-occurring and persistent emotional, mental health, developmental and/or behavioural needs that cause functional impairment in the home, school or community, (iii) require specialized, integrated treatment and service plans that are individualized and typically involve multiple service systems and (iv) are in need of a high level of care and support to manage behaviour on a daily basis.<sup>xxx</sup>

<sup>21</sup> POP for CYCCN is intended to provide outreach and support to CYCCN Residential Resources, including their CCI and care teams.

<sup>22</sup> CCI provides caregivers with a thorough understanding of the challenges facing CYCCN, a trauma-informed method of assessment and a range of specific strategies and interventions to meet the unique needs of each child or youth. This is currently available in six SDAs with plans to expand (although timelines have not been set).

<sup>23</sup> Provincial Network of Care Beds are provided in a provincial site and community sites. Their role is to provide (i) short-term, intensive residential treatment programs for CYCCN, (ii) provide a comprehensive suite of therapeutic services, caregiver support and day programming and (iii) promote stability and support reintegration into family-based settings. Currently, there are four beds in two locations (Vernon and Prince George) with the intention that more be developed (although timelines have not been set).

<sup>24</sup> The CCU provides a highly structured and supportive environment and uses positive behavioural supports. Six beds are located in Burnaby (although the unit is rarely at full occupancy).

As children and youth who engage in NSSI often do so more than once, may have one or more mental health diagnoses, may have suicidal thoughts or have attempted suicide, and engage in NSSI as a social or emotional coping mechanism, they could benefit from a comprehensive model of care, similar to CYCCN. As experts consulted by the Representative pointed out, youth with NSSI experience functional impairment: they may be brought into care and separated from their families, school attendance may be hindered and they experience distress to the extent that they cope with self-injury. However, MCFD often excludes youth with the profile of mental health challenges outlined in this report from the model of care for CYCCN. Children and youth who access programs and services for CYCCN are often developmentally delayed or have an intellectual disability and, while some may engage in self-injurious behaviours, these programs and services have no psychiatric component, nor do they offer mental health interventions. The Maples is the one program of the CCI that does offer mental health interventions, such as CBT, and can be accessed by youth with NSSI. A model of care such as this, designed for youth with mental health needs, including NSSI, would be beneficial.

However, few of the case reviews included evidence that youth accessed any of the specialized programs or that services were coordinated.

## Barriers to Service

Case examples highlight difficulties with accessing necessary mental health services. For example, records indicate Kendra was referred to CYMH multiple times resulting in only cursory contact and little to no follow-up despite symptoms escalating in severity. Anna is noted to have experienced waitlists and, when she did receive CYMH services, she was labelled as difficult to engage and her file was closed. Lindsay was similarly labelled as unwilling to engage. Kendra, on the other hand, was noted to be seeking attention rather than genuinely manifesting mental health challenges. This echoes research findings that NSSI for social purposes can be seen by care providers as “*superficial*.” Cassidy did not receive CYMH services because she was receiving counselling support related to sexual violence. In all five cases, CYMH was involved but often the youth were labelled as “*not engaging*” or “*difficult to engage*,” often resulting in closure of the file. As noted by experts consulted, interventions must be evidence-based, but they must also be timely. Mental health programs with long waitlists, strict eligibility criteria and geographic restrictions can limit access by youth with NSSI.

The research literature describes NSSI as serving different functions – one that is social in nature and one that serves to help regulate emotions. This suggests that interventions must be informed by the function served, rather than be offered as “*one size fits all*.” Even though the ministry offers CYMH clinicians training in different treatment modalities, the cases reviewed here paint a picture of CYMH as restricted to one or two treatment modalities. In most cases, youth were offered DBT, even when they advocated for another form of treatment. For example, Cassidy was adamant that she did not want to engage in group DBT but there is no record that individual therapy was offered. In Opal’s case, she is reported to have found DBT beneficial, but her clinician felt she could not provide therapy that was “*intensive enough*.” Likewise, Kendra was offered DBT as a brief intervention. Lindsay has recently reported that DBT was not helpful and she would like to try cognitive behavioural therapy (CBT) but it is unclear whether this was available to her. Experts consulted by the Representative noted that DBT is often the only treatment modality available to youth with NSSI. They were concerned by this since, while DBT does demonstrate some efficacy, the size of the positive effect is sometimes minimal. Experts noted that B.C. practitioners are rarely able to offer “full” DBT; rather, they can offer some components.

## Specialized Supports

A large number of children and youth in B.C. who need mental health supports may benefit from community-based services, such as CYMH. However, those children and youth who need more intensive supports, such as those who engage in repeated NSSI, would benefit from a model of supports such as those for CYCCN.<sup>xxxii</sup> In three of the five cases reviewed here, no evidence was found that the youth were engaged in intensive, specialized programs. Records indicate that Lindsay, who presents with repeat NSSI and other serious mental health symptoms, received one complex case consult in 2018. Only Anna has evidence of any tertiary mental health services. Anna has been regularly receiving specialized supports through her health authority, plus the Developmental Disabilities Mental Health Team (DDMHT).<sup>25</sup> Further, at this time, several programs can only be accessed by children and youth in care, potentially creating an impetus for bringing youth who engage in NSSI into care, rather than providing support services in their homes.

### NSSI and schools

Experts noted that schools can be an important source of support for youth with NSSI and their caregivers. Schools are an ideal location for youth and their caregivers to learn about NSSI, its underlying causes, and positive responses. However, experts noted that, in their experience, schools can also foster negative reactions to NSSI and can exacerbate NSSI. Experts remembered situations in which youth with visible injuries or scars due to NSSI were sent home from school or asked by school staff to cover the scars. These negative reactions can serve to increase NSSI for some youth. Instead, clinicians and physicians can provide education to school staff who can then contextualize NSSI and foster understanding in other youth and caregivers.

## Support for Caregivers

Research presented in this review describes how caregivers can have an impact on children who are engaging in NSSI in and out of care.<sup>xix</sup> However, analysis of the five cases revealed minimal evidence of services and supports targeted towards caregivers, both before and after youth coming into care. Experts consulted by the Representative pointed out that even the most capable families will struggle to meet their child's needs during the crisis that can be presented by NSSI, particularly when the situation is complicated by lack of knowledge related to NSSI and service systems that are complicated to navigate.

<sup>25</sup> DDMHT provides mental health services for individuals aged 14 years or older who have developmental disabilities.

## Education for Caregivers Before Youth Enter into Care

Research indicates that caregiver attitudes surrounding NSSI can be associated with negative impacts on parent-child relationships, as well as on a parent's and youth's willingness to seek support.<sup>xix,xxi</sup> MCFD also recognizes the importance of family members and caregivers developing an understanding of a child's capacity and ability.<sup>xxiii</sup> However, in two of the cases, caregivers were noted to maintain unrealistic expectations of these youth. For example, Opal's parents were noted as being unsympathetic about Opal's mental health concerns and maintained "*unrealistic expectations for Opal at times*," while Lindsay's grandmother felt she just needed to be off of her medications and to "*get over it*." In both cases these attitudes were a factor in removal.

Taken together this data uncovers possible barriers for families and youth to access early intervention. These examples reflect research findings indicating that caregiver attitudes towards and reactions to NSSI (e.g., unsympathetic and dismissive) can act as barriers to seeking help or supports, which can increase NSSI behaviours in youth. Specifically, Lindsay and Cassidy's caregivers' attitudes were highlighted in the records as contributing to barriers to access the necessary services to keep these youth healthy. In addition, they highlight the importance of education geared towards the families of youth with complex mental health needs (e.g., behaviours, capacity) – a service that was not included in the mental health services for these families.

## Stress Reduction and Skill Building for Caregivers

Research and the Representative's data indicate that parent-teen conflict is a significant stressor for youth who engage in NSSI. The literature demonstrates that conflictual parent-child interactions may increase the likelihood of youth engaging in NSSI and prevent youth from seeking help from caregivers. In this review, parent-teen conflict was a stressor in four of five cases. In addition, parents frequently expressed feelings of frustration, exhaustion and helplessness as they tried to support their child's significant and complex needs. For example, at one point, Kendra's mother reportedly quit her job to care for Kendra full time, but she required additional support to meet Kendra's needs. Following the first reported NSSI incident, Kendra's family was referred to a residential-based family program. Unfortunately, shortly after commencing treatment, staff determined that the program was unable to meet Kendra's complex needs.

Lindsay's family's experience is also instructive as, despite being eligible to receive respite, the family did not receive respite support because her presentation was "*too complex*." The unavailability of respite played a prominent role in the subsequent decision to bring Lindsay into care, despite her mother's high level of commitment to caring for her at home. To access the supports Lindsay needed, her mother was required to enter into an SNA.

Currently, the CYCCN model of care states that family members and caregivers should develop the skills and strategies to support their youth who have complex care needs. Respite supports geared towards complex care for families may help to relieve some of the stress experienced by caregivers of youth who experience complex mental health needs and who engage in NSSI. Respite may also serve a dual role by providing time for parents to engage in education and skill building. However, there was minimal evidence of this being facilitated before youth entered MCFD care. As a result, caregiver support and skill-building opportunities may be imperative for supporting caregivers of youth engaging in NSSI. This may be an area for future inquiry and action.

## Support for Caregivers if Youth are in Care

All of the youth profiled in this review experienced an abrupt transition into care. Placement breakdown due to foster parents not being able to meet the youth's complex care needs was a shared experience. This was especially true for Opal who had four placement breakdowns between October 2016 and April 2017.

While most research focuses on parents of youth who self harm, it is likely that surrogate caregivers, such as foster parents or SRR staff, have significant influence on NSSI behaviour as well. When working with youth who engage in frequent, severe and sometimes critical NSSI, caregivers are responsible for supporting significant and often complex mental health needs. Most of the youth in this review were placed in an SRR. During their time in these placements, the amount and intensity of NSSI is concerning. For example, from the time Lindsay was initially placed in an SRR in November 2017 to January 2019, she had seven severe NSSI attempts (e.g., cuts requiring 20 stitches, ingesting 90 Tylenol).

This data highlights the importance of training for individuals responsible for caring for these children and youth. However, with the data available for review, it remains unclear what additional and ongoing training supports caregivers receive around trauma and medical intervention. Staff do not appear to be well-equipped to respond to these types of incidents, and there are no specific qualifications in place for individuals working within the complex care context (e.g., employing nurses specialized in mental health and trauma care). Training could also minimize the vicarious trauma experienced by caregivers of youth who engage in often severe NSSI and better support youth who experience repeated NSSI.

### Hospitalization for NSSI

As highlighted by the case examples, youth with NSSI are often hospitalized for these injuries and broader mental health concerns. Caregivers are often desperate for youth with NSSI to receive treatment in hospital. The Representative heard that caregivers are often unable to cope with the demands of keeping youth safe, along with other practical concerns, such as lack of wound care knowledge.

Experts consulted by the Representative cautioned that inpatient units are often not the best fit for youth with NSSI. Hospital staff are often limited in the interventions they can provide and, in many cases, discharge youth to the same context in which they were previously self-injuring. Without adequate bridging services between hospital-based and community-based services, the benefit of hospitalization for NSSI may be minimal. Further, for youth who have experienced personal and/or intergenerational trauma, hospitals can trigger or retraumatize youth.

## Trauma-Informed Support

Four of the five youth whose files were analyzed experienced significant sexual assaults, which is confirmed in the literature to be a risk factor for NSSI. While MCFD recognizes the importance of a system wide trauma-informed approach to delivering services and supports to children and families, this has yet to be integrated into child welfare practice. Increased awareness and capacity among MCFD staff and service providers to provide trauma-informed service and supports to children and families could reduce the occurrence of NSSI among the four youth who experienced trauma.

Trauma treatments or interventions can be very effective but take time and a client must be emotionally prepared to face their trauma. Currently, mental health systems that have long wait-lists pressure clinicians to provide brief interventions and to close files if a client is not ready for treatment (this can present as a youth who is not engaging). Further, effective interventions assume that clients have a safe base and safe people at home to support them through the treatment process. Often, youth with NSSI do not have this safe base, particularly if they are newly in care or are in a new placement. Many of the youth included here experienced multiple placements and were placed in staffed resources with rotating caregivers. When youth come into care for mental health reasons, they need to enter a therapeutic placement immediately and experts noted that these resources are rare in B.C. Experts urged MCFD to connect each child or youth who comes into care for mental health reasons with a clinician, even if youth do not display obvious symptom profiles that fit with CYMH intake criteria. Establishing a supportive relationship with a mental health clinician could mitigate some of the issues that develop as youth settle into care placements.

Full implementation of MCFD's Trauma-Informed Practice Guide would require considerable resources; however, it would increase the capacity among service providers to deliver robust, appropriate and accessible services to children with complex needs. Similarly, trauma can be one cause of NSSI and

### Step-up/step-down mental health services

Experts consulted by the Representative noted the need for a comprehensive system of services for youth, including step-up/step-down (SUSD) services. SUSD services are intended to fill a gap between hospital-based care and community based mental support and recognize that young people with significant mental health concerns may need different types and levels of care over time. For example, a youth with serious and acute NSSI may "step-up" from community mental health services to inpatient stabilization and then "step-down" to intensive day treatment before returning to community mental health services. SUSD services offer transitional care to support successful reintegration into community for those with mental health concerns. Case examples particularly highlighted this need for youth placed in staffed residential resources (SRR). It is often the case that staff do not have the training to implement plans of care developed by hospital-based medical and mental health practitioners. Resources in which staff rotate pose a particular challenge for youth with severe NSSI who require more specialized services. Experts explicitly stated that for a youth who has been hospitalized for severe NSSI, simply returning to an SRR is not a treatment plan. Although funding for 20 new SUSD beds and two intensive day treatment programs was allocated to MCFD in the 2019/20 fiscal year, these resources were not established. The ministry recently advised the Representative that it will no longer be creating these resources. Instead, the ministry plans to create high intensity outreach teams to follow young people as they transition between acute and community settings. RCY has requested additional information from the ministry on the rationale for this shift.

## Discussion

experts consulted by the Representative highlighted the need to understand those causes when treating youth. Experts noted that a functional analysis of NSSI can illuminate trauma and other causes and direct the type of treatment that may be effective.

## Culture and Community Connections

Opal and Cassidy both appear to have had their Indigenous heritage ignored by service providers. In Opal's case, she self-advocated and identified herself as Métis on multiple occasions, yet cultural planning never took place. Lindsay's First Nations identity appears to have been ignored entirely as she is described consistently as "*white*" or "*caucasian*." In all of these instances, this represents a violation of MCFD policy that directs practitioners to explore a child or youth's identity from initial point of contact.<sup>xxxv</sup>

Unlike Opal and Cassidy, Lindsay appears to enjoy strong cultural connection to her communities. However, this appears to be the result of the ongoing efforts of Lindsay's family as her care plan notes, "*at this time the family is in charge of maintaining cultural connection*." Anna's Eastern European cultural identity was never explored in her care plans.

Further, experts consulted by the Representative added that First Nations, Métis and Inuit youth may have a different path to mental health challenges, including NSSI, and their symptoms do not always neatly fit diagnostic criteria. First Nations, Métis and Inuit communities have been subject to historic and contemporary colonization that has led to intergenerational trauma, as well as personal trauma. Lack of trust in medical, child welfare and education systems is not uncommon in Indigenous communities. The systems that provide interventions to Indigenous youth with NSSI, therefore, must emphasize cultural safety.

It appears as if cultural connections were viewed as secondary considerations or less in face of the chaos and crisis experienced by these youth as responses disregarded the ways in which cultural connections could serve as protective factors for these youth with complex needs.

## Positive Outcomes

The literature scan, aggregate data and case studies explored here demonstrate that, while NSSI can be associated with suicidality and death, there can be positive outcomes. Research reveals that NSSI peaks in adolescence and tends to decline in adulthood, so it may be beneficial for family members and service providers to know that keeping youth with repeated NSSI alive is an end in and of itself. For example, after aging into adulthood, Kendra attended school and lives independently. Opal was connected to adult mental health; she was excited to turn 19 and celebrated with her care team. Similarly, parents and caregivers can influence the occurrence of NSSI. Those parents who react calmly and support youth through NSSI help to reduce its occurrence. This may be encouraging to those supporting youth who engage in NSSI and shape how systems support parents and other caregivers.

Research also demonstrates that prevention of trauma or early intervention after trauma could prevent the onset of NSSI. Current theory highlights heterogeneity within the population that engages in NSSI. For example, youth may engage in NSSI for different reasons, and understanding the function of NSSI can help remediate the behaviour. There are interventions that reduce NSSI and associated symptoms, such as emotion dysregulation.



## Future Directions

The analyses presented in this report highlight significant concerns and raise questions that should be considered in the development and delivery of services and in the policies and practices working to support these youth. Data presented here emphasize the complex needs of youth engaging in NSSI including mental health and adverse experiences.

### Opportunities for Systems Change

The Representative has previously identified a lack of adequate services and supports for children experiencing mental health and trauma.<sup>26</sup> In the current report, while injuries and trauma were common and youth had multiple mental health diagnoses, few of the five youth whose cases were reviewed accessed intensive services and supports.

#### “Not engaging”

Youth with NSSI experience barriers to services. The case examples highlighted another significant barrier: youth were often characterized as “not engaging” with services or practitioners. The experts consulted by the Representative also noted this as a recurring and concerning theme. Concerns were expressed that this places responsibility for the successful “fit” between a youth and a service on the youth, rather than recognizing this as a breakdown of the system. The data presented here, and the opinions of the experts, point to the need for a comprehensive and flexible system of supports. When asked if they could wave a magic wand and produce new services for youth with NSSI, experts wished for:

- Client-centred services with the flexibility to use different treatment modalities, such as animal therapy or movement therapies (this includes funding for these therapies)
- The normalization and “de-medicalization” of NSSI so that supports are provided outside of hospital units and without psychiatric medication
- More practitioners available to work with youth and practitioners who can work with caregivers of youth in care to prevent placement breakdown
- An increased emphasis on family therapy
- Services that bridge the gap between in-patient and community services.

Further, there was little evidence of trauma-informed care for youth with NSSI. MCFD has developed a Trauma-Informed Practice Guide for working with children, youth and families intended for leaders, system planners and practitioners.<sup>xxxvi</sup> In this context, trauma-informed practice (TIP) is operationalized as “integrating an understanding of trauma into all levels of care, system engagement, workforce development, agency policy, and interagency work.” It appears that complete integration of TIP across MCFD services, particularly for those serving youth with NSSI, is incomplete.<sup>27</sup> Further support for practitioners to gain knowledge in TIP and integrate this into all MCFD services would benefit not only youth with NSSI, but all youth receiving services.

<sup>26</sup> See *Missing Pieces: Joshua’s Story*, October 2017; *Tragedy in Waiting*, September 2016; *Trauma, Turmoil and Tragedy: Understanding the Needs of Children and Youth at Risk of Suicide and Self-Harm*, November 2012; *Who Protected Him? How B.C.’s Child Welfare System Failed One of Its Most Vulnerable Children*, February 2013; *Much More than Paperwork: Proper Planning Essential to Better Lives for B.C.’s Children in Care*, March 2013; *Still Waiting First-hand Experiences with Youth Mental Health Services in B.C.*, April 2013.

<sup>27</sup> The Representative was pleased to learn that TIP orientation webinars, materials and resources were made available for all staff on MCFD’s intranet.

## Future Directions

Results revealed several barriers to services including waitlists and limited treatment options. Case examples and consultation revealed that youth with NSSI may not have benefitted from available mental health programs and services. In all five case examples, CYMH was involved but youth were labelled as “*not engaging*” or “*difficult to engage*,” often resulting in closure of the file. These youth missed appointments or presented as difficult to work with. Furthermore, framing youth as the problem places the onus on those youth to conform to program requirements in order to access support.<sup>28</sup>

Experts described that currently clinicians are working in inflexible systems, overburdened by too many clients and too few personnel. As a result, they often respond to difficulties engaging clients by closing files, consequentially leaving vulnerable youth without support.

Increasing the number of community-based mental health programs, hiring more practitioners, and reducing exclusion criteria may serve to reduce barriers to service for youth with NSSI and other mental health concerns. Increasing flexibility in the types of interventions provided through mental health programs may also entice youth with NSSI to engage. Experts noted that DBT for NSSI is useful but that other therapies are also useful, as well as alternative treatment modalities, such as equine therapy.

## Early Intervention and Prevention

In many of the cases examined, youth engaging in NSSI were brought into care in order to access the services and supports they needed to stay safe. In one case, although the youth’s parents were dedicated to keeping her safe, they were unable to access appropriate supports. Analyses of the five case examples suggested minimal supports for the youth engaging in NSSI and their families prior to coming into care. Research suggests that a family’s understanding of NSSI and participation in interventions leads to improved outcomes.<sup>xxxvii</sup> Together these results highlight missed opportunities for prevention and intervention prior to these youth coming into care. Widespread education to reduce stigma related to NSSI is an important first step in preventing families from isolating when a youth is self-injuring. Further, psychoeducation for parents and other loved ones of youth who engage in NSSI would be beneficial.

For youth who are in care of MCFD, providing supports for foster parents and resource staff to increase knowledge of trauma and its effects, mental health diagnoses and first aid, as well as support to prevent or reduce the effects of vicarious trauma could increase confidence that caregivers can meet the needs of youth with NSSI and prevent placement breakdown. Further, during the Representative’s consultation with experts, it was noted that there are different models of care in staffed resources. Some resources operate similarly to foster homes with consistent caregivers, while others have rotating staff. This may impact youth-staff rapport/attachment, consistency in following care plans and/or staff training. Future research should explore any differential impact on NSSI of different caregiving arrangements.

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<sup>28</sup> The Representative notes that when clinicians describe clients as “not engaging” or “difficult to engage,” this is nuanced and usually has a long history of connection attempts. Mental health services are voluntary. Clinicians may have “chased” a client and attempted to remove barriers to service and that client may still decline service. At the same time, there are always youth on a waitlist who are ready and waiting to engage in service. Further, ethical considerations are important to keep in mind. After a client declines service a number of times, is it ethical to continue following up? A youth’s right to decline service needs to be respected, and often this is to the disappointment of loved ones, other care providers and the clinician themselves. The Representative recognizes the important and good work undertaken by practitioners and highlights this theme as one that presented consistently in the case reviews and as a systems issue that must be addressed by policy makers, rather than clinicians.

## NSSI and Indigenous Youth

Two of five case studies involved First Nations youth and a third youth was Métis. Almost half (47 per cent) of the youth with reported NSSI between April 2018 and January 2020 were First Nations and nine per cent were Métis. These rates are particularly high given that, according to Statistics Canada, First Nations people made up eight per cent of B.C.'s total population and Métis people made up two per cent of B.C.'s population. Rates of NSSI for Indigenous youth reported to the Representative mirror the research literature. A survey of Canadian post-secondary students (34,039 participants with a mean age of 22 years) revealed that First Nations, Métis and Inuit students were significantly more likely to engage in NSSI than their non-Indigenous peers. Similarly, Indigenous students were more likely to think about and/or attempt suicide and be diagnosed with depression or anxiety than non-Indigenous students.<sup>xxxiii</sup>

It is interesting that, in the aggregated data, higher numbers of non-Indigenous youth engaged in repeated NSSI, as compared to Indigenous youth. Could it be that First Nations and Métis youth access informal supports (e.g., in community or through their Nations) after a serious NSSI that prevent further self-injury? Alternately, it may be the case that NSSI for Indigenous youth is under-reported or reported as a different injury type (e.g., suicide attempts, substance-related harm or sexualized violence). NSSI reported to the Representative revealed that, for those with repeated NSSI, sexualized violence was commonly reported, particularly for First Nations and Métis youth. Future research should examine NSSI patterns specifically for First Nations and Métis youth receiving MCFD services, both for pathways to NSSI that may differ from their non-Indigenous counterparts, and for responses to NSSI.

### Land-based healing practices

Experts consulted by the Representative were concerned by not only the availability of current supports for youth with NSSI, but also the lack of variety. Experts noted that DBT is often the treatment modality available to youth with NSSI. DBT research does demonstrate some efficacy for this intervention, although the positive effect is sometimes minimal. Experts noted that B.C. practitioners are rarely able to offer “full” DBT; rather, they can offer some components.

Not only did experts want to see a flexible system of supports that match the needs of youth with NSSI, they stressed the importance of land-based healing practices for Indigenous youth. Some guiding principles and examples of land-based healing include:

- activities that are culturally safe
- connection to local Elders
- cultural and language camps because Indigenous languages are foundational to health
- honouring local strengths and resources: “building the expertise at home”
- traditional food harvesting projects (e.g., berry picking, fishing, trapping) which foster connection to traditional territories and land-based values.<sup>a</sup>

<sup>a</sup> First Nations Health Authority, *What is Land-Based Treatment and Healing?* <https://www.fnha.ca/Documents/FNHA-What-is-Land-Based-Treatment-and-Healing.pdf>, Aug. 14, 2020.

For those First Nations, Métis, and Inuit youth with NSSI receiving services, it is imperative that identity is explored (as is currently directed by policy) and cultural connections supported. Research suggests that communities that have worked to restore cultural practices disrupted by colonization protect against youth suicide.<sup>xxxix</sup> It is reasonable to assume that what protects against youth suicide may protect against NSSI, given its links to suicide and trauma. MCFD and other child-serving systems that support individual communities to develop their own culturally relevant supports may mitigate risk of youth NSSI.

## Conclusion

The Representative is dedicated to supporting the provision of comprehensive services to children experiencing NSSI and their families. She hopes that this report, while not directive in nature, fosters systemic change to support youth who engage in NSSI, as well as their families. Further, the Representative will continue to monitor NSSI reported for youth receiving services. For this reason, RCY will follow up in 2022 with an update on services for children and youth who self-harm. Data related to health authority supports and services, as well as school experiences will also be explored.

## Appendix A: Glossary

**Agreement with Young Adults (AYA):** financial support to young adults aged 19 to 26 who (a) will attend an educational or vocational training program and/or a rehabilitative or life skills program, and (b) before age 19, were in a YAG, in the continuing custody of MCFD or a DAA, or in the guardianship of the director of adoption or of a director under s. 51 of the *Infants Act*.

**Anxiety disorders:** fear or worry in the absence of danger. An anxiety disorder negatively impacts a person's life, including how that person thinks, acts or feels. There are different anxiety disorders, including:

- generalized anxiety: excessive worry about a number of everyday problems that persists for six months or more.
- panic disorder: repeated and unexpected panic attacks (sudden, intense fear that causes physical fear reactions, such as racing heartbeat, shortness of breath, nausea, etc.).
- phobias: intense fears of specific objects, animals or situations. Agoraphobia is a specific fear of being in a social situation and having a panic attack or other feelings of anxiety.

**Borderline Personality Disorder (BPD):** is an enduring way of interacting with the world, feeling and thinking that often result in impulsive actions and problems in relationships with others.

**Children and Youth with Complex Care Needs (CYCCN):** are (i) between the ages of 7 and 18 years, (ii) those who have co-occurring and persistent emotional, mental health, developmental and/or behavioural needs that cause functional impairment in the home, school or community, (iii) require specialized, integrated treatment and service plans that are individualized and typically involve multiple service systems and (iv) are in need of a high level of care and support to manage behaviour on a daily basis.

**Cognitive-behavioural therapy (CBT):** a psychosocial intervention in which unhelpful thoughts and patterns of behaviour are challenged, facilitating the development of positive coping and emotion regulation strategies.

**Command hallucinations:** instruct a person to act in a certain way, often in a way that causes harm to oneself or others.

**Complex Care Intervention program (CCI):** provides caregivers with a thorough understanding of the challenges facing CYCCN, a trauma-informed method of assessment and a range of specific strategies and interventions to meet the unique needs of each child or youth. Currently available in six SDAs with plans to expand.

**Complex Care Community Residential Resources (CCRR):** Provincial Network of Care Beds are provided in a provincial site and community sites. Their role is to provide (i) short-term, intensive residential treatment programs for CYCCN, (ii) provide a comprehensive suite of therapeutic services, caregiver support and day programming and (iii) promote stability and support reintegration into family-based settings. Currently, there are four beds in two locations (Vernon and Prince George) with more to be developed.

## Appendices

**Complex Care Unit (CCU):** provides a highly structured and supportive environment and uses positive behavioural supports. Six inpatient beds located in Burnaby.

**Complex trauma:** is the result of exposure to multiple traumas, often interpersonal traumas, that have wide-ranging and long-term negative effects on thinking and behaviour.

**Deliberate self-harm or non-suicidal self-injuries (NSSI):** the intentional and direct injuring of one's body without suicidal intent.

**Dialectical behaviour therapy (DBT):** a type of CBT that was originally developed to treat BPD. DBT assumes that some people react to the world in a more intense manner than others, become highly reactive more quickly than others and take longer to return to baseline levels of arousal than others. DBT has three main components: it helps a person identify their strengths and build on them; it identifies thoughts, beliefs and assumptions that spur intense emotional reactions (e.g., "I have to be perfect at everything"); and it requires attention to relationships, particularly between a therapist and client.

**Dialectical behaviour therapy – adolescent version (DBT-A):** DBT modified to meet the needs of adolescents.

**Major Depressive Disorder (MDD):** persistent low mood that often occurs with feelings of sadness, lack of enjoyment, hopelessness and irritability.

**Post-traumatic stress disorder (PTSD):** intense disturbing thoughts and feelings that occur after the experience of trauma.

**Provincial Outreach Program for CYCCN (POP for CYCCN):** provides outreach and support to CYCCN Residential Resources, including their CCI and care teams.

**Special Needs Agreement (SNA):** an agreement between the guardian of a child and MCFD in which MCFD assumes care of the child but not custody. The intent is to provide services and supports for children with special needs.

**Voluntary Care Agreement (VCA):** an agreement between the guardian of a child and MCFD when a parent is temporarily unable to look after a child in the family home in which MCFD assumes care of the child, but not guardianship.

**Youth Agreement (YAG):** provides assistance to youth ages 16- to 18-years-old when a youth cannot remain in their family home. The youth is not in the care of MCFD but MCFD provides financial assistance and works with the youth to create a plan for independence.

## Appendix B: Methods and Limitations

### Reporting Critical Injuries and Deaths to the Representative

Reviewable services are those provided under the *Child, Family and Community Service Act*,<sup>29</sup> the *Youth Justice Act*, mental health services and addiction services.<sup>30</sup> The Representative has a mandate to review all critical injuries and deaths of children and youth who are (a) receiving reviewable services, (b) have received reviewable services within the 12 months prior to the critical injury or death and (c) whose families are receiving or were receiving reviewable services within the 12 months prior to the injury or death (e.g., family support services).

To this end, the *RCY Act* directs reviewable service providers to report all critical injuries and deaths for the above-mentioned population. Under the *RCY Act*, a critical injury is defined as one that results in, or has the potential to cause, serious or long-term impairment. Serious or long-term impairment is when an injury has, or could in the future, prevent a child or youth from carrying out their usual day-to-day activities or when the child or youth requires or could require considerable support to carry out their usual day-to-day activities as a result of the injury. This is interpreted to include physical and emotional injuries. For example, a child or youth who loses a parent by way of an overdose would be considered to have experienced an emotional injury.

### Injury and Death Data at RCY

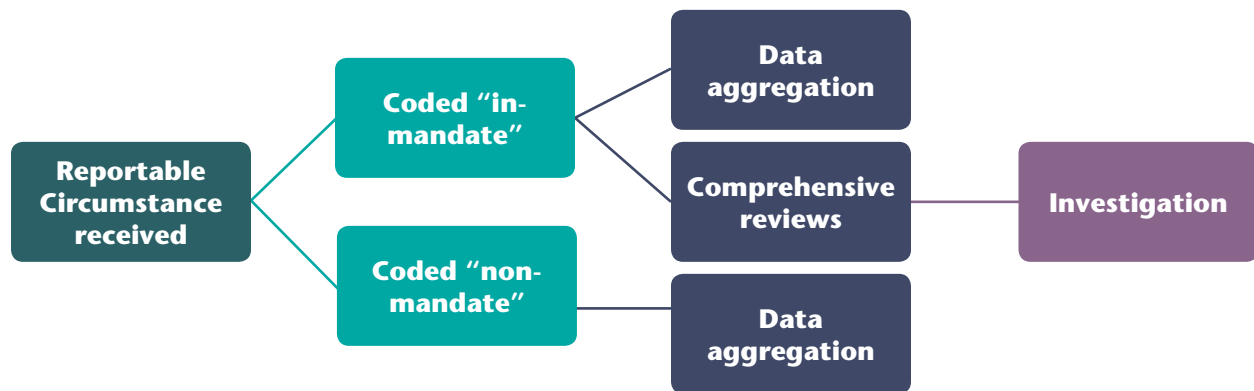
Critical injuries or deaths are reported to the Representative using a reportable circumstance form (RC) that is completed and submitted electronically. Reports include a youth's demographic information (e.g., birth date, gender, Indigenous nation), location (e.g., where the child or youth was living, where the child or youth was injured, where the child or youth received services), living arrangement at the time of injury (e.g., family home, foster home), the reviewable services involved with the child or youth (e.g., child protection, mental health services, etc.), the child or youth's history of services (e.g., date at which services became involved and for what reasons), a description of the injury or death and the response of the service providers (e.g., a safety plan is developed for a youth who expresses suicidal ideation).

When injury reports are received by the Representative, the information related to an injury is entered into RCY's case management system. Analysts conduct an initial review to determine whether reports meet the Representative's mandate under the *RCY Act*.

<sup>29</sup> These include the three service areas of MCFD: child protection, Child and Youth Mental Health and Children and Youth with Special Needs.

<sup>30</sup> *Representative for Children and Youth Act*, SBC 2006, c. 29.

Appendix B Figure 1: Pathway of reportable circumstances for research<sup>31</sup>



As part of the initial review, analysts examine the incident description and code the injury into one of nine categories, or death into one of five categories, based on the description provided (see Appendix A for all definitions). A review of relevant records in MCFD’s electronic system, ICM, is also conducted.<sup>32</sup> Operational definitions are followed for coding to increase reliability and validity.<sup>33</sup> Prior to the current data analysis, an analyst conducted quality assurance to ensure reliable and valid coding (e.g., ensuring clear NSSI with no evidence of suicidal ideation and that data was not mis-coded as a suicide attempt).

## Limitations

The Representative acknowledges that there are limitations to this type of research. First, focusing on injuries and deaths ignores instances in which children and youth were kept safe and may produce a blame culture in which social workers or service providers become the focus of intense scrutiny thereby removing the focus from systems and structures that uphold and reproduce circumstances of situated vulnerability. The Representative sought to overcome this limitation by focusing on systems characteristics, rather than individual practice.

This study is also based on administrative data, and thus privileges the voices of service providers, rather than those of children, families and communities. MCFD reporting policy is different for children and youth in care, as opposed to children and youth receiving other services. The threshold for considering an injury serious enough to report is lower for children in care than for those out of care. Therefore, the Representative is unable to compare rates of injury between those in and out of care.

The Representative reviewed all files related to MCFD service involvement for the five case examples. While these are comprehensive, they are still limited to information that practitioners record. Lastly, there may be variation with reporting compliance by region and service stream, which may impact the results presented in this report.

<sup>31</sup> The Representative’s staff can also take immediate action when needed, based on the information in an injury report. A child or youth may be referred to an RCY advocate or the case may be brought to the attention of the Provincial Director of Child Welfare.

<sup>32</sup> An initial review of electronic records includes case opening and/or closing recording, relevant case notes, relevant memos, incidents and service requests, and the Care Plan (for those children and youth in care).

<sup>33</sup> In this case, “reliability” refers to the chances that the same injury will be coded the same way by different raters and “validity” refers to the chance that an injury is correctly coded.



Finally, this report privileges practitioner voice over youth voice as all reports of injuries and deaths were submitted by practitioners. While analysts read reports carefully to determine a youth's perspective on an injury (e.g., in a report in which a youth ingested substances, analysts examine the incident description to determine whether this was a substance-related injury or a suicide attempt), this is not always included in the report. In cases in which there was some ambiguity as to whether an injury was NSSI or a suicide attempt, analysts examined the Reportable Circumstance form and notes on ICM carefully. In cases in which youth were noted to express suicidal intent, the injury was coded as a suicide attempt. A limitation of this report is that there may be cases classified incorrectly. Youth engagement and youth perspective is vital to understanding and gauging the effectiveness of services that youth receive from MCFD and various other agencies. The Representative is currently exploring a youth engagement strategy that considers the ethical implications of working with youth who have experienced significant trauma.

Despite these limitations, the Representative offers this exploratory data in an effort to improve systems and supports for youth with NSSI.

## Appendix C: Multidisciplinary Team Members

1. Dr. Tyler Black, MD FRCPC – Medical Director, Child and Adolescent Psychiatric Emergency Department, BC Children’s Hospital
2. Catherine Casey, MSc Psychology – Clinician, Child and Youth Mental Health Services, MCFD
3. Amber Lowdermilk, MCP, RCC – Mental Health Clinician, MCFD
4. Dr. Mary K. Nixon, MD, FRCPC – Clinical Associate Professor, Department of Psychiatry, University of British Columbia
5. Lori Raible – Parent in Residence, FamilySmart
6. Julia Sangha, MA, RCC – Mental Health Clinician, Child and Youth Mental Health, MCFD
7. Alex Scheiber – Deputy Director of Child Welfare, MCFD
8. Dr. Cornelia (Nel) Wieman, MSc, MD, FRCPC – Acting Deputy Chief Medical Officer, Office of the Chief Medical Officer, First Nations Health Authority

## Endnotes

- <sup>i</sup> Mary K. Nixon, “Understanding self-injury in young people: A clinician-researcher’s approach,” *Visions: B.C.’s Mental Health and Addictions Journal*, 17, 2 (2017): 5-7, <https://www.heretohelp.bc.ca/visions/young-people-self-injury-vol13/understanding-self-injury-in-young-people>.
- <sup>ii</sup> E. David Klonsky, “The functions of deliberate self-injury: A review of the evidence,” *Clinical Psychology Review*, 27, 2 (March 2007): 227-239.
- <sup>iii</sup> Michelle Lauw, Choon How How, & Cheryl Loh, “Deliberate self-harm in adolescents,” *Singapore Medical Journal*, 56, 6 (June 2015): 306-309.
- <sup>iv</sup> Jennifer J. Muehlenkamp, Laurence Claes, Lindsey Havertape, & Paul P. Plener, “International prevalence of adolescent non-suicidal self-injury and deliberate self-harm,” *Child & Adolescent Psychiatry & Mental Health*, 6 (March 2012): 10-19.
- <sup>v</sup> Helen Bergen, Keith Hawton, Keith Waters, Jennifer Ness, Jayne Cooper, Sarah Steeg, & Navneet Kapur, “How do methods of non-fatal self-harm relate to eventual suicide?” *Journal of Affective Disorders*, 136, 3 (February 2012): 526-533.
- <sup>vi</sup> Margaret S. Andover, Blair W. Morris, Abigail Wren, & Margaux E. Bruzese, “The co-occurrence of non-suicidal self-injury and attempted suicide among adolescents: Distinguishing risk factors and psychosocial correlates,” *Child & Adolescent Psychiatry and Mental Health*, 6 (March 2012): 11-18.
- <sup>vii</sup> Kate H. Bentley, Clair F. Cassiello-Robbins, Lisa Vittorio, Shannon Sauer-Zavala, & David H. Barlow, “The association between nonsuicidal self-injury and the emotional disorders: A meta-analytic review,” *Clinical Psychology Review*, 37 (April 2015): 72-88.
- <sup>viii</sup> Mary K. Nixon, Paula Cloutier, & S. Mikael Jansson, “Nonsuicidal self-harm in youth: A population-based survey,” *Canadian Medical Association Journal*, 178, 3 (January 2008): 306-312. DOI:10.1503/cmaj.061693
- <sup>ix</sup> Matthew K. Nock & Mitchell J. Prinstein, “A functional approach to the assessment of self-mutilative behaviour,” *Journal of Consulting and Clinical Psychology*, 72, 5 (2004): 885-890.
- <sup>x</sup> McCreary Centre Society, *Balance and Connection in B.C.: The Health and Well-Being of Our Youth* (Vancouver, B.C.: McCreary Centre Society): 2019.
- <sup>xi</sup> Rhiannon E. Evans, “Survival, signaling, and security: Foster carers’ and residential carers’ accounts of self-harming practices among children and young people in care,” *Qualitative Health Research*, 28, 6 (May 2018): 939-949.
- <sup>xii</sup> Elise N. Titelius, Emily Cook, Jayson Spas, Lindsay Orchowski, Katie Kivisto, Kimberly O’Brien et al., “Emotion dysregulation mediates the relationship between child maltreatment and non-suicidal self-injury,” *Journal of Aggression, Maltreatment & Trauma*, 27, 3 (2018): 323-331.
- <sup>xiii</sup> Nicola Madge, Keith Hawton, Elaine M. McMahon, Paul Corcoran, Diego De Leo, Erik Jan de Wilde, et al, “Psychological characteristics, stressful life events and deliberate self-harm: Findings from the Child & Adolescent Self-harm in Europe (CASE) study,” *European Child and Adolescent Psychiatry*, 20, 10 (October 2011): 499-508.
- <sup>xiv</sup> Shilpa Aggarwal, George Patton, Nicola Reavley, Shreenivas A. Sreenivasan, & Michael Berk, “Youth self-harm in low- and middle-income countries: Systematic review of the risk and protective factors,” *International Journal of Social Psychiatry*, 63, 4 (March 2017): 359-375.
- <sup>xv</sup> Jennifer J. Muehlenkamp, Laurence Claes, Lindsey Havertape, & Paul P. Plener, “International prevalence of adolescent non-suicidal self-injury and deliberate self-harm,” *Child & Adolescent Psychiatry & Mental Health*, 6 (March 2012): 10-19.
- <sup>xvi</sup> McCreary Centre Society, *Balance and Connection in B.C.: The Health and Well-Being of Our Youth* (Vancouver, B.C.: McCreary Centre Society): 2019.
- <sup>xvii</sup> Marco Bennardi, Elaine McMahon, Paul Corcoran, Eve Griffin, & Ella Arensman, “Risk of repeated self-harm and associated factors in children, adolescents, and young adults,” *BMC Psychiatry*, 16 (November 2016): 421-433.
- <sup>xviii</sup> Marco Bennardi, Elaine McMahon, Paul Corcoran, Eve Griffin, & Ella Arensman, “Risk of repeated self-harm and associated factors in children, adolescents, and young adults,” *BMC Psychiatry*, 16 (November 2016): 421-433.
- <sup>xix</sup> Jennifer Bethell, Susan J. Bondy, W.Y. Wendy Lou, Astrid Guttmann, & Anne E. Rhodes, “Emergency department presentations for self-harm among Ontario youth,” *Canadian Journal of Public Health*, 104, 2 (March/April 2013): e124-e130.
- <sup>xx</sup> Imke Baetens, Laurence Claes, Patrick Onghena, Hans Grietens, Karla Van Leeuwen, Ciska Pieters, et al., “Non-suicidal self-injury in adolescence: A longitudinal study of the relationship between NSSI, psychological distress and perceived parenting,” *Journal of Adolescence*, 37, 6 (August 2014): 817-826.

## Endnotes

- xxi McCreary Centre Society, *Balance and Connection in B.C.: The Health and Well-Being of Our Youth* (Vancouver, B.C.: McCreary Centre Society): 2019.
- xxii Sophie Curtis, Pinar Thorn, Alison McRoberts, Sarah Hetrick, Simon Rice, & Jo Robinson, "Caring for young people who self-harm: A review of perspectives from families and young people," *International Journal of Environmental Research and Public Health*, 15, 5 (May 2018): 950-964.
- xxiii Ruth Wadman, Panos Vostanis, Kapil Sayal, Pallab Majumder, Caroline Harroe, David Clarke, et al., "An interpretive phenomenological analysis of young people's self-harm in the context of interpersonal stressors and supports: Parents, peers, and clinical services," *Social Science & Medicine*, 212 (September 2018): 120-128.
- xxiv Kim Yurkowski, Jodi Martin, Christine Levesque, Jean-François Bureau, Marie-France Lafontaine, & Paula Cloutier, "Emotion dysregulation mediates the influence of relationship difficulties on non-suicidal self-injury behaviour in young adults," *Psychiatry Research*, 228, 3 (August 2015): 871-878.
- xxv Joy Gabrielli, Erin P. Hambrick, Angela M. Tunno, Yo Jackson, Amanda Spangler, & Rebecca M. Kanine, "Longitudinal assessment of self-harm statements of youth in foster care: Rates, reporters, and related factors," *Child Psychiatry and Human Development*, 46, 6 (December 2015): 893-902.
- xxvi Jeffrey Grenville, Deborah Goodman, & Alison K. MacPherson, "Characteristics of self-harm behaviour among identified self-harming youth in care," *International Journal of Mental Health & Addiction*, 10, 5 (October 2012): 646-659.
- xxvii Sarah E. Hetrick, Jo Robinson, Matthew J. Spittal, & Greg Carter, "Effective psychological and psychosocial approaches to reduce repetition of self-harm: A systematic review, meta-analysis and meta-regression," *BMJ Open*, 6, 9 (September 2016): 1-14.
- xxviii Réal Labelle, Louise Pouliot, & Alain Janelle, "A systematic review and meta-analysis of cognitive behavioural treatments for suicidal and self-harm behaviours in adolescents," *Canadian Psychology*, 56, 4 (November 2015): 368-378.
- xxix Karen Michelle Hunnicutt Hollenbaugh & A. Stephen Lenz, "Preliminary evidence for the effectiveness of dialectical behaviour therapy for adolescents," *Journal of Counseling & Development*, 96 (April 2018): 119-131.
- xxx MCFD, *Children and Youth with Complex Care Needs Policy* (Victoria, B.C.: MCFD), July 2014.
- xxxi MCFD, *Children and Youth with Complex Care Needs Policy* (Victoria, B.C.: MCFD), July 2014.
- xxxii MCFD, *Model of Care for Children and Youth Experiencing Complex Care Needs* (Victoria, B.C.: MCFD), July 2015.
- xxxiii Canada. Ministry of Child and Family Development. Model of Care for Children and Youth Experiencing Complex Care Needs. British Columbia: Ministry of Children and Family Development, 2016. <https://intranet.gov.bc.ca/assets/download/02872CAFDBE642DA9D32D87AE959715C>
- xxxiv MCFD, *Healing Families, Helping Systems: A Trauma-Informed Practice Guide for Working With Children, Youth, and Families* (Victoria, B.C.: MCFD): November 2016.
- xxxv MCFD, Policy 1.1 *Working with Indigenous Children, Youth, Families and Communities* (Victoria, B.C.: MCFD), 2020.
- xxxvi MCFD, *Healing Families, Helping Systems: A Trauma-Informed Practice Guide for Working With Children, Youth, and Families* (Victoria, B.C.: MCFD): November 2016.
- xxxvii Mary K. Nixon, "Understanding self-injury in young people: A clinician-researcher's approach," *Visions: B.C.'s Mental Health and Addictions Journal*, 17, 2 (2017): 5-7. <https://www.heretohelp.bc.ca/visions/young-people-self-injury-vol13/understanding-self-injury-in-young-people>.
- xxxviii Nolan K. Hop Wo, Kelly K. Anderson, Lloy Wylie, & Arlene MacDougall, "The prevalence of distress, depression, anxiety, and substance use issues among Indigenous post-secondary students in Canada," *Transcultural Psychiatry*, 57, 2 (October 2019): 263-274. DOI: 10.1177/1363461519861824 journals.sagepub.com/home/tps
- xxxix Michael J. Chandler & Christopher Lalonde, "Cultural continuity as a hedge against suicide in Canada's First Nations," *Transcultural Psychiatry*, 35, 2 (1998): 1-20. <https://doi.org/10.1177/136346159803500202>

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